Complexity and Context:
Staff Support Systems in Mental Health after Critical Incidents and Traumatic Events

Carole Adamson

A thesis presented in fulfilment of the requirement for the degree of Doctor of Philosophy in Social Work, School of Sociology, Social Policy and Social Work, Massey University, Wellington, New Zealand (2005)

2

Abstract

This thesis presents an ecological exploration of the experiences of mental health workers faced with critical incidents and traumatic events in the course of their work. A qualitative study, it takes the experiences of twenty workers from a range of disciplines and environments, and examines their preparation for exposure to extreme stress, their passage through the incidents that they chose to relate, and the organisational response to the events.

The central research question explores the knowledge bases currently utilised within trauma and critical incident response, and the degree to which these provide adequate explanatory, practice and evaluation models for responses to workplace incidents. It is examined through the narratives of the mental health workers, who self-define and explore the nature of their preparation for, and experience of, critical incidents and traumatic events in their workplace. The question is contextualised through a review of the knowledge bases of trauma and extreme stress, and of the mental health environment in which the workers practice. A case study of the workplace support known as debriefing illustrates the tensions between current knowledge bases in the area. Informed by this, the key issues of what did or did not work for the participants are explored.

The thesis argues that the paradigm shift signalled by the latest developments within conceptualisations of trauma is not yet complete, and that the ensuing tensions have created debate and confusion in the creation of adequate responses to workplace incidents. Whilst conceptualisations that attempt to address issues of complexity and context are evolving, it is argued that an ecological framework has the potential to both explain and respond to incidents that occur within the mental health environment.

The findings of the research raise issues of complexity in the design and implementation of appropriate support systems, and lend a perspective to the critique of debriefing that has been missing from existing debates. Key principles for the development of safe and sound support systems, and their evaluation, are developed.

Acknowledgements

Like its content, the writing process of this thesis has been an ecological journey, with a debt of gratitude owed to the following, without whose inspiration, wisdom and support, there would have been no research at all.

To the tangata whaiora, who are the reasons why we work in mental health;

To the participants in the research, whose voices, I hope, speak loud and clear in our desire to make the work the best it can be, and the workplace the healthiest;

To my supervisors, Professor Robyn Munford and Associate Professor Mike O'Brien, for their support, affirmation and encouragement over so many years; and

To my family, Katharine, Jessica, Edna, Agnes, Mouse and Tutaenui, for providing unconditional love and the right amount of fur.

Table of contents

Tables and Illustrations

Glossary

ACC: The state compensation and insurance system within Aotearoa New Zealand.

ACISA: Australasian Critical Incident Stress Association.

ANZAC: The Australian and New Zealand Army Corps.

Aotearoa New Zealand: the bicultural term for New Zealand. Aotearoa is usually translated into English as 'land of the long white cloud'.

ASTSS: Australasian Society for Traumatic Stress Studies.

Burnout: see Appendix 4.

CBT: Cognitive Behavioural Therapy.

CMHT: Community Mental Health Team.

Compassion Fatigue: see Appendix 4.

Countertransference: see Appendix 4.

CSW: Community Support Worker.

DESNOS: Disorders of Extreme Stress Not Otherwise Specified.

DHB: District Health Board, a regional provider of Health Services in Aotearoa New Zealand.

EAP: Employee Assistance Programmes. Occupational support systems provided usually within larger organisations, and usually provided by external providers.

ESTSS: European Society for Traumatic Stress Studies

Fono: Samoan term for whanau, or extended family.

Hapu: Sub-tribe.

Hinengaro: Mind.

ICISF: International Critical Incident Stress Foundation.

ISTSS: International Society for Traumatic Stress Studies.

Iwi: Tribe; people.

Karakia: Prayer

Karanga: Call of welcome onto a marae.

Kaumatua: Elders.

Kaupapa: Policy; matter for discussion.

Kaupapa Maori: Policy and procedure from a Maori perspective.

Kawa: Protocols and process.

Mana: Authority, prestige, power.

Marae: The meeting place of the whanau or hapu, where decision-making and other family and community events occur.

Pakeha: New Zealand people of European ethnicity.

Rangatiratanga: Authority, control (of).

Ritenga: Practice, custom.

Rongoa: Medications, cures.

Tangihanga: funeral, a process of mourning.

Tauiwi: Peoples from elsewhere, non-Maori residents of Aotearoa New Zealand defined in relation to Maori.

Tangata Whaiora: Mental Health consumers, 'people moving towards wellness'.

Tangata Whenua: 'people of the land', the indigenous peoples of Aotearoa New Zealand.

Tangi: cry; grieving; funeral.

Tangihanga: funeral; wake.

Tapu: sacred; prohibited.

Taro: a root vegetable and staple diet of many Pacific communities.

Te Tiriti (O Waitangi)/The Treaty of Waitangi: The founding document of Aotearoa New Zealand that lays out the terms of the relationship between Iwi Maori and the Crown.

Tikanga: correct procedure; method; practice.

Tinana: Body.

Tohunga: Skilled person, expert.

Vicarious traumatisation: see Appendix 4.

Waiata: Song; traditional chant.

Waka: Canoe.

Whanau: (Extended) family.

Whanaungatanga: The process of establishing and maintaining connection between people.

Whare: House; specifically at times, the wharenui, or meeting house, on a marae.

Wairua: Spirit.

Chapter One: Introduction

Introducing the research question

> Do people have the right to expect support when their own resources are inadequate, or do they have to live with their suffering and not expect any particular compensation for their pain? Are people encouraged to attend to their pain (and learn from the past), or should they cultivate a 'stiff upper lip', which does not allow them to reflect on the meaning of their experience?
>
> van der Kolk (1996a:xi)

This study takes the testimonies of twenty mental health workers whom I interviewed about critical incidents and traumatic events experienced in the course of their work. It explores their recollection of being in crisis or under extreme stress, and their perception of the response of their work environment to their needs. Its essential question is 'what worked for them?' It is a qualitative study borne out of a professional and political conviction that organisations must share the responsibility for the impact of work conducted within them.

The thesis argues that responses to traumatic events and critical incidents in the workplace require a dynamic, transtheoretical approach that can navigate the complex interface between personal and organisational reactions, responses and coping strategies, and between ambient stress levels and acute or traumatic stress. This interface will determine the nature and efficacy of organisationally based support systems. A fundamental premise alongside this is that all theoretical paradigms develop strength out of their interaction with others. My argument is that a reliance on single perspectives and approaches is likely to undermine complex interventions in complex environments.

The span of my social work career (from residential child care, child protection social work, community development, and finally to mental health) granted me opportunity to experience vicariously the stresses and traumas within the lives of the users of these services, to recognise with greater clarity the complexity, and systemic and structural components of people's lives, and to observe at first hand (for myself and others) both the acute and enduring impact on those choosing to work in the human services. Stress and trauma has appeared as a common factor across all the fields of practice and all the contexts in which I

worked. Systems for staff support, if in existence, did not appear to address the complexities of the work environment, and my own practice thinking began to focus upon the structural and systemic requirements that enabled safe and sound support systems to function.

A story from my own experience illustrates this drive towards understanding and appropriate intervention:

> *Within a secure mental health setting, one of the residents was found dead in bed one morning. As the social worker with links with the family, I was called to the unit for the task of informing the nearest relative. All staff were aware of the potential volatility of this task, as they had had prior encounters with the family, who had their own history of trauma. It was assumed (rightly) that a natural death, as it later turned out, would be misinterpreted as staff-on-patient assault. The escorted walk to the nurses' station went past the deceased's bedroom. Without waiting for my consent, the senior nurse accompanying me said, "You'll want to pay your respects, won't you?", and opened the door. I then immediately had to ring up the relative (a visit to the family home some distance away was not permitted), in a crowded office, convey the information, and then join in with the general flow of reaction and planning within the assembled team. At no point was there any acknowledgement of the stressors involved in this process. To be fair, the stress levels of all concerned were high. But it didn't feel fair.*

The personal and professional aftermath of this incident remained unexplored within a work context, with neither staff debriefing nor safe forum for my raising the inappropriateness of my being exposed to the corpse, lying as it was in the position of death, immediately prior to informing the relatives. At the time, no social work supervision existed that would have enabled exploration of my reactions to this, to my client's death, or to the considerable impact on a family already riven by an horrific past. Sense-making processes such as a gender analysis (I was the only female involved) or a structural analysis (I was the only social worker) could only be invoked by me personally without the benefit of weighing my meaning against that of others. Situations like this have determined my interest in the area of staff support systems.

My choice of research question for this thesis is a logical continuation of the mental health work in which I have been immersed. My experience within the mental health field instigated a desire to return something to the environments that had given me so much experience, pain and joy. I bring with me the 'fire in

my belly'[1] in regard to support for staff in their exposure to the distress and anger of consumers. With this commitment to practice comes a political and personal desire for change, to construct some workable solutions to the personal, systemic and structural barriers to organisational supports for staff within human services. My primary assumption is that in making the workplace a safe and sound environment, it in turn enriches the practice with those for whom the services exist, the mental health consumer.

The experience recounted above was also balanced by times where I have felt that it is possible, within these charged working environments, to conduct things properly, so that experiences are validated and participants enriched, in the true meaning of crisis as both 'danger' and 'opportunity'[2]. This illustration is again from my work experience. Again, like many of the incidents recounted in the course of the thesis, this is about a death.

> *One morning at about 7am, my children and I were at breakfast. Our hospital house looked over a paddock with a clear view of the hospital buildings. I could see a man standing in the pouring rain, holding an umbrella over a low mound on the grass. The mound was a body. Other neighbours were beginning to converge on the scene. Due to the age of my children, I stayed at home. Later I learned that one of the residents had 'done a runner' with a friend in the middle of the night, and during a moment when they thought they had been detected, they separated: his companion returned to the villa. The dead man had apparently had a heart attack whilst he, too, was heading back. Previous deaths at the hospital had resulted in the body laying at the funeral home off campus; however this time another approach prevailed, and he was returned to the chapel at the hospital and to a tangi. The tangihanga allowed for the dead man to be surrounded by friends. People became mourners, not patients and staff. Grief was shared, and comfort was given to his fellow absconder, who had been demonstrating a degree of remorse and self-perceived culpability for the death. My children, curious about the event, became small parts of this process.*

To me, this experience represented a reconnection after the shattering of life that is death. Compared to the previous incident, where grief and stress levels were privatised and hidden, it opened up the healing opportunities and, I

---

[1] This phrase is attributed to Professor Fraser of Massey University and handed down through the social science research tradition. Munford uses it to refer to the passion with which social work educators manage the competing demands of the profession and its stakeholders (Munford, 2003). Without this passion there is no soul within the work, and no integrity in the outcome.

[2] This conceptualisation of crisis emerges from the Chinese pictograms for crisis, depicted in Illustration 5.1.

believe as a participant, strengthened the hospital community. It affirmed the possibilities for the appropriate management of critical incidents and laid the foundation for this research.

My choice of subject matter should be opened to scrutiny. Why would anyone *choose* to spend years of time and energy on a study that explores the vicarious experience of other peoples' distress and trauma, and which inevitably has touched and changed me? My personal answer is an extension of the reasons for my career choice of social work. People and their experiences fascinate me. I find myself drawn to participating in those intense events and situations into which I neither expect nor desire my own personal life to lead. My career has been notable for employment in areas of human confinement, in child and adolescent care facilities, adolescent and adult mental health, acute and forensic psychiatry. My commitment seems to have been one of maximising the opportunities for those who become part of these systems, without, I hope, losing the profound political and emotional distaste that I have for some of the restrictions of these environments.

My choice of research in the area of human distress and trauma does not make for easy party conversation. For a practising social worker in Aotearoa New Zealand, a doctorate is not only unnecessary, but may be, as Irwin (1994) suggests, a positive disadvantage. It is equally a potentially indigestible admission to acknowledge that I positively enjoy the topic. I find the challenges that stress and trauma produce to be life-altering and life-affirming. My profound belief in the resilience of the human spirit, and in the appropriateness of forging alliances to overcome adversity, balances accusations of voyeurism that could easily be levelled at my intervention in someone else's crisis. Simply, I believe, as Bloom and Reichert (1998) argue, that seeking understanding, bearing witness, and devising strategies for change are part of the social and political struggle to create a better world.

I believe in a transformative process within my profession of social work and in the wider field of support for human beings in times of change, transition and distress. Two of the currently most influential researchers, thinkers and practitioners in the field echo this imperative:

> Why is the issue of suffering so important? It is the means through which both personal and social conceptions of knowledge and meaning are created. Ideally, the capacity for empathy and shared purpose is the ultimate product of this process. The paradox is that in the process of accepting the reality of trauma, it is easy to lose one's sensitivity and to

> retreat into dry scientific observation or cynical capitulation. However, beneath the tidiness of emotional distancing and scientific classification lie the human vitality and energy to struggle against, and to create meaning out of, what appears to be the random cruelty of fate. This struggle to transcend the effects of trauma is among the noblest aspects of human history.
>
> McFarlane & van der Kolk (1996a: 573-4)

The end result of this intellectual and personal immersion into other people's trauma thus centres upon the improvement in human rights within workplace situations of extreme stress.

Introducing the participants

The voices of the respondents in this study emerge in Chapters Eight and Nine, following contextual consideration of literature and the mental health workplace environment. As the unseen research companions of the literature, their commentaries provide the unique material by which we can gain fresh understanding of workplace incidents and best practice in organisational response. All twenty participants were currently employed within mental health services, all but one in active clinical practice at the time of interview. Thirteen out of the twenty were professionally trained for the role that they currently occupied: one quarter of those volunteering for the study had trained as nurses, with some now working as family or child psychotherapists. Another quarter were social workers or occupational therapists. Two psychiatrists, but no psychologists, stepped forward for interview. The remainder, variously titled as community or residential support workers or as Maori Health workers, had no formal qualifications related to their positions, but brought into the interviews their prior training as teachers, their current training in social work, and their considerable personal life experiences.

Like most of the mental health workforce, the gender weighting in this sample was predominantly female. At times this characteristic emerges within the text; at others, it has been masked to ensure anonymity for those in potentially identifiable positions. Similarly, the small world of mental health in Aotearoa New Zealand has at times required the withholding of ethnicity and cultural identifiers, an editorial obligation that carries with it the risk of suppressing emergent themes of culture and gender interaction within organisational settings. By introducing the participants in this way, it is hoped that a successful and transparent balance between the strengths of their narratives and the protection of their identities is achieved.

The use of multiple lenses

One important motivation for writing this thesis is to build bridges between knowledge in practice and in the academy, and between these two quite distinct worlds and that of the field of mental health. Simply by naming that there are different sites of knowledge, skills and experience, I signal that there is an ongoing dialogue. Ethically, epistemologically and personally, the challenge of the thesis is to combine knowledge and debate from all sources whilst retaining the integrity of each. It is the siting of this study at the juxtaposition of many pieces of knowledge and ways of interpreting the world that I hope creates its relevance to fields beyond that of mental health, social work or the university research arena. The accountability of the thesis certainly extends past each of these.

The necessity for acknowledging the complex interactions between different theoretical perspectives has been driven home to me by personal experience of the inadequacies of single perspectives. I grew up in a London suburb, down the road from Eltham Palace, believing that all adults in the sixteenth century were midgets because the palace walls were not much higher than my primary school self. The realisation that the walls continued down below the rising soil level coincided with my resolution to become an archaeologist, to delve below the surface of human society and to understand the ways that people have lived. My growing self learned that the history taught at school was all around me, a tangible manifestation of inherited ways of being. My education laid out human endeavour as a linear progression from the Stone Age, which whilst deviating mysteriously through Greek and Roman culture, retained an anglocentric air, and arrived back on British shores with the Danish and Norman conquests, undoubtedly marching to the tune of *The British Grenadiers*.

My environment constructed my sense of history and perspective. I knew that the roads radiating from London were straight because the Romans had built them, that Chaucer was the Clerk of Works at Eltham Palace, that one of my early (and few remaining) heroes, Sir Thomas More, was related by marriage to the Ropers, a mile away at Well Hall. Paxton's Crystal Palace, built as the symbol of British scientific and technological superiority for the Great Exhibition of 1851, was part of my familial and geographical identity. From a hillside nearby my mother had stood and watched its fiery destruction in 1936.

I was brought to Aotearoa New Zealand at the age of fourteen. Confident in my ways of thinking about the world, my identity had never been challenged. What happened to me as an immigrant is perhaps not unique but has shaped

the consideration of the paradigms in this thesis. Instead of living in towns and villages whose names identified early occupiers and origins as settlement or farm, I arrived in a partially non-European country, with place names derived from a language to which I had no access, into a society that had only a veneer of similarity to the one I had left. It was therefore an unresourced transition process[3]. In my fourteen-year-old perspective, marooned from my own roots, everybody seemed in a similar situation. People lived in the present with no sense of history or belonging. Even the archaeology was different. The digs I had gone on as a twelve and thirteen year old in England had revealed stone walls and pottery. I had one attempt here. The pits revealed postholes, but no pattern of settlement with which I could identify. Even the postholes have now disappeared, swallowed up in the mining of the Taharoa[4] ironsands.

Well's description of the Pakeha[5] experience resonates with mine:

> All Pakeha are to some extent disinherited people. We live separated from our home tribe. We all came to a new place - or at least a place new to us - and, our origins discreetly hidden by time and space, we set about recreating ourselves afresh. It's called reinvention. It's not all bad.
>
> Wells (2001:31)

Wells describes the lingering effects of migration as traumatic: disconnection, numbness, the amnesiac quality that is forced upon a migrant held responsible in some way for the sins of the colonial past. The decade in which I arrived in New Zealand was the decade in which he describes growing up. His culture...

> ... was stunted to a certain extent by various forms of trauma. These trauma I would qualify as the trauma of emigration itself, which is an act of division and removal from the motherland, a cutting off of links, or, as in New Zealand's case, a hallucinatory summoning up of links to another part of the world - a world that isn't there.
>
> Wells (2001:223)

It is perhaps disingenuous to jump on the bandwagon in order to claim that the act of migration (and as an adolescent, an enforced one) was traumatic by nature. Nonetheless, the disconnection and dislocation that I experienced was a formative process. Wells quotes Rushdie in saying that 'it is the fate of all migrants to be stripped of history' (op cit, p224). How true: history is kept alive by a collective immersion in culture. Stripped of these connections, the

---

[3] My thanks to Mathew Keen, a colleague in Mental Health, for this phrase.
[4] Taharoa is an isolated settlement south of Kawhia harbour on the North Island's west coast.
[5] 'Pakeha' is the Maori term for New Zealand people of European ethnicity.

individual must focus on the perpetuation of the self, and then seek to forge new connections and interrelationships with others.

The learning for me was about the notion of linearity, a concept that has an important bearing on the subject matter of this thesis. My English history had taught me a means of classifying the world that dismissed any ill-fitting narratives as irrelevant or untrue. My re-location to another place taught me that there is no universality. It upset the steady state of a lineal chronology, and began the process by which my brain could begin to understand how significant events could alter the relationship of space and time. I chose to switch from the archaeology of the past to that of the person. The fact that my first degree is in psychology is a continuity of my interest in people and was an intellectually and culturally smooth transition, both sets of knowledge originating within positivist knowledge.

The research for my Masters degree was a study of absconding from care, using records from the Assessment Centre in which I had started social work back in Britain (Adamson, 1982). Available theory at the time was psychodynamic[6] and behavioural, the research methodology entirely quantitative. Conclusions that I came to scarcely touched on the nature of the organisation or the complex interrelationships between children and staff. On reading the document, my ex-boss, Warden of the Centre, described the limited systems comments (such as the absconding rate appearing to be linked in some way to his presence or absence) as 'cheeky'.

The consequences of one incident has highlighted for me the importance of systems and interpretive perspectives, and the need to integrate all available perspectives in order to gain a complete understanding of complex workplace incidents.

> *One summer evening in 1981, when there were four of us on duty, there was a riot. On a grand scale of things, it was only a small one. But it is important to me because it was 'my' riot and because it is now, after over twenty years, that it has begun to make sense. Several of the adolescent boys coalesced into an unmanageable group, pushed and shoved past (and over) the two female staff members, and then absconded. We (the two females) called upon the two male staff for assistance. One, the young, recent appointee, came out from the distant part of the building where he had removed himself when tensions had risen. The other, the Warden of the*

[6] Audrey Mullender, my tutor at the University of Nottingham, and now Principal of Ruskin College, Oxford, wrote on one essay, as I recall, that I had 'suspect psychodynamic theoretical underpinnings'. This thesis is in part my response to her.

Centre, was recalled from the visit he had been making to a local residential school. Police were notified, incident reports filed, and my colleague and I repaired to the local pub for several swift rounds of comfort and informal debriefing, which was the only sense-making system available to us.

Until March 1997, this incident was stored away as one of the more dramatic components in my experience. It had fuelled my desire for further training and had served as a reality check in my knowledge that things can and do go wrong. Over the years, as my knowledge base about critical incidents and staff support systems developed, my critique of the lack of support has reinforced my understanding of the need for systems planning within organisations. I could now comment knowledgeably on the need for staff training and supervision, about the status of residential workers and about the functioning of total institutions. The distance from 'my' riot has added to my appreciation of the political and managerial dimensions of the incident.

Understanding of the incident crystallised in 1997 with the conviction of the Warden, the senior staff member on duty at the time, on multiple counts of paedophilia over a career spanning more than twenty years (Dutter, 1997; Farmer, 1997). The reason why he was off site at the time of the incident was that he was visiting an ex-resident, whom I now believe he had groomed for abuse. The motivation for the boys' absconding, many of whom I now believe to have been this man's victims, is something also to which I have no access.

The impact of this offending on the institution and myself has been significant. As Warden, this man controlled staff selection and references, client movement in and out of the institution, and staff contact with other arms of the social services. The systematic abuse of young people in care was protected by control of the communication with the outside world. Many of the constraints to staff development and client care were coloured by this style of management. Whilst no single explanation will ever account for the 'taste' of this institution in my sensory memory, his conviction has provided a missing link for me two decades later.

Experiences like this have determined for me both the subject matter of the thesis and the belief that individual narrative and comprehension of incidents within systems and structural contexts have a crucial role in the creation of responses and solutions to crisis and traumatic events. The manager's conviction made sense of my past experience for me, but also created new stresses and emotional experiences, and produced recall of hitherto mislaid memory. Without consideration of individual experience, we lose the voice of

the individuals who make up the workforce. Conversely, if we ignore context and focus instead merely on the characteristics of the individual and the incident, we obscure the environment in which both incidents and healing occur. The qualitative approach of this thesis allows for the development of meaning and interpretation that comes out of the person-in-environment context.

Such imperatives shape the research question. The narratives of the participants are embedded within an ecological knowledge base that explores the complexities of the relationships between positivist, systemic and constructionist perspectives, and between the understandings of theory and practice related to the fields of mental health, stress and trauma.

The structure of the thesis is as follows:

Chapter Two addresses the influence of intellectual traditions that structure our response to mental health, to crisis, stress and trauma, and to the methodology of this research. Woven into this discussion is a description of the conceptualisation of trauma within these frames of reference. It establishes a rationale for the ecological framework of analysis utilised in this research.

Chapter Three reinforces the ecological foundations of the study by contextualising the issues through examination of the nature of the mental health environment. It considers the historical development and current profile of mental health services, and the professional characteristics of those who identify as mental health workers.

Chapter Four reviews the development of the current classification systems of mental health and trauma. It addresses the issues of complexity that arise, and suggests areas of challenge and change that are crucial in a consideration of staff support systems after critical incidents and traumatic events.

Chapter Five focuses upon the impact of extreme stress and trauma upon body, mind, spirit and culture.

Chapter Six contextualises the issue of critical incidents within the workplace and addresses issues that arise in the evaluation of interventions, using the debate over psychological debriefing as a case study that illustrates the tensions between intellectual traditions.

Chapter Seven outlines the methodology of this study.

Chapters Eight and Nine analyse the research findings, focusing first on the context of mental health work, and then on the experience of critical incidents themselves.

Chapter Ten draws together the discussion; recommendations and conclusions are addressed in *Chapter Eleven.*

Chapter Two: The lenses that we use

> It may be that traumatology will lead the mind sciences out of their limited linear scientific vision, into their more natural home in non-linear paradigms, which are indeed the home of modern physics and mathematics... Traumatology, like physics, will be an ever more unifying and whole science. It will become the first science to truly subsume biological, psychological and social arenas, and include knowledge of processes of human harmony and disruptions, charted from molecular to spiritual dimensions.
>
> Valent (1999b:4)

This thesis argues that the knowledge bases we use to understand critical incidents and traumatic events in the field of mental health require a breadth of understanding of how epistemological change, and the relative contributions of knowledge from different paradigms and traditions, create tensions in the delivery of support systems within organisations. This chapter presents an overview of the paradigms in which perspectives of trauma and extreme stress are located, and suggests that a paradigm shift[7] is underway, but not yet complete, in the ways that we understand and respond to such experience. Using examples from historical conceptualisations, it illustrates the transition from the early scientific capture of trauma to a broader, ecological and human rights perspective, and serves as a knowledge component of triangulation for the thesis.

The thesis employs different lenses, depending on the subject under scrutiny. At times in this research a positivist paradigm is used as a means to understanding experience, behaviour or process. The close focus on the neurobiology of trauma reactions lies unashamedly within a positivist framework. An interpretive lens will be employed in an analysis of how both positivist and social knowledge, located within interactive and dynamic environments, can be made to work for the individuals and groups involved. Clashes between knowledge from separate paradigms are revealed within the debate over the most suitable response to critical incidents within the workplace (Chapter 6). An ecological framework that seeks to bind these perspectives together is promoted throughout.

---

[7] Kuhn's term is a description that has wide currency in philosophical and conceptual debates in health: see for instance, Atkins (2002).

The lens of positivism is now considered, as an aid to considering the origins of the field of trauma.

Positivism: the Crystal Palace of the mind

> They are ours, though they are not wee, Wee are
> The intelligences, they the spheares.
>
> Donne, in Hayward (1950:57)

This chapter is presented from the perspective that the positivist paradigm represents an attempt to understand the complexities of the world (Sarantakos, 1993), and as such, is a cultural construction that seeks to define our relationships within it. Guba and Lincoln (1994) draw a parallel between paradigms, cosmologies and theologies in this respect. A positivist interpretation of reality contributes a major part of the knowledge utilised within this research. It is characterised by a self-substantiating belief in its capacity for objectivity, and unlike Brown's artistic exploration below (Illustration 2.1), excludes notions of spirituality (Goswami, 1993; Marshall & Zohar, 1997; Smith, 1999). In this perspective, God is separate from mankind; the mind exists distinct from the body; and the individual can be studied in isolation from the environment (Foucault, 1977; Parton, 1998). By claiming a stance of objectivity, positivism implicitly suggests that other approaches to knowledge are subjective, interpretive and therefore biased. An ecological perspective, described within this chapter, argues that not only is bias unavoidable, but that the multiple influences on a given situation can, through their interconnections, shed light on complex environments. These tensions are embedded within the development of psychiatry, the science of psychology and the newly emergent study of traumatology (Valent, 1999b), and determine the evidence-based arguments in the debriefing debate (Chapter Six).

Illustration 2.1:
I am with soul
Nigel Brown (2000)

Smith (1999) suggests that positivism's cultural location influences the accepted norms of lineal causation, relationships in time and space, knowledge, language and power, issues that become crucial in the analysis of the impact of trauma and its resolution. Cartesian dualism (what McFarlane and van der Kolk (1996a:560) term 'the nefarious persistence of a body-mind split') set up an epistemological construct of reductionism in which single or root causes of

events become the focus of investigation. Language derived from positivism permeates our description of human behaviour, often acquired from the physical sciences (for example, *trauma*, *stress* (Selye, 1982), *burnout* (Maslach, 1987), and the notion of the *quantum* leap). The language of computing is well entrenched within our descriptions of some very human 'software' processes.

Whilst a reductionist approach runs risks through separating person and environment, and parts of the person from the whole, its contribution is immense, in terms of the detail gifted to issues such as traumatic memory and stress reactions. Nonetheless its construction is problematic when reduction is given preference over complexity (Rubin & Babbie, 1997). Positivism promotes a hierarchy of knowledge with physics, the science of the interactions between small things, at the top, with intellectual clout over knowledge bases such as sociology, the study of the interactions of bigger things. Such an ordering of the sciences prescribes a unity of methodology for their study, based on the presumption that the highly complex phenomena that are typically found at the lower levels are explained and caused by, and reducible to, the less complex and better understood phenomena at the higher levels (see, for example, Young's (1995) discussion of this way of organising knowledge).

The structuring and dividing of knowledge into hierarchies and categories is a cultural construction that has shaped perspectives on the world. It is now under challenge:

> The study of psychological trauma shows that the Cartesian distinction between body and mind, and to some degree even between individual and society, is utterly untenable.
>
> McFarlane (1996a:560)

As Valent (1999b) suggests in this chapter's initial quotation, it is the knowledge base of trauma that is a leader in challenging the hegemony of positivism. A historical analysis of trauma's passage through and beyond positivism illustrates some of the tensions now manifesting in the provision of staff support systems.

Traumatic experience in history

Thomas Mann hailed Freud as the discoverer of the unconscious. Freud's reply was that it was not he, but poets and writers through the centuries who should be acknowledged for its discovery (Shatan, 2001). Similarly, traumatic experience predates positivism, with myth, historical record, literature and art works that attest both to the experience and interpretation of human distress.

From the Sumerian *Epic of Gilgamesh* (2000 BC), early Egyptian medical writings (1900 BC) and Homer's *Iliad*, (circa 700 BC), there are references to death, guilt, trauma and the horror of warfare (Davies, 2001; Figley, 1995; Shay, 1994). Maclow rewrote the *Odyssey* as a fable of Vietnam (Shatan, 2001). Shay (1994) compares the battlefield experiences in the *Iliad* and in Vietnam. He points out that Homer emphasises two common events of continuous combat: betrayal of 'what's right' by a commander, and the onset of the berserk state[8]. Being let down by an organisational structure is a theme that resounds within modern work-related incidents, including this thesis (Huddleston, 2002).

Biblical depiction of trauma is embedded in Western culture, revealing experience and integration of traumatic experience. Jewish tribes committed and experienced genocide (for example, *Judges*). The transformation of Lot's wife into a pillar of salt after witnessing the destruction of Sodom and Gomorrah can be interpreted as a reference to sensorimotor paralysis or psychic numbing[9]. Seeing the Bible as a collective account of the traumatised mind (the lamentation songs providing graphic illustration) is one possible interpretation that can be said to link past human experience of trauma with that of the present day. Part of the global appeal of Shakespeare's plays to modern audiences is the keenly accurate depiction of human emotions under conditions of extreme stress: Hotspur's turmoil in *Henry IV Pt 1* exemplifying physiological, psychological and social effects of trauma.

The medicalisation of distress

It is, however, the dominance of biomedical science in Western culture that provided the metaphor for the conceptualisation of trauma from the latter part of the nineteenth century. Significantly, the word 'trauma' has somatic roots. The earliest entry for 'traumatic' in the Oxford English Dictionary is 1656, that is, 'belonging to wounds or the cure of wounds' (Young, 1995:13). This sense was current until the nineteenth century when for the first time it was extended to include mental injury. Somatic explanations were often first sought, functional heart disorders being the reason cited for over 15,000 hospital admissions of British troops in World War I. This was neither an epidemic of cardiac illness nor a misinterpretation of symptoms, but rather a reading of

---

[8] The berserk state (anger with no fear, insensibility to pain and a tunnel vision excluding peripheral stimuli) entered our language through the Norse invasions of Britain in the early centuries of the second millennium. It describes the physiological arousal and adrenaline rush that enables a threatened person to react and fight.

[9] A similar metaphor is used in Greek myth: Perseus fighting Medusa, the gorgon with the power to turn fighters to stone, by using his shield's mirror quality to view her image. Thus military training and weapons safeguard the soldier from incapacity. Note that we use the term 'petrify', to turn to stone, as a description of intense fear.

symptoms through contemporary understanding of illness and a direct reflection of the cultural paradigm of 'positivism'.

Jones et al (2002) trace the changes in conceptualisation of post-combat syndromes from the time of the Boer War through to that of the Gulf War. Traumatic reactions have over this time been variously described as soldier's heart, railway spine disorder, buried-alive neurosis, gas neurosis, shell shock, physioneurosis, combat fatigue, battle fatigue, hysteria, traumatic neurosis, survivor's syndrome, rape trauma syndrome, battered child syndrome, battered wife syndrome, and post-traumatic or acute stress disorder.

Young (1995) cites Erichsen's description of 'railway spine' in 1866 as illustrating a reductionist search for the physical root of traumatic impact and attributes the first psychological explanation to Charcot. From this point, the debate over the validity of symptoms without obvious physical cause has led to ongoing questioning of the reality of people's experiences, and has underpinned issues of compensation and liability that resonate in notions of hysteria, in the concept of malingering in relation to shellshock in World War I, and which continue to resonate in the recovered memory debates currently raging in the sexual abuse (Valent, 1999b; van der Kolk, 1996c). Trauma has a social and economic face that in part may influence the definition of what is construed as traumatic and what has caused the traumatic experience. Recognition of psychological distress within, for example, the Accident Compensation Corporation (ACC)[10], the Victims' Rights Act (2002), the amendment to the Health and Safety in Employment Act (2002) and within organisational structures is conceptually linked to arguments later in this thesis in regard to organisational acknowledgement of responsibility for impact.

The construction of hysteria is a case illustration of the manner in which cultural and social interpretations of experience shape our response to trauma.

Hysteria: the en-gendering of trauma

In the second half of the nineteenth century, hysteria (a paralysis simulating physical injury) emerged as a major neurological and psychiatric explanation for traumatic reactions. Interpreted within the male mores of the day as physical manifestations of intra-personal conflict, it is important for this thesis as an illustration of the social location and gendered representation of definitions of trauma, as an example of the ongoing struggle for the legitimisation and recognition of 'invisible' wounds, and as an illustration of

[10] The state compensation and insurance system within Aotearoa New Zealand.

the tensions that arise when a single perspective is utilised to investigate social phenomena. In terms of the ecological considerations implicit in this research topic, it is important to understand its linguistic and social roots, as their meanings play out in debates over appropriate intervention after traumatic experience.

'Hysteria' originated in classical medicine and is derived from the Greek *hystera*, meaning uterus. Psychological and unexplained somatic illnesses had been interpreted in medieval Europe as being caused by devils and demons, and those displaying such symptoms ran the risk of accusation of witchcraft[11]. Raftery (1997b) refers to Richmond's view of hysteria as originally a disease of spinsters, whose dry wombs wandered around their bodies in search of moisture. Whilst the theory of the wandering uterus was severed by the growth in the understanding of anatomy, physical language continued to shape the growing awareness of hysteria's psychological basis.

Illustration 2.2: *My grandmother's 'wandering womb'*

My mother was born in 1920 after a difficult forceps delivery. Afterwards, my grandmother complained of pain and discomfort in her abdomen, and during examination would often state that the site of the pain had moved. Physicians made the diagnosis of a psychological disorder; a stay in an asylum followed; my mother (and separately, her older sister) was removed from her birth family for most of the next three years. Eventually an internal physical examination found the medical swabs remaining within the uterus. The delivering doctor settled out of court with a seaside holiday for the family. One can speculate as to the reverberating impact of the disrupted attachment processes down the generations.

Charcot and Janet noted the relationship between childhood trauma and hysteria, Freud initially echoing this, although according to Masson, he later recanted this position in favour of the Oedipal theory because of the rejection that he received at its presentation in 1896 (Freud, 1896/1962; Masson, 1992 & 2002). The furore over Masson's allegations is further illustrative of the battles that rage over the power to interpret profound human experiences (de Mause, 1997; Esterson, 1998 & 2001; Herman, 1992a).

Valent (1999b) argues that conventional science and society in the Victorian era had great difficulty believing in a person's inability to be aware of experiencing what we now term post-traumatic symptoms. Freud never came to integrate

[11] The origin of this lies in the New Testament portrayal of conditions such as epilepsy as being caused by demon possession (for example, Luke 9:37-43).

the role of war trauma and childhood sexual abuse under the notion of hysteria in the way that earlier theorists had done; soldiers experiencing paralysis were seen as malingering (Freud, 1920/1961; van der Kolk, 1996c). There is perhaps a gendered explanation as to why there was a separation in explanation between the two trauma-related phenomena. Van der Kolk, Weisaeth and van der Hart (1996) comment that between 1895 and 1974, the study of trauma centred almost exclusively on white males. Such integration required a change in perception and the impetus of the women's movement from the 1970s, considered below (Herman, 1992a). Issues of disbelief and lack of recognition resonate within the experiences of organisational stress within this thesis.

Despite this critique of the gendered notions of hysteria, its major legacy is the acceptance of the existence of unconscious processes whereby the impact of trauma can be experienced in physiological, behavioural, cognitive and emotional terms, as well as the social, cultural and spiritual. It further reminds us that such studies are framed within contemporary gender and power relationships. Showalter's debate (1997) regarding the 'hystories' of contemporary western society (anorexia and bulimia, false memory syndrome, satanic ritual abuse, chronic fatigue syndrome, for example) suggests that feminism can provide a lens with which to view trauma. Significantly, the psychiatric classification of hysteria left nosological systems in 1980, co-temporaneous with the introduction of the classification of Posttraumatic Stress Disorder (and the new wave of feminism) and temporarily burying the link between traumatic stress reactions, somatisation and dissociation (van der Kolk, van der Hart & Marmar, 1996). These debates and conceptualisations add a complexity but also a framework for this thesis and its exploration of the literature.

The historical development of concepts of trauma continues with consideration of the role of warfare in the shaping of knowledge.

Hell's Bells and Buckets of Blood: war and the development of psychotraumatology

> History is written in blood.
> van der Kolk & McFarlane (1996:3)

The conceptualisation of trauma is in itself an illustration of the cultural, social and political location of knowledge. World War I was a defining moment for its role in shaping this country's current identity, for our contemporary understanding of trauma, and for suggesting a lens for the interpretation of

workplace incidents. National and global experience in this war shaped many subsequent attitudes to traumatic experience.

For Aotearoa New Zealand, the images of nationhood are those of epic waka voyages, settler families breaking the land, and the Anzacs, all images of strength and endurance. The stained glass memorial below illustrates clearly the mixing of symbolic representations and the synergy that results (Illustration 2.3). The colonial school system inculcated within pupils the belief that military training and demeanour were part of the development of good male character that applied to civilian life as much as to military conduct[12]. School songs and journals, and the history curriculum, all glorified the exploits of fighting men such as the British Grenadiers, Admiral Nelson, Lord Clive, and captured the heroes of other cultures such as Achilles and the Vikings as in some way representative of the perceived strengths of British colonial character.

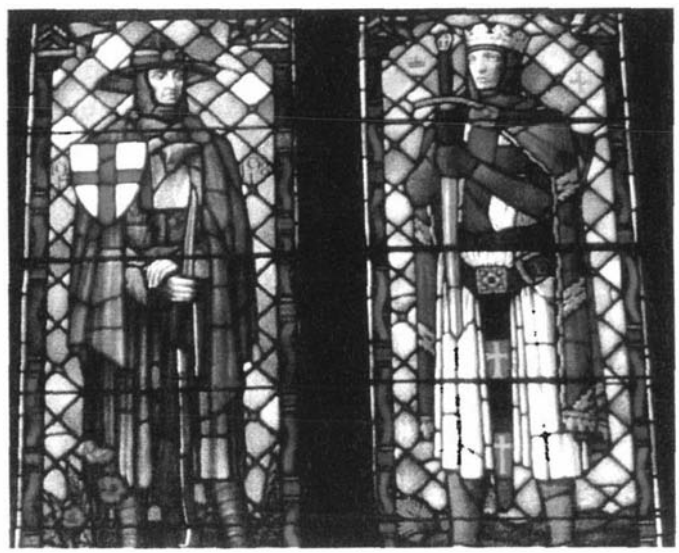


Illustration 2.3: *Anzac and Crusader*
War memorial window, Council Chamber, Victoria University, Wellington

By the outbreak of World War I, Pakeha men had been taught that 'war was the acid test of their masculinity' (Phillips, 1996:158). Establishments such as the Church supported and condoned military activity:

> This synod is convinced that the forces of the Allies are being used of God to vindicate the rights of the weak and to maintain the moral order of the world.
>
> *Anglican Synod*, Melbourne, 1916, in Page (1983:18)

Peer pressure and the code of military conduct provided the environmental conditions in which New Zealand soldiers entered battle. Men enlisted alongside friends, relatives and neighbours. The Maori[13] Battalion in World

[12] When my schoolteacher father obtained a teaching job in 1968, he was horrified to discover that military cadets were still very much part of school life. He became a conscientious objector and ran the stationery room instead.

[13] Maori are the indigenous peoples of Aotearoa New Zealand.

War II was organised along tribal groupings. Peer pressure would apply not only to pressures exerted at the front but also to the relationships that existed within the communities at home (Gardiner, 1992).

Military traditions do not encourage emotional expression:

> It would be a bad thing for the world as a whole were war abolished... We should lose our virility, and sink into unhonoured ease and sloth... does anyone imagine that if we despised war, as the Chinese despise it, that we would not quickly sink into the depths of luxury as the Romans did? In an age like ours which is essentially an age of materialism and money-making and pleasure-seeking, war is the antiseptic that prevents the putrefaction of the whole social system.
>
> *New Zealand Herald*, 14.10.1899, in Phillips (1996:139)

Indeed, McFarlane and van der Kolk (1996b) challenge whether nations need their traumas in order to have develop a sense of national community. Gallipolli[14] emerged in our national psyche not as the legacy of political and military decision making of dubious wisdom but as a symbol of bravery and a key turning point in the formation of the nation state (Burton, 1935).

World War I was equally pivotal in shaping our understanding of traumatic stress. Whilst national belief systems, professional codes and traditions in military and other environments encouraged suppression of affect as counterproductive to discipline, the scale of the slaughter in the war focused attention on trauma. Prior to this point, as discussed above, trauma had been viewed through the lens of the gendered intra-psychic world of hysteria, or the search for physical causes of neurotic breakdown. The world now had to come to terms with a realisation of the impact of recognisable external events on the psyche (Young, 1995). The dissonance that the experience created was immense, forcing a conceptual reorganisation of the understanding of trauma.

The sheer numbers of casualties stand out: for Aotearoa New Zealand, one in every four men between the ages of 20 to 45 were either killed or wounded in the war: this was 58% of those who actually went overseas, but only a small proportion of the total eight million soldiers who died. On the first day of the battle of the Somme, there were more British casualties than there were on the American side in the entire war in Vietnam (McFarlane & van der Kolk, 1996a). Raftery (1997b) reports that during the Somme alone, the British Expeditionary Force had nearly 35,000 'neurotic' casualties. By war's end, 80,000 cases of shell

[14] Gelibolu, near Cannakale in Turkey, was a significant battle for Australasian and Turkish nations.

shock had been treated in British Royal Army Medical Corps (RAMC) medical units. After the war 200,000 ex-servicemen received pensions for nervous disorders (Young, 1995).

Conceptualisation of traumatic impact reflects both the medicalisation of distress, and the gender and class assumptions embedded within it. The war's emblematic disorder, shell shock, was one of RAMC's four diagnoses of war neurosis, the others being hysteria, neurasthenia, and disordered action of the heart (Young, 1995). The term 'shell shock' is credited to Myers of the RAMC in 1915, with symptoms linked to a soldier's proximity to a shell burst (Clarke, 1991). Although the causal link between shell shock and concussion was broken by 1916, the term's usage reflects the reliance on the constructions of physical science. It remains in common parlance today to describe a stunned reaction to an experience, its reliance on an etiological event of significance to this research.

A class and gender analysis applies to the notions of hysteria and neurasthenia, echoes of which resonate in the experiences of mental health workers within this thesis. The RAMC's classification of hysteria utilised Charcot's work but applied it to officers rather than women, producing dissonance in the conceptualisation of hysteria as a war neurosis (Clarke, 1991). Beard had described neurasthenia in 1880 as exhaustion of the brain and spinal cord, surmising that stress for educated and professional men and women had precipitated mental and physical fatigue with organic causes (Raftery, 1997b). Neurasthenia as a diagnosis was used frequently as a euphemism for insanity in a patient where for some reason the word insanity should not be mentioned (Clarke, 1991). It was applied to officers and was thus, Clarke argues, a class differentiation hat avoided stigma. Regular (conscripted) soldiers were more likely to be described as having symptoms of hysteria.

The RAMC's fourth diagnosis of 'disordered action of the heart' also attempted to link psychological symptomatology to an organic cause, but acknowledged that such sensations could originate from activities and events that took place far from the front line. In 1917 a fifth classification, 'not yet diagnosed (nervous)' (NYD[N]) was added (Young, 1995). This was intended to be an interim diagnosis until a final diagnosis in a specialised hospital, but in fact it was often the only diagnosis that men received for symptoms associated with war neuroses. This is echoed in the current proposed classification of Complex Trauma/DESNOS (Chapter 4) and is illustrative of developing concepts of trauma that impact upon perceptions of workplace incidents.

Social implications of a diagnosis of shell shock were considerable. Raftery (1997b) cites Salmon's wartime concern that the growing incidence of shell shock and neurological symptoms would endanger the morale and discipline of the troops. Showalter (1997) argues that class prejudice influenced the military view that soldiers who broke down came from the dregs of society and therefore lacked moral fibre, an argument exemplified by Freud's assertion that 'war neurosis' could arise only in a conscripted army, not amongst professional soldiers (in Young, 1995:79). Shell shock was seen as malingering or cowardice, justifying Yealland's use of shaming and electric shock (Herman, 1992a), and as Lett's poem *The Deserter* vividly illustrates (Marshall, 1975). The syllabus for the fourth Anzac Medical Officer School of 1917 bracketed together shell shock, neurasthenia and malingering in a common category for teaching, thus illustrating the enmeshment of medical concepts and socio-political attitudes (Clarke, 1991).

The sheer scale of impact of warfare and its psychological sequalae created dissonance in military medicine and psychiatry which challenged the dominant view that mental illness was a result of moral and hereditary degeneracy from which officers, as representatives of the privileged classes, were immune. In Australasia, the numbers of veterans with psychological problems forced the development of special facilities so that they could avoid the stigma of the certification that other mental health patients endured (Clarke, 1991; Lewis, 2001). There was very little focus on (and perhaps, very little resulting permission for) returning soldiers to acknowledge the heavy psychological impact that they may be carrying (Phillips, 1996; Raftery, 1997b). The relevance of the debate about class, malingering and the impact of warfare continues to be played out in the workplace, confronting issues of belief, immunity to harm and the individualisation of distress.

World War I lodged explanations for traumatic impact within dominant scientific and social constructions, perspectives that endured despite the social changes of subsequent decades. By 1918 there had been a flurry of publications about war neurosis. Yet subsequent decades saw little published. In Aotearoa New Zealand, Phillips (1996) saw the inter-war period as constructing combat as a test of manhood and an integral part of nationhood. War memorials (such as at Victoria University, illustrated above) tended to depict bravery and chivalry. Such a perception limited the open expression of dissent and disillusionment. Anzac Day, under laws in 1920 and 1921, became a day of almost religious significance, with hotels, shops and businesses closed. Phillips points out that it was not until the 1936-39 period that publications such as

Lee's autobiography revealed another side to the official image of war (Lee, 1985; Phillips, 1996).

The Western interest in the study of trauma revived during World War II with the activities of Kardiner, Grinker and Spiegel, but then declined again (Young, 1995). Valent (1999b) suggests that the remembering and forgetting of trauma within the scientific and political establishment, and its resurgence after many global conflicts, is symbolic of trauma itself (also, Bloom & Reichert, 1998; Kardiner, 1941; McFarlane, 2000). Post-traumatic reactions are, by definition, post-facto. The political and social context may actively work against acknowledgement of trauma, as Showalter illustrates in the context of World War II:

> You are just a god-damned coward, you yellow son of a bitch. You are a disgrace to the Army and you are going back to the front to fight, although that's too good for you. You ought to be lined up against a wall and be shot. In fact, I ought to shoot you myself right now, goddamn you.
>
> General Patton, in Showalter (1997:74)

Patton's outburst, one of a sequence occurring whilst visiting American casualties in military hospitals in 1943, was covered up at Eisenhower's urging that it was against public morale for this to be published. A similar dynamic may operate within organisations such as mental health providers, who operate at the cusp of public and private worlds and under a media spotlight, for whom an open exploration of the cost to workers may jeopardise both morale and public image.

The influence of warfare on our perceptions of trauma has changed as a reflection of its nature. Proportionately, fewer soldiers and more civilians are now affected. Ninety five percent of the casualties of World War I were military; fifty percent of World War II; and only twenty percent in the Vietnam conflict (Summerfield, 1995). War is not always characterised as a noble endeavour with justifiable casualties[15], with current armed conflicts around the war exacting their impact on civilian populations, and involving the poor, civil unrest, ethnic cleansing and the unravelling of colonialism.

In many ways, this sea change in perspective is due also to the emergence of a systems approach and the continued move towards an ecological understanding of human experience and trauma, which has taken its analysis out of a purely military context and into a broader examination of context.

---

[15] Although the American regime's use of the word *crusade* to justify the invasion of Iraq may suggest this.

The whole is greater than the sum of its parts: the intellectual revolution of systems theory

An analysis of the origins and characteristics of systems perspectives suggests that the roots of the current debates about the management of workplace incidents are embedded deeply in the epistemological changes of the twentieth century.

World War I had begun the destruction of deeply held assumptions about the nature and stability of European culture and about the primacy of technology and positivist thought. Shared assumptions about the world were no longer possible (Geering, 1994). Changes in thinking promoted the acceptance of relative positions, social difference and an increased emphasis on context[16]. Key social, artistic and scientific movements reflect these changes over the twentieth century, in such diverse fields as quantum physics, Gestalt psychology and cubist art. The social impact of this intellectual revolution caused Einstein to comment that it was as if the ground had been pulled out from underneath the foundations of belief (in Capra, 1996). Heisenberg (one of the founders of quantum theory) illustrated the relational shift between object and environment by saying that 'we never end up with any 'things'; we always deal with interconnections' (in Capra, 1996:30). The emphasis of Gestalt psychology on the integration of human experience into meaningful wholes provided the opportunity for the development of constructivism as a school of thought, and the legitimising of meaning and subjectivity as an ingredient in human activity and traumatic experience.

For others, of course, there has been no need of a paradigm shift. Durie, in his description of *paiheretia*, Maori relational therapy, outlines that this figure-ground relationship recognises fundamental Maori cosmological knowledge that exercises synthesis rather than analysis:

> Maori gain understanding not so much from being able to recognise each single component part as from an appreciation of the whole, and the relationships that occur between phenomena and structures.
>
> Durie (2001:171-2)

The advent of systems thinking thus increased potential dialogue between Western and Tangata Whenua knowledge bases.

---

[16] Many older New Zealanders appear to mourn the passing of the age of certainty in this country, from a time when we all 'knew' where we stood on issues of race, religion and sport, to a post-1981 legitimisation of difference that in some ways has been a stripping of an identity and the birth-pangs of another. Viewed in this way, the furore over the racially-segregated Springbok (South African) rugby tour was a national critical incident.

As explored in later chapters, this paradigm shift is not yet complete, and the service delivery environments of both mental health and staff support systems reflect confusions and epistemological tensions (Chapters 3 and 6). The emergence of particular professions within health, on a chronological basis from medicine, psychology to social work, tells a story of successively different knowledge bases and reveals much about the shape of mental health service delivery today. Capra (1996) argues that this change process is not merely an intellectual transition but an intense emotional and even existential crisis. The debriefing debate in Chapter Six can be seen as an illustration of the passions that transitions such as these produce.

A review of the key features of systems thinking illustrates both its role in conceptual change and its compound identity as a bridge between positivist and holistic paradigms. A systems perspective[17] has its roots but not its branches within a positivist paradigm and is an attempt to recognise and map the dynamic processes of interconnection and context. A system is the gestalt, the integrated whole whose properties and behaviour can be attributed to the relationships between its parts. These properties, with boundaries and patterned relationships, cannot exist when the system is broken up into its separate elements, or forced into lineal progression. Systems thinking therefore addresses connectedness, relationships and context, and contributes important terminology to an ecological perspective.

From General Systems Theory comes the concept of open systems that require a continual flow of energy in order to maintain function (von Bertalanffy, 1967; 1971). This underpins the understanding that we have of the continual adjustments and changes that a system experiences in order to achieve a balance and/or growth, and contributes to our appreciation of the manner in which organisations behave. Cannon (1932) developed this in terms of the notion of 'homeostasis', an important concept in the development of notions of stress and crisis. Whilst systems such as organisms are open, with permeable boundaries that can exchange energy with their environments, systems tend to work to preserve their structures and characteristics in a dynamic homeostasis.

The increased attention to context enabled the intellectual re-combination of previously separate bodies of knowledge. Cybernetics, dating from World War II, was a movement that combined biology and psychology in its

[17] Capra traces the meaning of the word 'system' back to the Greek, synhistanai, 'to place together' and credits the development of Systems Theory to Bogdanov, whose work was published between 1912 and 1917, von Bertalanffy and to the development of cybernetics (Bateson, 1972; Capra, 1996; von Bertalanffy, 1967; 1971).

understanding of communication. The term derives from the Greek, *kybernetes* or 'steersman', which indicates its hypotheses about the relationship between systems and control of information. It coined terms of feedback and closed loops and developed the understandings of self-regulation that can also be seen in General Systems Theory. The Macy conferences (1946) combined scientists, mathematicians, engineers, biologists and anthropologists who were charting new links between established knowledge bases. Bateson, initially a biologist, used this systems approach to develop a cybernetic, systemic understanding of health and welfare issues such as addiction and schizophrenia. Capra (1996) acknowledges him as a major contributor to the waning of the influence of Cartesian dualism. Cybernetics emerges as a major forerunner of the coalescing of various independent sciences and knowledge bases, such as the field of traumatology.

In relation to trauma, the development of systems approaches marks the beginning of a paradigm shift away from solely positivist interpretations. The key concept within systems thinking is that of the distinction between *figure* (the object under study) and *ground* (the context in which it is located). The relationships between people become a focus rather than either the people or the events, thus requiring that positivism's attention to detail interact with context without assuming a dominant position (Smith, 1991; Young, 1995). Such a shift in thinking enables viewing a critical incident and its effects in the context of the organisational and social environment.

Another key feature of a systems approach is the ability to shift one's attention back and forth between systems levels, each having a different complexity with emerging characteristics that other levels do not have. This constructs a different, non-lineal and non-hierarchical set of potential relationships between a person and their environment, potentially challenging the initial conceptualisation of the impact of trauma. Trauma's impact on a whole system may have emergent properties that are not apparent in the experiences of the component parts. These emergent properties provide the characteristics whereby we can recognise and determine the most appropriate interventions at any point, and also provide the rationale for multi-level interventions (Compton & Galaway, 1989; Sanders et al, 1999). Thus it may be less appropriate to describe human emotions and interactions in neurophysiological terms than it is to use behavioural or social terminology. Human behaviour, diluted down to chemistry, may lose some of its qualities.

The notion of emergent properties, of the *whole* of knowledge at each ecological level being greater than the *sum* of the knowledge at each smaller level, is a key

concept in the development of this thesis question, and marks the ability of systems theory to step away from its positivist origins towards an ecological stance. Intellectually the growth of systems thinking provides the basis for the development of post-modern approaches that depend upon the acceptance of relativity for their conceptual existence, and which further remove systems perspectives from their positivist origins.

Flaws in the system: the challenge of post-modernism

Systems theory, in signifying the shift of attention toward 'ground' and the connections between components of a system, provides a conceptual change of direction away from positivism. Marshall and Zohar (1997) suggest that systems theory still remains intellectually shaped by science. Their criticism is that it cannot model a kind of holism in which the parts of a system change through participation in the system. They present this as a rationale for the development of post-modernist, constructivist and narrative approaches, a perspective that represents a paradigm that is based on diversity, on 'both/and' thinking rather than the 'either/or' of the positivist inquiry.

I interpret these intellectual developments in a slightly different manner than Marshall and Zohar, and find Capra's work of great relevance here (1996). His description of living systems (which for this thesis can be an individual, their social environment and the organisation in which they work) extends a systems approach into what I think can fully be called another paradigm, holism, well away from a reliance on positivist roots. Rather than viewing systems theory as a logical progression towards constructivism, which I explore below, I would locate systems theory as the force that broke the dominance of positivist thought and which enabled an ecological perspective to gain credibility. From this stance, an ecological framework (discussed below) is a holistic device that can reconcile constructivist and positivist perspectives, within an understanding of systemic interconnection and awareness of the environment.

According to Siporin (in Payne, 1997), a weakness of the systems perspective is that it suggests that an event occurring in one part of a system will have an effect in all other connected parts. Clearly this may occur in open systems but not in all. For instance, the Thatcherite argument for 'trickle-down' economics, whereby the stimulation of certain parts of the economy would have benefits in others, is open to challenge (Kavanagh, 1987). Events occurring in mental health organisations may not reverberate through all teams. There is a need to include a structural analysis in order to explain the barriers to a systemic effect across levels. Structural theories suggest that a systems approach omits a

radical critique of causation in favour of a potentially conservative accommodation to environmental factors.

Systems theory can be challenged in terms of the language used, for instance, by Selye (1982) and Walrond-Skinner (1976). However even these early texts reinforce the non-linear approach that systems theory takes in its understanding of interconnected relationships, and both Walrond-Skinner and Minuchin et al (1996) are clear in their break from the (linear) psychodynamic tradition.

A growing critique of a systems orientation comes also from a constructivist stance that makes the claim that the uniqueness of the individual or community, and the importance of the meaning that they place on events and situations, can be overlooked in favour of seeing a person's location within a set of interlocking systems. Constructivism legitimately challenges whether systems theory can provide explanations for self-organising systems and social change. Some theorists regard systems theory as acknowledging the capacity of people to change, generate new patterns of behaviour and new environments (for example, Compton and Galaway, 1989). It is probably more accurate to regard systems theory as developing over time, so that whilst it offers access into a holistic paradigm, many of its constructs (language, methodology, and applied practice) have undifferentiated connection to its positivist past.

This is particularly true when we look at the applied arms of a systems approach, such as the bio-psycho-social perspective currently utilised by mental health systems (Falloon, 1993). Emerging, as did systems theory itself, in the 1970s, its application to psychiatry was described by Engel (1980). This systems-inspired model underwent analysis and a process of redefinition according to the dominant biomedical perspectives. Systems theory in practice was seen as embedded within a medical model, with biological interpretations given primacy (Young, 1995) and some levels of intervention (for example, the pharmacological) being favoured over others. When the development of classification systems such as the DSM are considered, the primacy given to the identification of an Axis I (mental disorder) diagnosis over an Axis IV (social issues) will be an illustration of this (Chapter Four).

A major contribution to the theoretical understanding of trauma's impact within workplace contexts comes from the development of chaos and autopoietical theories that have arisen out of systems perspectives.

Using chaos to make sense of the world

> In the nonlinear paradigm, the pebble hitting the pond (trauma) may be visualized as akin to big bang or a quantum mechanic event of great energy.
>
> Valent (1999a:84)

The abandonment of a linear imperative in the understanding of the impact of an event is a significant feature that aids the interpretation of workplace response to incidents. A non-linear notion of context as a dynamic force leads to an understanding of the contribution of Chaos (or Chaos-and-Complexity) theory and the work of Lorenz (Capra, 1996). A meteorologist, Lorenz hypothesised that a butterfly stirring the air in Beijing could create storm conditions in New York in the next month. Initial conditions could create infinite possibilities, with prediction relying on our understanding of the quality not the quantity of the components and their relationships. An added development within systems theory in the last three decades of the twentieth century, which removed it further from its positivist origins, was the notion of autopoiesis[18]. This concept, coined by Maturana and Varela (1980 & 1987), refers to the organisation of living systems that is circular in character, and suggests that systems evolve and adapt, but within overall patterns. This occurs as a response to environmental changes regardless of the degree of consciousness, thus removing any emphasis on Cartesian dualism. As did Bateson (1972), they redefine for us our understanding of cognition. They see all living systems as cognitive, whether or not there is conscious awareness of the process of change: the relationship between the members or components of a system is what determines the change and which maintains it within defined patterns and structures. It can be applied usefully not only to a conceptual understanding of cognition, brain function and trauma, but also to an appreciation of the complexities of organisational functioning.

In my view, a major contribution of chaos and autopoietical theories is to relieve us of the anxiety of always assuming that there are linear solutions in the way that the world (both physical and human) is constructed. Here there is an approach that recognises structure, relationship, identity and change. This is at the core of my understanding of an ecological perspective, as discussed below. This approach accepts that systems involving complexity will be both dynamic and chaotic. Providing us with a non-linear, random perspective of events and processes connects physics and existentialism, mathematics and psychotherapy. A chaos contribution to a therapeutic intervention may lead to

---

[18] From the Greek *auto*, meaning 'self' and referring to the self-regulatory capacity of systems, and from *poiesis*, 'poetry', referring to the process of making.

acceptance that as complex beings, therapeutic progress may well not be linear, as each shift in a behavioural pattern produces its own effect. The query as to why two people experiencing the same traumatic event may demonstrate very different reactions may be explainable by chaos theory's emphasis on the sensitive dependence on initial conditions, that is, the individual experiences and qualities, strengths and vulnerabilities that a person may take into a situation (Rapp, 1993; Valent, 1999a). The systems in which people work may appear very straightforward and simple, but the behaviour arising within them may be complex, the complexity arising because of the nonlinear relationships between the parts of the system. A chaos theory of intervention in organisations, for example, might argue that trying to impose too much regularity (a template for a critical incident debriefing, for example) may cause problems. Responsiveness to local conditions may lead to better homeostatic maintenance. A mental health environment, as this research study suggests, is a complex environment indeed.

Whilst the possibility of extending an autopoietical understanding to that of human organisations and social systems is still debated (Capra, 1996), as a metaphor it enables us to understand that organisational functioning is comprehensible only through an understanding that the systems under study appear to acquire a life of their own, over and above the contributions of individuals and the roles and relationships that they represent. Cognition, in this sense, does not imply that organisations have a conscious mind, but that the structure, process, patterns and activity go toward creating a living process. The emphasis on organisation and on pattern-recognition as a means to both stability and change is appealing as a means to understanding the complexities of traumatic events and critical incidents within the workplace.

Patterns and structures: the function of the conflict paradigm

Using structure, relationship, identity and change as the corners of an autopoietical framework introduces new notions to the initial concept of systems theory in relation to workplace incidents. Structural issues are of paramount importance in the outcome of any intervention into critical incidents and traumatic events in the workplace. Significantly, however, structural concerns did not figure prominently in the trauma literature until the last two decades of the twentieth century, when systems approaches, feminist and human rights issues came to the fore. Structural issues and the 'conflict paradigm', as Rubin and Babbie (1997) term it, require acknowledgement of environment and context, although I would argue that this is not in such an interactive way as systems perspectives suggest. Structural or radical theories

can be criticised for under-emphasising the uniqueness of the individual in favour of looking at larger-scale processes.

Whilst structural theories arose in the late nineteenth and early twentieth centuries as explanations for social processes, they made little contribution to an understanding of trauma until a systems perspective located the person within the environment. The conflict paradigm has some roots in a positivist frame of analysis (Corrigan & Leonard, 1978; Dominelli, 1988; and Langan & Day, 1992). Some components of this paradigm span positivist, systems and constructivist perspectives, reflective of their emergence at particular stages of the twentieth century. Feminist thinking is an example of this.

Feminist thinking revealed a gendered perspective on the notion of traumatogenic environments (Showalter, 1997). Sexual abuse, rape, assault within the home, miscarriage, all are potential personal and social traumas to which the scientific community has only paid focused attention within the last generation of social research (Burgess & Holstrom, 1974; Kempe et al, 1962; Walker, 1979). Van der Kolk, Weisaeth and van der Hart (1996) record that the leading psychiatric textbook in 1980 claimed that incest occurred to fewer than one in one million women's lives. In the mid-1970s there began a process of integrating military and civilian knowledge about extreme stress and trauma, captured in the work of Horowitz (1986) and of Terr (1979). Terr's classic contribution lent a much-needed developmental perspective to the growing understanding of trauma, and differentiated between one-off and chronic traumatisation, a key factor in the organisational experience of extreme stress. Organisational trauma, I argue, has become visible only after these issues laid the foundation, with its patterns and relationships only visible when attention to context became of relevance to scientific scrutiny.

Critical theory provides a link between structural critiques of positivism and the political and social climate in which research and practice originating from other than positivist sources is operationalised. The theory suggests an inseparability of theory and practice and an imperative to engage with 'real' problems (Gibson, 1986). It challenges the givens of the positivist world, arguing instead (as constructivism does) that 'facts' are socially constructed according to the interests of various power groups in society. Nonetheless it also has its roots within positivism, and an interesting relationship with psychodynamic theory (perhaps underplayed by some critical theorists!) with an assumption similar to that of chaos theory, that deep unconscious structures and processes can be instrumental in explaining behaviour (see, for example, Gibson, 1986). It has a theoretical location that draws upon many critiques of,

and reactions to, positivism, including structuralism and post-structuralism, feminism, systems approaches, post-modernism and constructivism, and the emancipatory politics of Freire (1972). It has been called the philosophical voice of the new Left (Kincheloe & McLaren, 1994) and is often the dominant orientation of Maori research (Kiro, 2000).

The relevance of critical theory within this review of theory is its function as a bridging perspective between a weighting on the positivist attention to structure and the valuing of interpretation and meaning, the social construction of reality. From within the ecological framework articulated below, critical theory serves as a reminder about the powerful influence of structure within systems interactions, an important factor when regarding the behaviour of mental health workers within agencies. One of the key attractions of critical theory is that of education for critical empowerment (Kincheloe & McLaren, 1994). This places an emphasis on the legitimation of the knowledge of workers. Furthermore, its emphasis on action-reflection and the use of language to develop meaning is of great significance in the discussion about the use of language-based interventions in staff support.

Structural and political issues of power and empowerment are interwoven into the fabric of this research inquiry, and of the agencies and environments in which mental health workers practice. Issues of gender and resource allocation, for example, are crucial to the inquiry and to the construction of appropriate responses to incidents and events within the workplace. Critical theory offers a lens by which the influence of such structural concerns can be interpreted alongside the systemic and positivist perspectives previously addressed.

Recognising the construction of reality

> Truth ... is a thing with fuzzy outlines, when you look up close.
>
> Brin (1994:99)

As argued above, the advent of a systems perspective in Western thinking encouraged the intellectual and cultural acceptance of relativity. In physics, it is represented by quantum dynamics; in philosophy, by existentialism; in social sciences, in part by the movement that is known as postmodernism; and in clinical settings it has manifested as a constructivist stance that uses narrative tools and a Strengths perspective. The relationship between figure and ground in relation to the impact of trauma becomes open to interpretation according to one's location.

There is a lengthy historical tradition that debates the nature of reality. Hermeneutics is a modern manifestation of Kant's distinction between the world of objects in themselves (*noumena*) and world of objects as we know them, or as they appear to us to be (*phenomena*) (Schwandt, 1994). I view constructivism as a logical component of a holistic paradigm, and in recognising, for instance, that the class, gender and culture of both the researcher and the researched will impact upon the quality of the data, this perspective appears entirely congruent with the ecological framework that I will shortly introduce. It rests within a quantum acknowledgement that what we see will depend on our location, that reality is both pluralistic and plastic, and that social science inquiry is a sense-making process focusing more on the collective generation of meaning than on the individual mind.

I do not see the constructivist or interpretive perspective as a separate and stand alone paradigm, as Freedman and Coombs (1996), and Marshall and Zohar (1997) would argue. This position does not reduce its significance. Its importance to this inquiry is not so much in the discreteness of its approach but in the methodologies it suggests. Language lies at the heart of a constructivist approach. Narrative, the importance of the individual voice, and the process by which individual voices become collective, can represent a credible methodology by which data is obtained. As a collective voice, through waiata, myth, or critical incident debriefing, it is a powerful tool for reconnection and healing. Within this perspective there is a fundamental acceptance of human experience as a social and meaning-making activity that profoundly challenges the empirical and objective stance of biomedical science (Bracken & Thomas, 2003).

Constructivism recognises that a person's location and perspective will influence the interpretation of what they see and how they behave. To report on reality is to engage in distortion (Opie, 1999). A constructivist or interpretive perspective contributes to an understanding of the complexity of our response to critical incidents and traumatic events in the workplace (for example, Berger & Luckmann, 1971; Cooper, 2001; Davidson & Tolich, 1999; Rubin & Babbie, 1997). Specifically, it can be seen at work in research findings such as Rydstedt et al's 2004 study about subjective stress in the workplace. It is interpretive in its attempt to gain an empathetic understanding of someone's feelings, and in interpreting the experience of individuals. It offers the opportunity for in-depth subjective understanding of the specific, and for the construction of subjective meanings within social contexts (Davidson & Tolich, 1999).

In a therapeutic context it can be termed a narrative approach, granting recognition to the importance of a person developing their own meaning about experience (Epston & White, 1990; Freedman & Coombs, 1996). Constructivism has influenced and re-branded older intervention approaches. Thus crisis intervention, emerging initially from within a psychodynamic and developmental perspective, has emerged as a blend of cognitive-behavioural and constructivist elements (Kalliath & Kalliath, 2002).

One of the risks of the use of a constructivist perspective is one that is often directed at post-modernism in general. This is the suggestion that 'anything goes', and that all opinions and positions are valid. Cooper's promotion of a constructivist perspective in social work practice is tempered by an acknowledgement of this balancing act between different viewpoints (2001). He suggests that the argument that all accounts are valid is not the same as saying that they are all equally acceptable or viable. This practical reality is especially important in a situation of crisis and potential trauma, where a person's grip on their own notion of a stable reality may have been temporarily but profoundly shaken, to the point where engagement with their own construct is ineffective because, simply, they do not yet have one. The argument of this thesis is that a constructivist perspective operates best within an ecological acknowledgement of context and structure.

The ecological perspective as a response to complexity

The concluding part of this chapter is concerned with defining the characteristics of an ecological framework, and addressing its use in understanding the complexity of extreme stress and trauma in the workplace.

Within this chapter there has been an historical presentation of culturally located theory and a changing conceptualisation of trauma. I have argued that trauma's capture by the scientific processes of positivism has an enduring legacy in the interpretation and response to trauma. Furthermore I am suggesting that changes in intellectual thinking and perception of trauma through systems, constructivist and autopoietic perspectives in particular, require that trauma-related support systems within organisations must be cognisant of all the lenses through which trauma is viewed. As a result of this, a framework of analysis that is transtheoretical, actively integrating the various theoretical contributions, is suggested as the soundest approach (Macdonald, 1999; Trevillion, 2000). I term this approach an ecological framework, standing as a Western perspective on holism. This provides opportunity for comparison with indigenous and non-Western perspectives, but it should be stressed that

such comparisons are approximate rather than literal, as they exist in different cultural frames of reference.

The terms *system* and *ecology* are occasionally used interchangeably (Capra, 1996; Cormier & Hackney, 1987). Freedman and Coombs (1996) refer to the 'Ecological Systems Paradigm'. They place this paradigm on a continuum between the positivist and the interpretive paradigms, as it uses the metaphors of both biology and ecology. Meyer (1995) suggests that an ecosystems perspective is a way of seeing people and their environments that accepts their connectivity and multi-layered characteristics, so that we can begin to comprehend their complexities and thus avoid over-simplification and the reductionism that would result from use of a single lens. Gilliland and James (1997) coin the term 'ecosystem theory', which extends the application of systems theory to include such forces as the media that give us the opportunity for a global perspective. This encourages an acknowledgement of systemic dependencies and the need for a macro-perspective of the context in which critical incidents and traumatic events occur.

I argue that a distinction is should be made between the two terms, *systems* and *ecology,* because many of the concepts and language of systems theory remain hardwired into a positivist and 'hard' science knowledge base, and as such it is still emerging as a separate paradigm. At times, it refers to interactions between smaller levels or systems, and is not employed as a term inclusive of the wider political, cultural and spiritual contexts that true ecological approaches incorporate, in the spirit of autopoiesis (Capra, 1996). Ecological approaches offer the opportunity of integrating divergent perspectives and non-lineal causality (Belsky, 1980). Under an ecological umbrella, we see political and social marriages such as between church and welfare groups, political and indigenous activism, green philosophy, feminism, and spirituality. A paradigm shift in social organisation represents a move from hierarchies to networks, the network being the central metaphor of ecology that describes the transactional processes in nature, and potentially in the way that workers within organisations construct meaning and gain support. The study of trauma, I suggest, is also representative of interconnection between levels of human experience.

Fundamentally, an ecological perspective integrates constructivist and structural stances, in which people's subjective appraisals of their own circumstances and location are significant determinants of outcome (Jack, 2000; Neisser, 1992). People within this framework of intervention are active participants, this dynamic interaction between levels creating political

imperatives through structural awareness (Corby, 2002). When we look at the conceptual interaction of trauma, extreme stress and organisations, this thesis suggests that a linking of ideologies, structural factors and systemic factors is necessary.

This thesis employs ecological perspectives that emphasise the autopoietical concepts of structure, relationship, identity and change. Ecological models and terminology aid this discussion, with particular reference to two holistic constructions, *Te Whare Tapa Wha* (Durie, 1994), and the ecological perspectives derived from Bronfonbrenner (1977; 1979) and Belsky (1980).

The use of a Maori model of holism is not without tension. *Te Whare Tapa Wha*, widely utilised in health, welfare and education in Aotearoa New Zealand, has its identity within a Tangata Whenua world view, but has philosophical synergy with other indigenous perspectives (Durie, 2003), and, I argue, with Western philosophical approaches. Symbolising the necessary four cornerstones of a house, the elements of health in this representation are portrayed as *te taha hinengaro* (mental processes), *te taha tinana* (physical processes), *te taha whanau* (family and social processes) and *te taha wairua* (spiritual processes). Whole health and wellbeing is to be achieved by maintaining a balance in each of these areas. This model manifests in many applied forms, such as *Te Pounamu*[19].

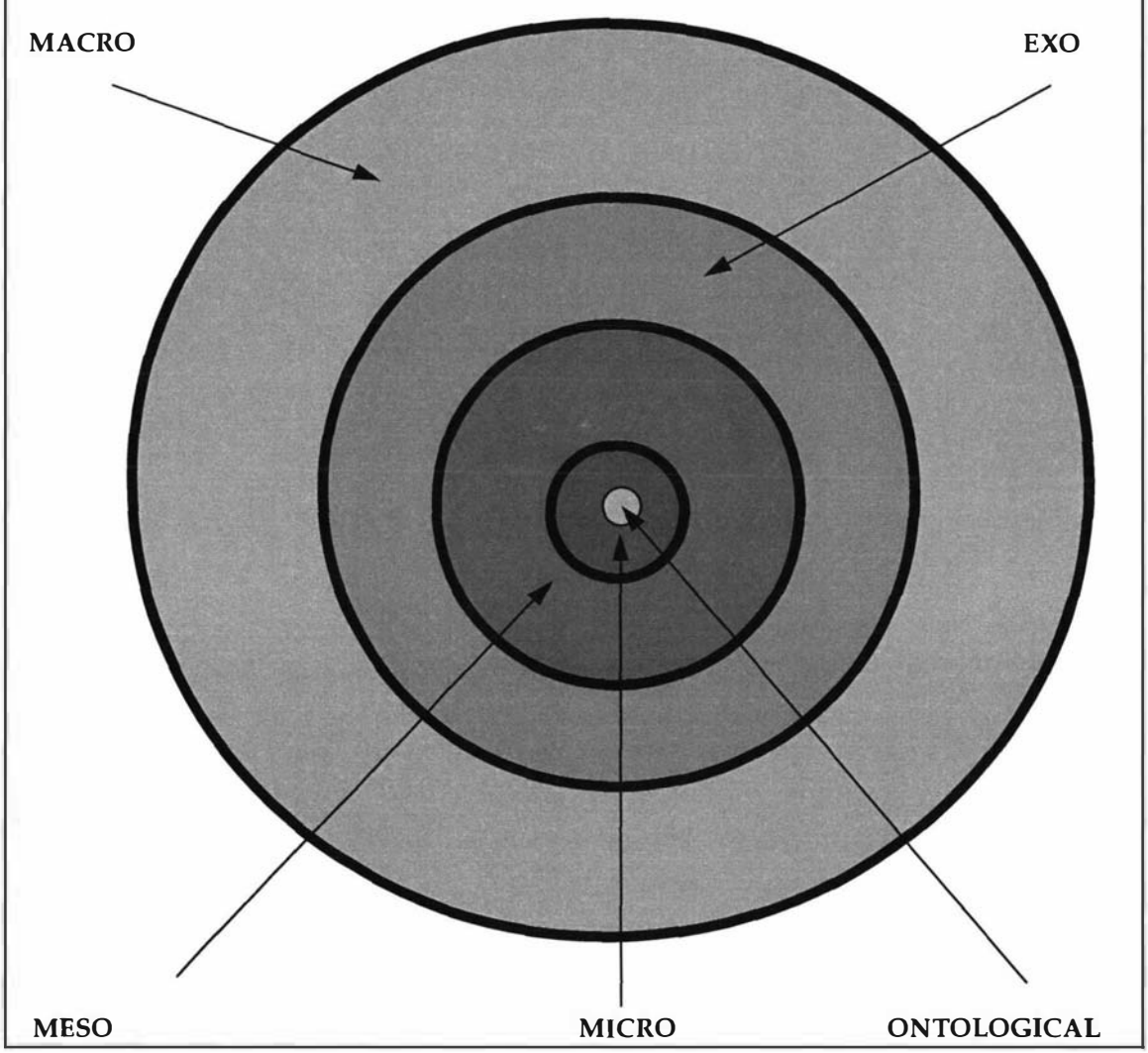
I explored *Te Whare Tapa Wha*'s relationship to Western explanations of trauma during the development of a post-graduate paper in social work and trauma at Massey University in 2003. The potential loss of subtle meaning in a cross-cultural application formed the basis of a discussion with Kingi, co-author of a mental health evaluation tool (*Hua Oranga*) based upon *Te Whare Tapa Wha* (Kingi & Durie, 2000 & 2001). This discussion, and the publication of *Hua Oranga* alongside other constructions linking indigenous and Western perspectives, further reinforced the potential use of *Te Whare Tapa Wha* as a framework for conceptualising trauma and is utilised in Chapter Five.

An ecological model of Western origin is also embedded within the thesis, its terminology and construction utilised within the tenor of the discussion concerning the complexity of organisational responses to critical incidents and traumatic events. This framework is based upon research by Bronfenbrenner and Belsky (op cit), in the 1970s and 80s. Bronfenbrenner (1977; 1979) explored an ecological perspective in relation to child development, and Belsky (1980)

[19] This model is utilised as both an assessment and intervention tool at *Te Whare Marie*, the Maori Mental Health team at Capital and Coast Health, the Wellington DHB in New Zealand.

developed this in relation to child maltreatment and abuse, which he argued is multiply determined by factors that are ecologically nested within each other. These ecological 'nests', or levels, are termed *micro*, *exo* and *macro* levels: Belsky added in the possibilities stemming from individual difference, to make levels of *ontogenic* development at the core of the model. The ecological framework addresses structural concerns, by making explicit that meso-, micro- and ontological level activity exists within exo- and macro-level influences (Durie, 2003). Such an ecological framework can be depicted as follows (Table 2.1):

Table 2.1: The Ecological Framework



Ontogenic influences are the factors that individuals bring into any given situation: personality, genetic structure, previous formative experiences, and so on. *Micro* influences are those patterns and conditions located within the immediate environment (the family, the work team). This includes activities, roles and relationships. An *exo-level* analysis considers the structures in the environment, both formal and informal, that do not themselves actively involve

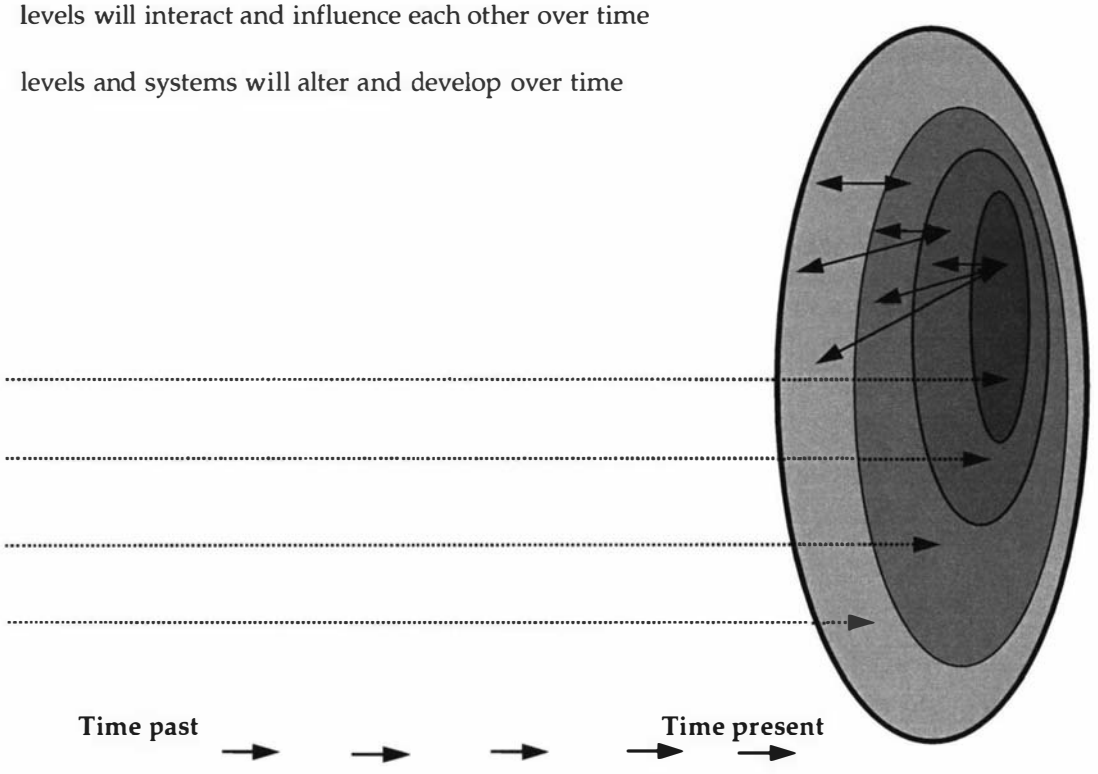
the person but which impact upon them through work practices, neighbourhoods and informal social networks, resource allocation, the legal and state administration system, and so on. The *macro* system addresses the influence of cultural and spiritual values, gender and sexuality, class and social attitudes. Bronfenbrenner (1977) talks in terms of the macrosystem representing consistencies demonstrated by the other levels of the system.

Belsky's outline of ecological systems (1980) does not include the description of the *meso*-system, which is now customarily included within education of ecological principles, as described by Bronfenbrenner (1979). The mesosystem describes the strengths and influences in the relationship between the different settings in which a person may find themselves: the congruency or dissonance, the strength or weakness of the links between microsystems (family and workplace, for example) or between micro and macrosystems (such as a clash between family and organisational expressions of religious belief) is highlighted in this term. For me, it is a key description of ecological systems that takes this model out of a static presentation of development into a dynamic and interactive consideration of influences. Whilst a Western model, it has some synergies with indigenous thinking: Davis (2003) suggests a similar model in her teaching of social work students. In a continuum from *au*, *whanau*, *whanaunga* to *whanaungatanga*, attention moves from issues of identity building, through engagement and connection with others, linking with the external world, to a greater sense of spiritual connection with the world.

The added dimension of the *chronosystem* (Table 2.2) allows for variable influences from all ecosystem levels over time (Santrock, 1997), and is reflective of the notion of change in chaos theory. This quantum perspective is illuminated in ecology by the notion of the 'ecological self', a concept that allows for interactive appraisals and a constructivist slant to the understanding of our location in relation to others (Neisser, 1992). How the ecological self perceives the environment's challenges and opportunities will determine the quality of human behaviour and cognition. Such a concept draws upon behavioural theory and such theoretical arguments such as learned helplessness (Seligman, 1992), and developmental and cognitive perspectives such as emotional intelligence (Salovey & Sluyter, 1997) and relational theory (Bergman, 1991; Covington & Surrey, 2000). This notion is inclusive of the concept of the extended self, so that past, present and future are intrinsically and inextricably linked. This is of significance to the study of the impact of extreme stress and trauma, as such events may threaten this dynamic relationship and sever ecological connectivity.

Table 2.2: The chronosystem in relation to the ecological framework

- levels will interact and influence each other over time
- levels and systems will alter and develop over time



An ecological construction which views personal and societal influences within an ever-changing dynamic has considerable traction within health and social welfare literature, in domestic violence (Edelson & Tolman, 1992); addiction (Barber, 1995); child protection (Cicchetti & Lynch, 1993; Corcoran & Casebolt, 2004; Fraser, 2004); explorations of inequalities and environmental factors in the community (Garbarino & Sherman, 1980); HIV work (Fouché, 2005) and in the trauma field (Adamson, 2005; Yassen, 1995).

Theory into practice: the Strengths perspective

An autopoietically-based, ecological perspective of human experience suggests that for every person, a unique matrix of personal and environmental features will combine to shape their reactions to events. Constructivism's emphasis on narrative and the power of personal interpretation, for example, suggests that there may be multiple pathways through an incident. The interaction of person and environment, the contribution of a systems approach to human experience, suggests that solutions to potentially overwhelming events may lie within the environment, within a person's interpretation and interaction with their surroundings.

Conceptually, the reduction in the influence of positivist thinking, with a focus upon pathology, and the growing concurrent recognition of complex causation and response is often described as a Strengths approach. Significantly, it has emerged since the 1980s and the growth of systems thinking. Within mental health, it manifests as the Recovery movement (Chapter 3; Rapp, 1993 & 1998; Rapp & Hanson, 1998). Within our understanding of trauma, it manifests as an enhanced appreciation of resilience and posttraumatic growth, an issue explored in Chapter Five. A Strengths approach emphasises not only what needs to be changed in order to gain a positive outcome for any situation, but what existing strengths and skills can be reinforced. A person's resilience, in an ecological appreciation of their situation, will arise not only from strengths within them but within their context.

This theme lies at the heart of the thesis question, and through its emphasis on interaction of complex variables, is revisited throughout the thesis, as the question of 'what works?' in staff support systems is explored.

With the acknowledgement of the complex interrelationship between person, perception, environment and time, it is clear that the environmental response to trauma's impact will have far-reaching consequences. The political dimension of the concepts of trauma and extreme stress is now explored.

Chronology, human rights and the study of traumatology

> Let us not make any mistake about it. By knowing and facing the greatest pains of mankind, as it were by eating from the tree of knowledge of good and evil, we are giving original sin new words in human trauma.
>
> Valent (1999b:4)

From an ecological perspective, a key contribution to the understanding of traumatic impact comes from the understanding of the holistic interrelationship between person, context and time. The risk of a reductionist approach to the study of traumatic impact lies in its attention to detail and to moments captured in time. Historical and cultural experience attests, however, to the enduring legacy of trauma over time. Chronosystem influence on generational transmission of trauma is manifest both in literature on child abuse and the Shoah, the Holocaust, a focus previously omitted from military-inspired study (Yehuda, 1999). From our perspective in Aotearoa New Zealand, immersion in race-based debates about social equity and the impact of colonisation forces us to understand the impact of trauma on many different levels simultaneously (Tomas, 2004). For this thesis, the longitudinal impact of critical incidents and traumatic events within the workplace becomes a key question, as behavioural

and social responses may potentially affect both personal and organisational functioning, and can therefore be constructed as not only an individual but a collective and political legacy.

From early writings (Eitinger, 1961; Frankl, 1964) to longitudinal studies of survivors (Bastiaans, 1974; Thygesen et al, 1970) to generational studies of descendents of survivors (Rowland-Klein & Dunlop, 1998; Steinberg, 1989), the forced relocation, imprisonment and systematic extermination of entire communities has framed much recent and current trauma research with cultural, political, transgenerational and global motifs. The European community, in particular, is sensitised to the long-term and generational consequences of extreme stress, providing one explanation for the difference in classification of trauma between the American and European systems (explored in Chapter Four). It has provided many with the necessary 'fire in the belly' (Munford, 2003; op cit) and political will (Herman, 1992a).

The study of trauma is a study of human rights and as such is influenced by political, cultural, racial, religious and social biases. It does not stand outside of these sites of tension and can be selective in the populations that it studies (Herman, 1992a). The silencing and social denial of the impact of trauma where acknowledgement is not in the public best interest may be a theme that emerges for occupational groups within mental health, where dynamics of stigma, the duty of care and professional and organisational loyalties play out against the backdrop of the public perceptions of mental illness.

An ecological perspective recognises that trauma occurs across all facets of human experience, and in many contexts. The effect of media coverage of civil war and genocide, for example, has been to make links between political, economic, social, cultural and religious movements and issues, and the effects on the individual. Once that lens is used, it is increasingly harder for an entirely individualistic frame of reference to have validity. Summerfield (1995), for instance, suggests that proposals for rape counselling in Bosnia may not be the most appropriate intervention, as rape, although a horrendous experience, may not stand out as any more traumatic than any of the other bereavements, losses and displacements within that war (Adjukovic & Adjukovic, 2003). It is arguments such as this that underscore the ecological framework utilised in the analysis of trauma's impact.

Trauma theorists are increasingly arguing that the perspectives gained from trauma have the power to influence human rights. Van der Kolk and McFarlane (1996) define the study of trauma as the 'scientific investigation of human

suffering', describing an important shift in the conceptualisation of traumatic experience. They suggest that psychiatry's process of classifying experience on the basis of what they term 'surface manifestations' has minimised our understanding of the human mind, and that it is the study of trauma - and explicitly the naming of the diagnosis of posttraumatic stress disorder - that has lifted psychiatry into new possibilities. A major point made in this thesis is that the analysis of workplace incidents has not yet incorporated the human rights element that characterises other aspects of the study of trauma.

Thus feminism, social empowerment models in disability, western interest in, and acceptance of, indigenous ways of seeing and thinking, post-modernism, constructivism and narrative therapy, all represent intellectual and cultural moves away from the positivist tradition (van der Kolk, Weisaeth & van der Hart, 1996). Putting context back into psychiatry focuses attention back on the living person as subject rather than object, linking past and present, and biology and spirituality (McFarlane & van der Kolk, 1996a). Bloom (1998a) describes the origin of ISTSS, the American-based organisation for the study of traumatic stress, as arising out of these social and political dynamics. As a result, a new synthesis, that of *traumatology*, has emerged.

> ... the study of trauma has become the soul of psychiatry.
>
> van der Kolk & McFarlane (1996:4)

Gold and Faust (2002) chart the evolution of traumatology after the introduction of psychological trauma into DSM-III. Their literature search on PsychINFO (an academic database for published psychological research) shows an exponential growth with no entries for 'trauma' in 1960; 51 in 1970; 75 in 1980; 430 in 1990 and 796 in 2000. There was a parallel development of specially designated journals from the mid to late 1980s (for example, the Journal of Traumatic Stress in 1986), with a heavy weighting on the reporting of empirical studies and less on practitioner-driven material. This emphasis is based upon trauma's conceptual roots within positivism and highlights the ongoing potential for tension between practitioner and researcher, as exemplified in Chapter Six.

The first World Conference on Traumatic Stress was held in Amsterdam in 1992. The European Society for Traumatic Stress Studies (ESTSS), originally conceived as the European Trauma Network in 1988, was established as a society in 1993, and now holds bi-annual conferences in the field. New alliances, too, are formed on the basis of these new mergers in ideas. The 'Trauma, Grief and Growth' conference in Sydney, in May 1998, marked a co-operation between the Australasian Society for Traumatic Stress Studies

(ASTSS), the Australasian Critical Incident Stress Association (ACISA) and the National Association for Loss and Grief (NALAG).

Like all nosological and philosophical movements, the science of traumatology should in no way be interpreted as definitive and permanent. Indeed, when we come to consider the range of available and appropriate interventions, this thesis will review the debate over the 'correct' model for Critical Incident Stress Management and Debriefing as a case study in the need for flexible, contextual-based intervention (Chapter 6). There is a very real risk that the popularity of the concept of trauma, and the embeddedness of the diagnosis within our health, social and economic institutions, will lend itself to the overuse of the term. In the same way that psychological symptoms were masked by current knowledge and schemata for human experience (the notion of 'shell shock' for instance), so too can a psychological construct be employed in a way that may mask very real symptoms. In re-focusing the lens onto trauma, we have to be at pains not to overlook other constructions of human experience.

Conclusion

Located as we are in the twenty-first century, we can now see how the dominance of positivist paradigms from the seventeenth century is now in question in many fields of life and inquiry. We live in truly exciting intellectual times, and I identify with Valent's belief, in the quotation heading this chapter, that the development of traumatology is well up with this sea change in ideas (Valent, 1999b). Leaders in the field such as van der Kolk, Herman, Bloom and McFarlane, all scientifically trained, are also all spokespeople for human rights and a contextual appreciation of the contexts in which trauma occurs (Bloom, 1997; Collins, 1999; Herman, 1992a; van der Kolk, 1996a). For me, the study and knowledge base of traumatology is one current example of the paradigm shift that has occurred in twentieth century western thinking, to cross the border between mind and body that these earlier constructions had created.

Recognition of the importance of the context in which incidents and potentially traumatic events occur provides the rationale for the consideration of the mental health environment in the subsequent chapter. The conceptual, structural and systemic development of service delivery environments and professional groupings describes the ecological environment in which the participants in this study were located.

Chapter Three: The Mental Health Context

Illustration 3.1:

Dayroom, Forensic Unit, Lake Alice Psychiatric Hospital, 2000.

Jono Rotman

The ecological perspective employed within this thesis requires that incidents and their responses be interpreted within an understanding of the contexts in which they occur. The environment of mental health service delivery is explored in this chapter, on the premise that many of the challenges and tensions experienced in the course of critical incidents and traumatic events can be best understood through historical and contextual analysis. The chapter begins with an historical review of the tension between the need for detention and 'disposal', and the demand for treatment and therapeutic response to those living with mental ill-health. Contributing to this are the socio-political circumstances of deinstitutionalisation, the challenges to the appropriateness of service delivery from the bi-cultural imperative upon which current mental health policy is predicated, and the issues of professionalisation and training that emerge in an environment of care within the community.

Detention and treatment: tensions within the development of mental health services

Mental health service delivery in Aotearoa New Zealand reflects global trends, a British colonial legacy and the paradigm shifts described in Chapter Two. Early government initiatives and public debates mirror the tensions and

concerns of current mental health policy, which constantly strives to strike a balance between the protection of the wider community and the therapeutic care of the consumer. There was early and clear construction of mental health as a public order issue rather than as a health problem. The legacy of the British Poor Law determined the inclusion of 'lunacy' within the vagrancy legislation. Williams (1987), writing in relation to the history of Porirua Hospital[20], comments that in the early years of colonisation it was not thought necessary nor was it practical to separate the mentally ill ('lunatics') from criminals in jail. Both lunatics and criminals were used for labour and care was custodial.

The abiding feature of nineteenth century mental health service delivery was the establishment of the institution. The first piece of mental health legislation, the 1846 Lunatics Ordnance, echoes the remit of the Mental Health (Compulsory Assessment and Treatment) Act (1992) in its intention to provide:

> ... safe custody and the prevention of offences by persons dangerously insane and for the care and maintenance of persons of unsound mind.
>
> Brunton (1996:4)

Brunton (1996) describes the classifications of insanity during the period of colonial establishment as socially and legally constructed, defined by poverty, dangerousness, criminality, and destitution. One of the earliest references to the Wellington Gaol Asylum-Annexe was to the 'pauper lunatic asylum'. General hospital wards were for temporary reception only, a model on which the legislation functioned until the 1992 Act. Social conditions from the 1860s onwards determined that asylums became repositories of the poor, as alcohol, syphilis, accidental injury, and the ageing of the country's large bachelor population all took their mental toll within a national climate of economic depression (Brunton, 1996). Vogel's immigration policies were blamed for filling the country with what Brunton terms Britain's 'social detritus' (p11), fuelling debate over correct disposal policy, which was commented upon in 1882:

> The question respecting lunatics and inebriates being placed in prisons or hospitals ought to be settled once and for all. It has been for ten years, a case of each institution refusing to take them in.
>
> *Annual report of the first Inspector of Prisons*, to Parliament, 1882 (Mason, 1988:11)

[20] Porirua Hospital: the psychiatric hospital serving the Greater Wellington region.

Acknowledging the repetition of patterns of service delivery, this quotation is included a century later within the Psychiatric Report of 1988, which had profound significance in the development of community, forensic and Maori-oriented services. Tensions over appropriate 'disposal' emerge as potent issues for the participants in this thesis.

Wider socio-political trends, and public and state awareness of the conditions within asylums, fuelled debate over their purpose and the roles of staff working within them. The dynamic created by the abolition of provincial government and the transfer of responsibility to central government in 1876 meant that regional services could 'dump' problems for which they were not resourced. This coincided with a decline in tolerance for the mentally ill within growing and more complex communities (Brunton, 1987). From the 1870s onwards, stigma increased. Brunton refers to the influence of the penny daily papers (the 'penny dreadfuls'), whose stories led to the alienation of the mentally ill. There is a parallel with the current role of the media in perpetuating stigma and discrimination, a factor which not only colours the workplace environment but which may actively discourage workers from entering it (Hatcher et al, 2005; Health Education Authority, 1999). Mental health workers, it is suggested, experience discrimination through low relative status, poor resource allocation and prioritisation in the health service (Thompson & Thompson, 1997).

The conflicted perception of the needs of mental health consumers played out in the delineation of the roles of staff. On one hand lay the notion of moral therapy and management inherited from the Quaker movement in Britain, the non-restraint of patients and an emphasis on the positive influences of staff, a view that interpreted mental illness as a moral weakness amenable to role modelling:

> Patience, gentle treatment, nourishing diet, cleanliness with light employment or exercise goes far to recover the lunatic, and in chronic cases serves to make them comfortable and even happy.
>
> *Journal of the Dunedin Asylum Keeper*, 20.4.1884, in Brunton (1985)

However, these beliefs had limited impact on what was largely medical and custodial control over the influx of chronic and incurable cases in the 1870s (Brunton, 1987). Treatments reflected the knowledge and perspectives of the times: bleeding, head shaving, blistering, and purges were used up to 1860s. In the late nineteenth century, chemical controls were introduced. Such 'disposal' solutions to problems experienced in society inevitably produced conflict about

how mental health patients were treated, and staff defined. Williams (1987) describes the 1872 prosecution for cruelty and unnecessary violence of the husband and wife who were in charge of the Karori asylum. This fuelled the demand for suitable control of the institutions. With the abolition of provincial governments, central funding created the Lunacy Department, and Dr Skae, the colony's first 'Inspector of Lunatic Asylums', was appointed.

In many ways Skae can be interpreted as one of the first commentators about conditions for both staff and patients within the mental health system (Williams, 1987). He highlighted the tensions between envisaging institutional care as detaining the incurable or as therapy for the acutely ill. Skae's first report in 1877 talked of poor conditions and violence in the Mt View Asylum, the present site of Government House in Wellington. He felt that lunatics should be happy and comfortable, occupied with a trade or with farming. Despite describing conditions as unendurable in his 1879 report, Skae was held responsible for them.

Skae can also be viewed as one of the first known casualties of occupational stress within the mental health system: overworked and depressed he died in June 1881, aged 39 years. His obituary in the New Zealand Times read:

> [His death was caused through] mental distress excited by the result of the recent Mount View Lunatic Asylum Enquiry. [...] He left a widow and nine children indifferently provided for.
>
> Williams (1987:33)

Skae's death followed the findings of a royal commission in 1881 in which he did not defend himself well (Brunton, personal communication). His memorial (Illustration 3.2) cites having been shown 'great and bitter troubles'. The threat and impact of inquiries persists as a dynamic in current mental health practice, which participants in this thesis explore in Chapters Eight and Nine.

Illustration 3.2:
'Great and bitter troubles': Dr Skae's memorial
Porirua hospital

Concern over conditions in hospitals in the 1880s led to the building of large rural asylums, their geographical isolation, self-sufficiency and limitation of public access consolidating the image of fear and incurability. Brunton (1996) describes the six month curability test for inmates, who had to pass or else they were regarded as there for life.

The proportion of patients deemed incurable rose from three quarters in the 1870s to 93% in the first decade of the twentieth century. Williams (1987) details that after 1907, if a married man entered an asylum, his wife became entitled by law to a widow's pension. Differentiation of *chronic* and *acute* by means of the villa system had become government policy by 1903. In the 1920s at Porirua Hospital, admission villas were set up out of sight of the main institution so that these 'curables' would not be tainted by mixing with the chronic patients. Even by 1945, when new physical treatments became available, two thirds were still regarded as therapeutic 'write-offs'. By 1945 more patients died in mental hospitals than were discharged as recovered. The limit to knowledge about mental disorder combined with social stereotypes to perpetuate these beliefs, and potentially impacted upon the quality of the work environment.

As acknowledged in the previous chapter, trauma, medicine and war have a close relationship, and each have influenced the development of mental health services. The Mental Defectives Act of 1911 provides a window into the attitudes and language of the time: the use of 'lunatics' was dropped in favour of inmate; 'asylum' became mental hospital; and 'attendants' metamorphosed into nurses. It further marks the medicalisation of mental health. For Aotearoa New Zealand in the aftermath of World War I, soldiers returning from war appeared to need a different sort of response to that of traditional asylum care, with growing attention to the concepts of shell shock and neurasthenia, this latter term having been dropped in 1917 because of the psychiatric stigma it had acquired. Clarke (1991) talks of the dissonance created by the dual images of the returned soldier: the cultural icon of nationhood, and the mental patient.

One soldier in ten was invalided home with a nervous disease (Brunton, 1996). The growing public awareness of mental illness that followed the Anzacs' return contributed to the development of community mental health services. There was a call for halfway or 'borderland' houses, and outpatient clinics, to meet the needs of the nations' heroes. Outpatient clinics attached to the general hospitals in the main centres were authorised in 1925. The Mental Defectives Amendment Act (1928) further extended this process.

Nonetheless, the focal point for mental health services and staff until the 1980s remained the asylum, and the major treatment modalities remained medical in nature. Scientific intervention expanded with the use of electro-convulsive therapy (ECT) and insulin therapy in the 1940s. Both of these have proved controversial, both in scientific debates over their effectiveness, and in the civil rights issues surrounding how they have been employed, issues which have far-reaching consequences for the behaviour and perception of staff.

In parallel with the development of scientific techniques remained the influence of moral management, a peaceful environment and the notion of gainful activity. This manifested professionally in the opening of the School of Occupational Therapy in 1942. Patients were to be kept busy, highlighting one of the key roles of mental health staff to the present day:

> No occupation is not rest, a mind vacant is a mind distressed.
> Occupational Therapy Newsletter in 1949, in Williams (1987:216)

This ongoing theme is exemplified by this excerpt from an unpublished in-service talk on the subject of *The Role of Various Specialists in the Psychiatric Team*, by Dr Pugmire, Medical Superintendent of Lake Alice Hospital in 1978, which states:

> The most important factor is certainly, in my mind, the therapeutic atmosphere of the hospital. The great majority of our patients would fall into three categories, Schizophrenics, Manic Depressions and Feeble-minded. [...] it is pure good luck that they all happen to respond well to the same type of regime, that is to a very calm, peaceful type of management that provokes no stress.
>
> Pugmire (1978:14)

Medical developments had a major influence on mental health issues and institutions after World War II. The late 1950s and early 1960s saw the introduction of the anti-psychotic, stelazine; amitriptyline, an anti-depressant; and lithium carbonate for affective disorder (then known as manic depression). It was not until these developments in drug regimes that the statistics such as those in 1961 began to change (Williams, 1987). The census of mental hospital patients in that year reported that 52.1% of those with schizophrenia had been in hospital for more than twenty years (Williams, op cit, p4). Longer lasting drugs administered by injection ('depot drugs') made the development of outpatient care in the community a viable option. Introduction of the major tranquillisers meant that patient management within the institutions could be conducted in open ward settings. New order anti-psychotic medication, it can be argued, currently enables those previously institutionalised to live within the community.

The interrelationship between scientific technology and the shape of service delivery, policy and legislative change cannot be overlooked. In 1961, an amendment to the Mental Health Act simplified committal procedures and opened the door for treatment outside the hospital, thus allowing for the development of community services. The Mental Health Act of 1969, the most

significant piece of legislation since the Mental Defectives Act of 1911, revised outdated words such as idiot and imbecile, further simplified the process of committing patients and provided a statutory basis for the increasingly more accepted trends in community care. Deinstitutionalisation became an active possibility.

Another significant characteristic of mental health policy in this country has been the role that crises and inquiries have had in shaping the development of services before, during and after deinstitutionalisation. Inquiries continue to dominate the work environment, as evidenced within this research study. Between 1987 and 1996 there were sixty-seven inquiries into aspects of mental health services (Mason et al, 1996), and the narratives of participants in the thesis attest to their ongoing incidence. An inquiry can perhaps be viewed as a knee-jerk response, post-facto, to a systemic or structural problem; nevertheless, reviews of practice and recommendations for change are embedded in the fabric of the mental health workplace and form markers for the context and style of the service delivery environment.

> Inquiries are ... a very old method of facilitating quality assurance.
>
> Mason et al (1996:12)

Significantly, out of the inquiries acknowledged in this 1996 report, issues concerning the work environment emerged as concerns, as well as patient environments and treatments. In particular, the 1988 Psychiatric Report offers a seminal review of the issues surrounding the period of deinstitutionalisation and care in the community (Mason, 1988). It gave insight into the growth of appropriate services for tangata whenua, and in many ways provided the impetus for the change of legislation in 1992, as acknowledged in Chapter Four. It highlighted barriers that existed in the provision of services in the community, inadequate funding, and the shortage of trained mental health workers. Citing negative public attitude to psychiatric illness and an uneducated community, it highlighted poor co-ordination of information resources and a lack of research into effectiveness of community services. Moreover it highlighted the shifting of gateposts in regard to admission to mental hospitals, in this case through resource allocation and political dynamics that decreased the emphasis on detention and provided a greater spotlight on treatment.

Deinstitutionalisation, community and care

> Ever since Karl Marx and the communists started talking about community, everybody has been shouting 'let's be modern and move everything into the community' regardless of cost or efficiency. They seem to forget that community care is what the world started out with. It meant that all sick people were allowed to stay at home and die ...
>
> Pugmire, Medical Superintendent, Lake Alice Hospital
> Pugmire (1978:3)

The current context for the occurrence of critical incidents and traumatic events in mental health emerged out of developments in service delivery determined by the processes of deinstitutionalisation and care within communities. An expanding welfare state in the mid-1960s saw the growth in philosophies in which community treatment was promoted. Changing perspectives about the nature of mental distress and disorder, the increasing awareness of the importance of psychosocial factors, civil and indigenous rights and economic imperatives contributed to this policy change and to the environment of the current workplace.

Deinstitutionalisation can be viewed as a political movement, just as institutionalisation was an economically-driven political solution in the early days of the colony (Brunton, 1996). Economic growth, followed in the 1980s by the shifting sands of economic restraint, determined that institutions came under the spotlight not only as philosophical but also as economic dinosaurs (Gibbs et al, 1988). The large institutions were deemed to be too costly to be maintained by governments faced with the rationalisation of health and welfare services: the re-organisation of resources from Vote Health into those that funded health services and those that provided them (the 'funder-provider split') produced a focus on accountability and outputs which further determined the location and nature of mental health employment.

Rejection of the notion of institution can be made on ideological grounds, with the acceptability of the institution as a solution to mental health problems (or the problems that society has with mental health) no longer tenable. The Italian community mental health movement is a case in point (Mezzina, 2000). On a humanitarian level, incarceration in large institutions had become conceptualised as anti-therapeutic. New anti-psychotic medications had enabled the focus to be moved from the custody and restraint of acutely ill people, to maximising their opportunities within their communities of origin. Caird (2001) suggests that the impetus for deinstitutionalisation came from both civil and humanitarian rights and the academic social constructionist

debate. With a changed understanding of mental health, the emphasis in service delivery moved from 'disposal' towards prevention and normalisation (Haines & Abbott, 1985). This can be illustrated by the shift in legislative emphasis within the 1969 and the 1992 Mental Health Acts, the former based upon the assumption of institutional care, the latter espousing the principle of the least restrictive detention. The relationship of legislation to psychiatry is explored further in Chapter Four.

The 1980s marks the move towards community in Aotearoa New Zealand. This mirrors the international trend within western psychiatry, as exemplified by the experience in the United States and Britain (Bachrach, 1996; Leff & Trieman, 2000; Szmukler, 1999). On a population basis, in 1971, some 350 in every 100,000 in Aotearoa New Zealand was resident in a psychiatric hospital; by 2000 the figure had dropped to about 50 per 100,000 (Simpson et al, 2003). In Aotearoa New Zealand, the sale of the state-owned Telecom by Labour in 1986 funded the development of community mental health centres, to act as physical and organisational bases for the mental health staff relocated from their institutional settings.

The process of re-locating the focus for service delivery created fresh emphases and tensions for both consumers (Durie, 2001) and the occupational groupings employed in mental health. Not the least of this was a re-organisation of the understanding of community. In undergraduate sociology I was introduced to Cohen's statement that there are twenty-six possible definitions of the word 'community' in the English language (1980). It is perhaps glib, then, to talk about 'the community' as distinct from 'the institution' as a site for the care and treatment of mental health problems. Unlike the institution, community has no clear boundaries and delineations. In an increasingly urban society, a person can live in one geographical area and work in another; and in both locations they can be oblivious to the identity of their neighbour. Communities of interest can transcend geographical borders, and communities comprised of cultural and familial networks may be neighbourhoods or composed of less tangible connections. Mezzina (2000) commented that the community has the potential to be either empty or full, and as such can either sustain or undermine recovery. Rapp (1998) describes the community as having 'enabling' or 'entrapping' niches.

The process of unpacking hospitals into the community produced an altered environment for both consumers and staff. The needs of those living within communities acquired a different profile. Care in the community requires acknowledgement of diversity in terms of geographical, cultural and

socioeconomic backgrounds of consumers, who have diverse needs such as transport, mobility, finance and age. Services are required to become client rather than institution-focused. Mosher and Burti (1994) refer to an ecosystemic view using the context of people's problems that contributes to their resolution. The interface with other fields of practice becomes more apparent, as the issues and solutions facing people living with a mental disorder cease to be categorised as 'merely' mental health but may be interlaced, for example, with environmental stressors, substance abuse and infringements of the law. As the areas of vulnerability for people in the community are different from those living within the institutions, the environment in which incidents may occur is similarly transformed.

As hospitals closed, consumers deemed less acute were relocated into communities first. Many were not, under changing definitions of mental disorder, actually mentally ill. This included the intellectually disabled and the elderly, many of whom wore a primary diagnosis of 'institutionalisation', a diagnosis made by medical staff at Lake Alice Hospital. For both of these two categories of former patients, this transition marked the end of a mental health label. With this went a change in the occupational composition of both management and those caring for them, from medical and nursing-focused staff to a growing population of support workers within supported accommodation.

Deregulation of funding enabled groups with differing community identities (cultural; regional; needs-focused) to tender to provide services. Whilst the withdrawal of state-run health services from the daily lives of many people with mental health problems undoubtedly produced advantage to many, for some, however, an emphasis on short-term treatment and involvement by a variety of health workers has tended to work against long term planning and support which many require. Shortage of both funding and staff resources worked against effective service delivery (Mason, 1988). Internationally it has been noted that placing patients in the community without adequate outpatient services and care has not been well prioritised, funding does not follow the consumer into the community, and needs of housing and employment are not addressed (Human Rights Watch, 2003).

Evaluation of care in the community appears to suggest that if the research includes measures of consumer satisfaction and quality of life measures, the process of deinstitutionalisation has been successful (Abergavenny, 2000; Leff & Trieman, 2000). Abergavenny's study, however, also observes a significant readmission rate (38%), with 10% needing respite care or acute re-admission at

any one time. Integration with acute services appeared as a problem and is highlighted in the experiences of participants in this thesis. Warren's research (1997) into care in the community in Aotearoa New Zealand confirms that very few people in acute settings were new to the mental health system, a common feature of all readmissions being a breakdown in the caregiving system. Her interpretation, like that of the Health Research Council (1994), was that mental health policy has idealised the notion of community and that current social changes (with social attachments simultaneously more geographically spread and more privatised within nuclear families) have not been taken into account.

Abergavenny's study (2000, op cit) suggests that whilst the costs of hospital and community care were similar, the economic responsibility in the community had shifted away from the health service. The use of untrained and/or low paid workers, and the introduction of competitive tendering through the funder-provider split also suggests that community-based services may appeal as a lower-cost option to the State. Warren (1997) also suggests that 'community care' often means care by women in the immediate family, who experienced isolation, a decline in standard of living, and for many, deteriorating physical and mental health. Cheyne et al (1997) make a similar point, and Burns et al (1994) cautions:

> The success of deinstitutionalisation often came to be measured by reduced rates of hospitalisation rather than improved rates of access to treatment or support [...]
>
> Burns et al (1994:3)

The pressures on families, themselves often fragmented, under economic and social strain and nuclear rather than extended, becomes a major issue within the context of care in the community. Mental health workers thus may work with family as much as with the consumer, revealing tensions of confidentiality and privacy, role confusion, and debate over accountability and client identity. Funding may follow the identified individual, but the whole family may be the focal point for the professional engagement.

The re-location of the focus of mental health care from the larger institution to the community does not of course eliminate residential care. From the smaller but no less secure forensic units[21], to sub-acute settings, and various levels of

[21] Although the criminally insane was identified in the New Zealand literature as far back as the 1880s, specific treatment facilities for forensic patients did not emerge until the late 1960s with the opening of the National Secure Unit at Lake Alice Hospital. This remained the purpose-built secure unit until the establishment of the regional Forensic Services as recommended in the 1988 Psychiatric Report (Mason, 1988). The overlap between mental disorder and the law remains an issue to this day, in part due to the ongoing debate about 'disposal' and in part due

sheltered and supported accommodation, mental health consumers are more visible in the community but remain 'in care' to various degrees. Rapp (1998) describes the ways in which consumer autonomy and dignity can be compromised by the community model, suggesting that consumers are in the community but not of the community. Use of space, time and mobility are all compromised by organisational needs and policies. Relationships are also constricted through staff keeping professional distance and living arrangements of consumers are often single gender houses that may not reflect choice.

There is also international evidence of 're-institutionalisation' processes in mental health. Research suggests a European trend of increases in the number of forensic beds, a rise in compulsory admissions and in the numbers of placements in supported housing at various levels (Priebe & Turner, 2003; Priebe et al, 2005). These authors also consider that assertive outreach (within a New Zealand context, teams such as Early Psychosis Intervention projects) also forms part of a re-institutionalisation process, rather than care in the community, as might be suggested by its location. Several of the participants in this thesis were employed in such teams.

The often prominent location of vulnerable consumers within community settings raises major concerns about the effect of stigma and discrimination. Community norms of behaviour may mean that community is less tolerant of difference than the institution, and that for some, their 'asylum' becomes a room within a boarding house. For others in the community, the relatively unrestricted or unsupported lifestyle can lead to issues of treatment compliance, a phrase largely referring to a degree of willingness to take medication as prescribed. Clinicians suggest that compliance rates and treatment outcomes can be influenced by environmental and interactive processes such as a person feeling understood by staff, involvement of family or community supports, acknowledgement of cultural influences, and collaboration in the planning of care (Craig, 1999). The issues of compliance and conformity become high profile within mental health in the community, and become a powerful dynamic in the lives of mental health workers.

As the prime location of mental health services has shifted to the community, the nature of these communities has come into sharper focus, demanding responsiveness to cultural identity and highlighting the challenges inherent within the delivery of culturally-informed practice. Approaches to the mental

---

to the epidemiological overlap between the mental health and offender populations (Brinded et al, 2001).

health of Maori form the basis of considerable discussion within the narratives in this study, and are considered below.

Approaches to Maori Mental Health

With deinstitutionalisation came the increasing inclusion of Maori within both consumer and workforce numbers, a dynamic embedded in this thesis study and reflective of the increasing awareness and acknowledgement of New Zealand's bicultural identity and the partnership imperatives of the Treaty of Waitangi. The cultural bias implicit in the history and nature of the mental health service delivery environment can be observed (Brookes & Thomson, 2001). Brunton (1996) suggests that institutional responses to Maori mental health had perpetuated processes of colonisation. Maori mental health needs have gained greater prominence as mental health services have progressed in ecological awareness. The working environment in mental health is an active arena for the playing out of bicultural processes and tensions, issues which emerge as key for the participants in this thesis.

Durie (1994 & 2001) identifies three phases for Maori within the mental health system. Prior to 1970, Maori were underrepresented in statistics, converging with non-Maori in the period 1970-4. Brunton's historical review (1996) reveals that in early Pakeha accounts there are few records of mental disability or psychotic behaviour amongst Maori, although there were instances of suicide. Given an understanding of cultural bias within mental health classification (explored in Chapter Four), it can be assumed that such issues have been invisible to Pakeha scrutiny. Early colonists would at times transfer Maori 'lunatics' back to tribal authorities (Brunton, op cit). Conversations with people from various iwi have detailed cleansing processes and methods of exclusion and expulsion, suggesting similar themes but different processes for what to Pakeha is seen as mental illness.

From 1975, Maori rates have exceeded non-Maori for some groups and some diagnostic categories, with the trend towards increasing disparity. The lower rates were not necessarily due to a lower incidence of illness but to alternative management strategies. Durie (1994) speculates that actual rates of mental illness may have increased amongst Maori, and although baseline statistics will never be available for this, an understanding of the aetiology of mental disorders suggests this as a possibility. Since 1975 the rise in Maori admissions has been higher in the areas of drug and alcohol problems and psychosis. Some of these statistics may be due to increased access to hospitals through urbanisation and greater acceptance of western approaches to health, but may

also reflect a change in definition of 'Maori', and cultural discrimination factors within the diagnostic process.

In recent years, Maori first admissions to hospital have been about the same as the Pakeha rate. In 1994 Maori were 14% of first admissions and 18% of all readmissions. However, the Maori experience is that of a poorer outcome after the first admission, leading to more re-admissions and chronicity (Te Puni Kokiri, 1993). The Ministry of Health (1997) reported that Maori are 40% more likely to be re-admitted to psychiatric services than are Pakeha. There is a suggestion that when an individual enters the mental health system they submit to a Eurocentric philosophy of health, illness and care delivery. This suggests that the relationship between culture, health practices and illness presentations in assessments is overlooked, risking not only misdiagnosis, but also inappropriate treatments (Craig, 1999). The photograph below (Illustration 3.2) demonstrates an early attempt to create a bicultural balance in service delivery through a cleansing ceremony of sites where spiritual conflict had occurred.

Illustration 3.3:
Lifting the Tapu, Wai-o-hine
(National Security Unit, Lake Alice Hospital), 1991

These issues may determine conditions in which incidents can occur. For Maori, there is a characteristic of enforcement, compulsory admissions accounting for one third of all admissions for Maori men under the Mental Health Act (1992) and the Criminal Justice Act (1985). Involuntary admission is 154% higher for Maori men than for Pakeha men and 55% higher for Maori women than for Pakeha women (Ministry of Health, 1997). There is speculation that Maori are perceived by health professionals as more aggressive and were treated in a more physical manner, similar to the treatment of Blacks in the UK and USA (Te Puni Kokiri, 1993). Suggesting a broader trend of social and institutional racism and the outplaying of colonisation processes, there are also higher rates of imprisonment of Maori evident within the same time frame (Durie, 2001).

Recognition of factors such as these created a demand for a more culturally appropriate service delivery. This is an ongoing process to which the

participants in this thesis often refer, as it has created significant tensions and environments in which the effects of incidents play out. Maori mental health services in mainstream hospitals were initially established in 1983, with Whaiora at Tokanui, and Te Whare Paia at Carrington in 1987. Retrospectively, these units, established in socially and politically resistant environments, were doomed to be stigmatised and set up to fail (Durie, 2001).

Currently, the existence of Maori-focused units within the psychiatric mainstream is endorsed by national policy that gives identification and support towards Kaupapa Maori[22] services (Mental Health Commission, 1997 & 1998). The Health Funding Authority (1999), then funding health services, laid down specifications for Kaupapa Maori services not only in hospital settings but also for community residential homes. It identified groups of values in its promotional meetings, firstly underpinned by *Te Whare Tapa Wha* (Durie, 2004), and reflecting interconnectedness, the use of spiritual processes such as karakia (prayer) and tohunga (experts); caring and support, and rangatiratanga (the embedded cultural processes that govern power relationships such as ritenga (custom), kawa (protocol), tikanga (practice) and the marae, or meeting place). Such principles, powerful statements of Maori cosmological perspectives, are made more visible by the increased ecological awareness of Western mental health practice.

Resources nevertheless govern the implementation of Kaupapa Maori services. Maori numbers in the mental health workforce do not sustain adequate representation in all occupational groups. In 1996, less than 1% of clinical psychologists and occupational therapists, 1.6% doctors and less than 4% nurses identified as Maori (Durie, 1996). Twenty percent of the 123 Maori doctors was a psychiatrist. Much of the movement toward Kaupapa Maori systems within mental health has manifested within community-based organisations such as community support work agencies. The older institutional frameworks of hospitals and established professional groupings generally reflect less bicultural awareness. Implications for this in terms of the management of critical incidents emerge in the consideration of the skills and orientations of the workforce. As a lesser representation of Maori workers is evident in psychiatry than in community support work, it can be argued that not only does the Western construction of psychiatry (still arguably the watch keeper if not the gatekeeper of mental health) continue to dominate, but that tensions may result in the delivery of services and the experiences of mental health workers, not all of whom may share these cultural perspectives.

---

[22] Kaupapa Maori services are those run from a Maori cultural perspective.

The Mental Health worker: the evolution of professional identities

> ... the Matron, Secretary and the Medical Superintendent make a three-cornered administrative body which runs a modern hospital. [...] This is probably in its purest form in Lake Alice, because Lake Alice is a State Hospital, everybody employed here is a State Servant, and there is no hospital committee. The principal nurse, secretary and superintendent each have their superiors at Head Office in the Department of Health, Wellington. There is a straight line of command right through the Civil Service and if you kept following it up you go through the Governor-General, through Whitehall and you eventually get to the Queen. [...] It's a pure dictatorship and it has no relationship whatever to democracy. [...] All other hospitals have their administration impaired [...] by a committee of local nincompoops called the Hospital Management Committee.
>
> Pugmire (1978:13)

This idiosyncratic account of hospital management before deinstitutionalisation reflects a strict hierarchical demarcation of roles within institutions. With the shift to community as a focus for care, such roles underwent significant change, creating new dynamics in any analysis of the impact of incidents that may stem from the interactions of roles, tasks and power relationships, and through the implementation of mental health policies and practice. In the community treatment becomes an active, multidimensional process, with each contact potentially therapeutic (Mosher & Burti, 1994). This impacts on the existence and status of hands-on jobs in the community (community support workers, for instance) that are outside of traditional, institution-based professions. New professional and occupational groupings spring up out of need but are not necessarily housed within the professional identities that might give power, identity, status and support.

In New Zealand's early mental health history, attendants (or warders) had no training and the aptitudes and behaviour of some had been the cause of considerable concern during several inquiries. There had been strict gender divisions in the early asylums, the introduction of females into male areas occurring with soldiers in Auckland Mental Hospital after World War I (Brunton, 1996). Brunton says that contemporaneous reports suggest a reduction in 'misbehaviour' and improved standards of care. The introduction of female nurses into the National Security Unit at Lake Alice (circa 1990) anecdotally had the same outcomes.

Psychiatry was (and in some cases, still is) seen as the poor relation of medical training. Salary levels and working conditions were poorer than in general medicine, and psychiatry was not incorporated into the medical school curriculum until 1914 (Brunton, 1996). Despite its relative low status amongst medical specialties, psychiatry has been the dominant profession within mental health services in this country, and shares an acquired mantle of prestige with other medically-trained practitioners. The paradigm shift in the conceptualisation of mental health was in part responsible for the service delivery changes that have seen the emphasis move from detention to treatment and from hospital to community-based services. The introduction and promotion of a recovery perspective, informed by biopsychosocial principles and a greater weighting upon Kaupapa Maori has shifted the emphasis towards a partnership with community and consumer and has affected power balances and role identity within the mental health professions.

Funding for mental health services, separated from the provider function by the Health Reforms, is now competitively tendered for by both District Health Boards (DHBs) and a range of providers that often reflect local characteristics, and which are most represented by community support agencies. DHBs are the descendents of the Hospital Boards that typified the colonial structure of service delivery. They provide both inpatient (acute, rehabilitation and forensic services, for example) and community mental health teams (CMHTs). Within the CMHT structure, teams have as the majority profession the mental health nurse, with a variation of other professions according to local resourcing. 'Point five' of a psychiatrist, for example, is often an illustration of the sharing of professional resources across patch boundaries or services.

Clinical roles and identity have undergone change. The notion of the generic mental health worker has emerged latterly within CMHT structures, with job descriptions depicting a skills-mix of clinical and therapeutic abilities and education, for which a range of professions can apply. There is thus a reconfiguration of occupational identity that reflects a breaking down of the old professions and increased sharing of knowledge bases and skills.

In reality, a mental health worker from a CMHT may see a client perhaps once a week (or fortnight) depending on need. Involvement may be time-limited, according to dictates of notions of recovery and an emphasis on evidence-based outcomes. Gibbs (2001) describes the work environment as having changed to that of the tension between devolved budgets and centralised control, maintained by contractual obligations and standardisation of tasks. Interventions are more likely to be accepted as practice if they have measurable

outcomes or reduced costs (hence an emphasis on cognitive-behavioural therapy (CBT), short-term task-centred contracts and group work, rather than open ended or one-on-one casework). Within mental health we have seen this through the impact of and emphasis on evidence-based, output-focused intervention, and the support for lower-costing, community-based support systems. From a paradigm perspective, interventions open to quantification by positivist methodology such as CBT have been favoured, an argument that re-occurs in the consideration of debriefing in Chapter Six. Such clinical services may, however, provide limited support for people dealing with the consequences of mental illness, where the issues may be housing, isolation and stigma, entertainment, income and employment, as well as symptom management.

Lying at times outside of the DHB service delivery structure are a range of community-based providers, funded largely but not exclusively through Vote Health and working, in principle at least, alongside the DHBs. Some are specialist tertiary services employing mental health professionals (for example, therapeutic services such as psychotherapy for child trauma victims) but others offer a range of services geared at the support of consumers within the community. It is to this new occupational grouping, the community support worker, that this discussion now turns, as they are a significant body of workers who engage on a daily basis with consumers and their needs, and it is statistically and environmentally likely that this group will be likely to experience the impact of critical incidents within the mental health workplace.

The Community Support Worker

As a newly emergent occupational group, this thesis suggests that the community support worker (CSW) may be vulnerably exposed to critical incidents both by their location in communities, and by their relative lack of training.

The creation of the role has its origin in the deinstitutionalisation process. The shifting of the gateposts of care from hospital to community meant that the needs of consumers had to be met within community settings; in their own homes, sheltered housing, or at times, on the street. Policy changes led to a different manifestation of employment patterns within mental health, as within the health system in general. Public sector restructuring and cutbacks ('repositioning' is the sanitised term often employed to describe a managerial and corporate process of organisational realignment) resulted in the blurring of existing professional boundaries, contracted jobs and programmes, and the rise

of a new breed of mental health worker whose role in caring for members of the community with mental health problems is less determined by professional identity than their community skills or past experience (Cheyne, O'Brien & Belgrave, 1997; O'Brien, 1999).

It is into this area of non-clinical support for consumers that the role of the CSW has developed. The role brings people into closer and more frequent contact with consumers than other mental health roles, and is more holistic and environmentally sensitive. In many ways CSWs have filled the occupational niche once filled within the hospitals by psychiatric assistants or nurse aides, and at times, by enrolled nurses or untrained 'social workers'. From the early 1990s some of the non-governmental residential support providers, in particular, began to organise 'community care' or 'outreach' services, funded through the Income Support Special Benefit, to provide home-based support services to consumers (CSW Principles and Values Working Party, 1998). From 1995 a range of organisations have provided community support work. Some are managed through trusts and incorporated societies representing the pastoral arm of churches (Baptist and Methodist, for instance). Others are culturally specific, located in iwi or hapu, or in Pacific Island communities. Twenty percent of all Maori mental health workers are in community support (Health Workforce Advisory Committee, 2002). A few CSW teams and workers are located within DHBs and are here focused upon specific consumer groups such as early intervention in psychosis. The diversity of agency and management structures reflects both the range of needs, and a potential difference in emphasis in the skills and tasks of which the CSW is required to be capable. For Maori and Pacific Island communities, for example, the CSW role is envisaged as having 'a proactive role in liaising between the service user, their whanau and the responsible clinician', a role not dissimilar to that of a social worker (*North Health Purchasing Contract*, in CSW Principles and Values Working Party, 1998:14). The purpose of this role, this contract states, is to minimise cross-cultural misdiagnosis and mistreatment[23], concepts explored in Chapter Four. Caird (2001) cites Wade's unpublished research that suggests that CSW has had a positive influence on the development of Maori and Pacific Island services, with increased status and numbers of staff in 'mainstream' and in Kaupapa Maori agencies (p24). The research suggests that the CSW process sits comfortably with Polynesian models of care.

---

[23] The North Health contract defines these as follows: *Cross-cultural misdiagnosis*: inaccurate description of culturally derived behaviours, beliefs and expressions that are consistent with mental illness. *Cross-cultural mistreatment*: treatment being provided on the basis of cross-cultural diagnosis (CSW Principles and Values Working Party, 1998).

Throughout the first few years of the development of CSW service delivery, various models evolved in order to explain their role to consumers, families and providers. A CSW Working Party (1998) provides examples of both written and symbolic models. Baptist Mental Health, for instance, described the model ecologically with the individual in the centre, with overlocking systems of self-help (including groups); family, friends and whanau; community resources; and mental health services. Framework Trust described the consumer as an apple tree, with the CSW as the farmer charged with caring for the growing environment. Lotofale, a Pacific Island CSW agency, used the images of the three coconut trees and the taro to capture the symbolic essence of the work. Here the spiritual and generational aspects of Pacific Island culture are emphasised.

Caird (2001) reviews various models of Community Support Work from an international basis, and suggests that the CSW role in Aotearoa New Zealand still needs to evolve its own distinctive focus. It is increasingly subject to evaluations and assessment of outcomes which suggest that a consistent sense of direction for coordinating and unifying the various services is required. Curtis (2004) suggests that the sector, in relationship to other mental health occupations, experiences low wages, limited access to training despite a government grant scheme, low levels of unionisation and other indications of low status. Power relationships with other occupational groups, and a low rate of training-induced awareness of risk are likely to be a dynamic in the playing out of workplace incidents.

In response to calls for upskilling the CSW workforce, an educational initiative has been articulated by the Ministry of Health in the form of the National Certificate in Mental Health (Support Work) (Curtis, 2004). Offered at various sites around the country since 1998, these courses are designed to provide CSWs, some with no other mental health training or education, with the essential knowledge and tools for working in the area. The Blueprint specifically suggests that people with experience of mental illness will be part of this (Mental Health Commission, 1998). From my knowledge of the curriculum (I served as academic mentor for one), the content reflects the Strengths perspective and of the New Zealand Recovery Competencies (Rapp & Hanson, 1988; Mental Health Commission, 2001) and attempts to put this knowledge in the context of the Treaty of Waitangi, bi-and multi-cultural processes, and current mental health knowledge. Acquisition of the Certificate can, for some workers, be the entry point into other educational opportunities. As such, it is open to criticism that it professionalises caring, may objectify the consumer, and distance the community-based initiatives from the communities

in which they operate, a debate suggestive of the contested definitions of social and community work. Certainly, the act of identifying and educating about the desired competencies is in itself an act of identity creation, and measurement of skills within the workplace can produce occupational and professional identity and its concomitant demands for increased recognition and remuneration. Identification and achievement of competencies in such diverse areas as crisis prevention, advocacy, cultural communication, resource acquisition and public education is resulting in the emergence of a new workforce group (Caird, 2001; Curtis, 2004; Curtis & Hodge, 1994).

This re-definition of mental health work, infused with goals of empowerment and a Strengths perspective, requires that standards and ethics come into sharp focus. With such variety of role and perspective, there can be a blurring of old boundaries that can make the worker (who may well have a consumer background or work closely with consumers) more vulnerable (Curtis & Hodge, 1994).

From the perspective of the workplace environment, this impacts upon the quality and the nature of the relationship between the CSW and the consumer, relationships that may not only be professional but community, experientially and culturally based connections. Issues of boundaries and role clarity are crucial, as is the nature of the authority by which one person works with another. Curtis and Hodge (1994) define boundaries as the highly personal translations of moral codes in our relationships with others. Close proximity to consumers may increase the opportunity for stress and burnout (Grossman, 1996). This is explored in Chapter Five. The need for boundaries emphasises the cultural and personal skills and process needed to work with someone in a change process, issues which were explored in the interviews for this thesis.

Conclusion

These historical, policy and professional elements in the mental health environment form the basis for any response to workplace incidents. They demonstrate tensions in service delivery and treatment modality that define the environment in which workers practice, and the degree to which they are equipped to respond to the crisis needs of consumers. The location of mental health service delivery in the community, and the delivery of its services by a growing number of community support workers, suggests that new levels of vulnerability require new responses to the management of incidents. A further dimension is added by analysis of the conceptualisation of mental health and

trauma, and the environmental imperative for these concepts to incorporate understanding of complexity. This is considered in the following chapter.

Chapter Four: Classification of mental health and trauma

> 'What's the use of their having names,' the Gnat said,
> 'if they won't answer to them?'
>
> 'No use to *them*,' said Alice, 'but it's useful to the people who name them, I suppose.'
>
> Lewis Carroll (undated:143)

This chapter explores the relationship between psychiatric classification and conceptualisations of trauma and extreme stress, and signals issues that result from the failure of these classification systems to competently address issues of complexity that arise in the experience of workplace incidents.

The current system of psychiatric classification is one that has considerable effect on the delivery of services to mental health consumers with whom the participants in this thesis engage. It determines many of the structures and relationships within clinical practice, resource allocation and systems organisation in which the workers operate. As an organised method of description and classification, it has strong interconnections with the legal frameworks of mental health currently in place in this country. Its medical origins delineate much of the current interpretations of trauma, and its current ideological debates concerning the impact of the environment on human experience signal the terrain in which staff support systems of the future will be constructed.

The map is not the territory: the scientific classification of mental disorder

Throughout history there have been attempts to describe and categorise human behaviour, records dating back to Egypt in 3000BC and to Hippocrates in Greece around 400BC (Parsons & Armstrong, 2000). It is suggested that the first official attempt to collect statistical information about mental illness in the current medical era was in the 1840 United States census, which had one category of idiocy or insanity (APA, 1994). The New Zealand Mental Defectives

Act (1911), blurring distinction between mental health and disability, introduced six classes of mental defective: persons of unsound mind, persons mentally infirm, idiots, imbeciles, the feebleminded and epileptics.

Our current nosological systems in mental health broadly reflect the dominance of positivist scientific thought, and their evolution reflects changes in the nature of the medical construction of experience. Whilst in the 1950s more than half of the departmental chairs of psychiatry in the United States were members of psychoanalytic societies, a shift occurred in the 1960s through the redefinition of mental disorders in terms of disease, renewing and legitimising psychiatry's historical connections with biological medicine (Young, 1995). This growth in biologically-based psychiatry brought about a call for a standardised classification system through which clinicians could come to a common understanding of symptoms and experiences. The focus of psychiatry moved from psychotherapy to the medical management of psychoactive drugs. As a result we see the emergence of occupations such as psychology and social work providing therapeutic intervention, with diagnostic power nonetheless retained by psychiatry. The current debates surrounding classification reflect these ongoing interpretations of experience ranging from biological determinism through to ecological complexity, with this thesis taking the position that any classification system is merely the map, rather than the actual territory of human experience.

Two major systems of classification emerged, the International Classification of Diseases (ICD) from the World Health Organisation (WHO), and the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association (APA). The ICD nosological system is utilised within Europe; the DSM is the basis for diagnosis in the United States, Canada, Australia and Aotearoa New Zealand. Statistics within this country are collected by the Ministry of Health using ICD terminology to assist analysis by WHO.

ICD-6 was the first WHO classification to include mental disorder (WHO, 1948). The DSM has only ever referred to mental health. Both systems have undergone different editions and revisions, the ICD now in its tenth edition (ICD-10, WHO, 1992) and the DSM reaching its fourth text-revised edition in 2000 (APA, 2000). The fifth edition of the DSM is due in about 2010. Whilst the two systems are now developed with compatibility in mind, there remains some differentiation in their consideration of trauma, an issue that is addressed in a discussion later in this chapter concerning complexity in classification.

Editions of the DSM mirror the growth in sophistication of the scientific scrutiny of mental health and the inclusion of systems influences. Whilst the first edition in 1952 constructed a picture of a single gradient stretching from mental health to mental illness, DSM-II organised mental disorders into ten major categories, the system of classification differing from one category to another (APA, 1952; APA, 1968). The significance of DSM-II was in its consideration of mental health syndromes as illnesses rather than as reactions to underlying processes, signalling a move towards biology and away from psychodynamic theory.

The goal of DSM-III was to develop a classification system that reflected current medical knowledge about mental health and disorders and in ensuring compatibility with ICD-9, it worked towards the development of a global nosological language (APA, 1980). This edition was radically different from its predecessors, with substantial changes to structure and philosophy, but nonetheless, the conceptualisation of its two hundred or so named disorders focused on the pathology of experience rather than symptoms of good health (Nemiah, in van der Kolk, 1996b). A disorder was described as:

> ...a clinically significant behavioral or psychological syndrome or pattern that... is typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability).
>
> APA (1980:6)

A major significance of DSM-III was the introduction of the diagnosis of Posttraumatic Stress Disorder, a concept central to discussions within this thesis and considered in greater detail at a later stage of this chapter. This diagnosis entered the classification systems at a time when the DSM was moving solidly towards claiming identity as an atheoretical, research-based medical model. Its rejection of psychodynamic processes was aided by scientific discoveries that revealed the root causes of disorders which had been hitherto defined as psychiatric, such as vitamin deficiency, syphilis, and epilepsy (Young, 1995). The development of psychoactive drugs in the early 1950s further enabled changes in the shape of service delivery, as Chapter Three described (Williams, 1987).

Young (1995) considers that DSM-III's three main assumptions continue to shape current perceptions of trauma. It suggests that mental disorders are best understood by analogy with physical diseases; that classification of mental disorders requires observation of visible phenomena (and therefore that inferences based on ætiologial theories that lack solid empirical evidence or

which invoke the operation of invisible mechanisms have to be rejected); and that empirical research will eventually show that the serious mental disorders have organic and biochemical origins. These assumptions have a significant bearing on the manner in which incidents are interpreted within the context of the workplace, as Chapter Six explores.

The definition of mental disorder in DSM-IV (APA, 1994) and its text revision, DSM-IV-TR (APA 2000), was substantially similar, identifying experience of subjective distress, impairment, risk of disability, injury or loss of freedom, and (significantly for this thesis study) excluding reactions to normal stressful life events. DSM-IV continued to assert psychiatry's place as a biological science and is of significance to this study in its introduction of the disorder of Acute Stress Disorder, or ASD, explored later in this chapter.

Whilst the DSM system retains its biological basis in conceptualisation, it has been expanded to incorporate environmental and historical factors in a person's experience. DSM-III's introduction of a multi-axial structure is reflected in the current revised edition, DSM-IV-TR (APA, 2000). This polythetic construction (that is, situations where a person displays behaviour or symptoms that belong to more than one classification) was an attempt to be more comprehensive and systematic, and inclusive of both psychological and environmental problems and levels of functioning. It can be read as a first attempt to address complexity within diagnostic systems, but remains essentially reductionist as opposed to dynamic. The multiaxial system gives priority to the pathology rather than the strengths of networks, natural coping methods or cultural patterns of adaptation (Kleber, Figley & Gersons, 1995).

The axes of the DSM link this classification system with its application in the legal and service delivery environments in Aotearoa New Zealand. Axis I diagnoses refer to the major categories of mental disorder, which as state-dependent disorders are largely defined by treatability. PTSD and ASD are located here. It is possible to have more than one Axis I diagnosis. Axis II contains trait features such as personality disorders and intellectual disability. Other issues in the lives of consumers are embedded in Axis III (general medical conditions) and Axis IV, psychosocial and environmental problems that affect diagnosis and treatment. Axis V refers to a scaled assessment of functioning on a single continuum.

The major criticism levelled at the nosology from an ecological perspective is that it continues to underemphasise or deny contributory problems that are

external in origin (Durie, 2001). PTSD became the first classification to explicitly require an external event, as discussed later in the chapter.

Issues in the implementation of classification systems

> I am not a number, I am a free man!
>
> Patrick McGoohan as *The Prisoner*, 1967-8

Major tensions arise in the implementation of classification systems within current mental health environments, and these play out in the understanding about the impact of incidents on the wellbeing of those working in the field. These issues arise in the relationship between the medical construction of mental disorder, and the socio-legal environment in which responses to those diagnosed with disorders are made. In addition, challenge to the philosophical appropriateness of using any classification system, and to the medical bias of the current DSM structure, is of some relevance to this thesis, both in terms of further highlighting the cultural location of nosological systems, and in recognising the potential dissonance for workers whose frame of reference is not medical: this includes occupational groupings such as social work, and those workers whose cultural perspectives sit outside of a positivist paradigm.

The act of classification, despite attempts at a rigorous atheoretical stance, is interactively located in a legal and clinical context of service delivery, focused upon the construction of the definition of mental disorder (Bell, 1996; Kutchins & Kirk, 1999). The current mental health legislation in this country closely aligns its definition of mental disorder with the DSM's Axis I, thereby delineating the boundaries over who is treatable and treated within the mental health system and services. This creates dynamics and tensions for mental health workers, and for the nature of incidents occurring within mental health.

The trends in legislation in this country have, between the two recent Mental Health Acts in 1969 and 1992, reflected a tightening of the definition of mental disorder. In 1969 this still included intellectual disability, brain injury and age-related deterioration of function. Changes in 1992 in the Mental Health (Compulsory Assessment and Treatment) Act highlighted issues of treatability, reflecting global and national moves towards deinstitutionalisation and the path of least restrictive detention and treatment (Chapter 3). Civil rights and issues of harm and risk became prominent characteristics of the 1992 legislation, factors which were further consolidated in an amendment in 1999. These changes have had profound implications for mental health practitioners, whose work with consumers may now operate within community treatment provisions in complex community settings, the terrains of which offer very

different environments for the occurrence of critical incidents and traumatic events. These social and legislative changes have increased not only the visibility of mental illness within communities, but have also moved the gateposts of care, reducing the physical distancing between consumer and community. The spotlight of community concern, debate and at times disapproval, is now firmly placed on mental health workers working in community settings. Workers in these contexts are often faced with ethical, cultural, assessment and safety dilemmas surrounding notions of normality and risk (Ministry of Health, 2000). The legal view that a court must be convinced of someone's insanity is often in conflict with the mental health imperative for early intervention and support (Brunton, 1996). Whilst the current legislation addresses only those consumers whose mental disorder may require compulsory assessment and treatment, many involved with mental health services and workers within community settings engage on an informal basis, signalling the fundamental importance of context and relationship when we consider support for staff after critical incidents. The experience of participants in this study reflects these tensions.

One particular medico-legal issue that has seriously impacted upon the mental health workforce is the effective exclusion of DSM Axis II diagnoses from the provisions of the Mental Health Act. In particular, consumers with diagnoses of personality disorders (which as trait rather than state disorders are often deemed outside of the remit of the law) now at times become the focus of debates over gate-keeping and access to services (Ansley, 1995). Britain includes personality disorders under its compulsory mental health legislation and is considering increasing these powers (Duckworth, 2002), but workers in New Zealand may face the additional requirements of negotiating the interface between health and justice whilst working with severely distressed or threatening consumers.

In addition to the concerns potentially raised by the close relationship of medical and legal definitions and categorisations, resistance to the use of classification systems themselves can be problematic for workers. Ambivalence to the application of labels, the embedded nature of scientific terminology within a mental health system increasingly re-defining itself in multi-cultural and ecological terms, and a growing critique of psychiatry's lack of appreciation of complexity, all contribute to the dynamics that are daily negotiated by mental health workers. The critiques are complex and well-addressed within reviews of psychiatry (for instance, in Breggin, 1991; Lembcke, 1998; Rapp, 1998; Scheff, 1996; Schwartz, Pickering, & Landsbergis, 1996; Straton, 1999; Szasz, 1961; Thorogood, 1992). Challenge takes the form of

both critiques of classification itself, and of the particular characteristics of the current DSM/ICD structures. Of significance to the evolution of the dominant power structures of psychiatry is the growing critique from within the profession (Bracken & Thomas, 2001; Tomm, 1990).

A crucial dynamic for many workers within this country stems from the critique of classification systems that assume universality of experience, a critique informed by an understanding of colonisation, the processes of which suggest that 'we have truth but they have customs' (Littlewood, 2001:9). An ecological stance argues that whilst most cultures in some way may classify behaviour and experience, each explanatory model is essentially culture-bound (Kleinman & Good, 1985). If classification systems themselves are culturally determined, it follows that diagnostic tools and intervention modalities may also be (Anning & Hornung, 2000; Chakraborty, 1991; Friedman & Marsella, 1996; Reynolds & Leininger, 1993). Medical perspectives and indigenous perspectives clash over fundamental premises, Durie (2003) describing indigenous knowledge as collective, intergenerational, and holistic. He also refers to 'short' and 'long distance' factors, with some causal relationships having a short distance between them, such as changes on a cellular level, and other causes of ill health having long distance and more tenuous factors such as the influence of government policies and the effects of colonisation. These issues lie at the core of the experience of many mental health workers in Aotearoa New Zealand (Durie, 1994 & 2001; Sachdev, 2001; Te Puni Kokiri, 1993), and contribute to our knowledge base about the complexities of contextually located acute stress and trauma, as discussed later in this chapter.

These debates, running as long as the nosological systems have been in existence, provide a means of monitoring how mental health and wellbeing is perceived, and therefore how our responses to distress are shaped. Mindful of these critiques, attention now turns to the emergence of trauma within current classification systems, and considers issues of complexity that may determine the construction of critical incident response.

The evolution of trauma within classification systems

In the previous chapter I noted van der Kolk and McFarlane's suggestion that the study of trauma has become the soul of psychiatry (1999). They observe that the conceptual development of Posttraumatic Stress Disorder has provided the framework for looking at the interconnections between biology, construction of meaning, and personality. PTSD as a classification was the first in the DSM to explicitly locate the person in relation to their environment, and thus introduce

relational issues into psychiatric diagnosis. It is therefore a key to the understanding of the issues surrounding the construction of, and response to, critical incidents in the workplace.

The notion of traumatic stress entered classification in 1980, with its inclusion in DSM-III (APA, 1980). To a considerable extent it owes its existence to the impact of the American war in Vietnam. This was the first conflict since World War I in which any significant attention was paid to the psychological damage within the military forces, McFarlane (1995) suggesting that the war's domestic unpopularity allowed for public debate about its impact on military personnel. Prior DSM editions had not described trauma as a distinct entity. DSM-I in 1952 had included a diagnosis of 'gross stress reaction', defined as a psychoneurotic disorder originating in an experience of intolerable stress (APA, 1952). Unlike the current conceptualisation of PTSD, it was defined as transient and its symptomatology, like the rest of the manual, was somewhat vague.

DSM-II (1968) dropped the reference to 'gross stress reaction', the closest diagnosis in this edition being an adult adjustment disorder, or 'transient situational disturbance', which assumed that an ability to adapt would allow recovery, unless there was another underlying disorder (APA, 1968). Little mention of the consequences of trauma was made, perhaps because the military toll in Vietnam had not yet reached its peak. Bloom and Reichert (1998) point out that DSM-II was published at the same time as the Tet offensive began to change the direction of the American war. When veterans returned from Vietnam with symptoms clearly resulting from combat exposure, there was no way to diagnose their disorders adequately and therefore no link in with legal or insurance avenues to address their needs. Against resistance from the US military and FBI, it took activism by veterans, mental health professionals and clergy, and public testimony before Congress, before DSM-III in 1980 made PTSD a diagnostic category. Two decades after the fall of Saigon, scientific research on PTSD continued to be based largely on Vietnam veterans (Young, 1995). The Veterans Administration remains the most significant source of research funds and cases for studying the disorder. A similar situation exists in Australia with the Australian Centre for Posttraumatic Mental Health operating in collaboration between the University of Melbourne, the Department of Veterans Affairs and the Australian Defence Force.

Raftery (1997b) argues that the introduction of the PTSD diagnosis has significantly increased the sophistication of treatment and if anything, has shifted the focus back from the effects of trauma being 'all in the mind' to its having a physiological basis. By creating a diagnostic category, it has removed

some of the stigma still associated with some other mental disorders. Nevertheless, it provides a further marker for the entrenchment of traumatic experience within psychiatry.

The introduction of the diagnosis of Acute Stress Disorder (ASD) into DSM-IV in 1994 exemplified the recognition that not all experiences of trauma would lead to a diagnosis of PTSD. Some experiences, although greatly distressing in the immediate aftermath of an event, were observed to be more transitory and less enduring in nature, but having nonetheless major clinical and treatment relevance. Current versions of the DSM diagnoses for Posttraumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) can be found in Appendices One and Two.

Like PTSD, ASD is defined as a disorder that follows experiencing, witnessing, or being confronted with events involving actual or threatened death, physical injury, or other threats to the physical integrity of the self or others. In addition, meeting the definition of an appropriate stressor (Criterion A), the response must entail intense fear, helplessness, or horror. Acute Stress Disorder must last for a minimum of two days and can only be diagnosed up to one month after the stressor: the criterion for PTSD reflects disturbance that has lasted for more than one month. The classification of ASD also differs from PTSD in its emphasis on dissociation. ASD is explicitly formulated as a dissociative response to trauma. (Dissociation as a concept is further explored in Chapter Five.) It requires at least three dissociative symptoms (criterion B) but only one symptom from each of the reexperiencing (criterion C), avoidance (criterion D) and arousal (criterion E) categories. Impairment (criterion F) is also deemed necessary and is formulated differently from that of PTSD.

Research interest is now focused on the accuracy and applicability of this recent category of stress disorder (Brewin et al, 1999; Bryant, Guthrie, & Moulds, 2001; Elklit & Brink, 2004). Interest appears to centre on the quality of various dissociative symptoms as predictors of PTSD, and the relationship of the different criteria to each other. Brewin et al's 1999 exploratory study suggests that ASD is a strong predictor of later PTSD. This raises major issues for the management of stress reactions within the workplace, as it suggests that key predictive indicators of distress may be identifiable at an early stage, suggesting the possibility of the prevention of PTSD by early intervention.

Thus the classification of traumatic impact continues to develop throughout the editions of the DSM and the ICD. Of note is the manner in which the emphasis on developmental issues, especially in the DSM, has receded in prominence,

giving way to stressor-focused phenomenological features. The ICD classification has retained acknowledgement of the enduring effect of chronic exposure to traumatic stressors, thus more effectively recognising complexity. Comparison between ICD and DSM is therefore not unproblematic. For example, in ICD-10 the definition of PTSD requires intrusive symptoms but not numbing or avoidance symptoms, and considers the arousal and other disturbances less important. The DSM-IV criteria are harder to satisfy than those of the ICD-10, and reported rates of PTSD are therefore likely to be higher in countries using ICD rather than DSM.

There is current debate about whether classification of posttraumatic reaction should be subsumed within broader classifications of recognised mental health disorders, or whether there is wisdom in considering trauma to be a new paradigm upon which other disorders may be based. McNally (2004), for instance, argues that the conceptual definition of trauma has become too broad and threatens the viability of a diagnosis. PTSD is currently conceptualised as an anxiety disorder rather than a dissociative or stress disorder, a decision last made by the DSM-IV taskforce (Brett, 1996; Davidson & Foa, 1991). The reasons for this were the symptoms of fear and avoidance (similar to panic disorder) and the treatment responsiveness of people with simple PTSD using methods designed initially for treatment of anxiety. Davidson and Foa (1991) are in favour of it remaining an anxiety disorder; Brett (1996) on the other hand argues that while the arousal and numbing phases of PTSD have similarities to processes of mourning and bereavement, PTSD appears distinct from other anxiety disorders in terms of the memory components such as traumatic amnesia. Brett (1996) argues that classifying it as an anxiety disorder narrows options, with variation in presentation excluded from the diagnosis.

The current status of trauma classification reflects the fluid nature of the conceptualisation of the impact of extreme events. PTSD and ASD are but two current manifestations of distress, discussion of which has highlighted the potential for complexity in both conceptualisation and response to critical incidents within the workplace. The key role that the environment plays throws the entire ætiological basis of mental health disorders into high relief. Challenges to the accepted wisdom of biological causes lying at the root of a disorder, perhaps inevitable in the light of paradigm shifts in epistemology, come into focus in consideration of the unique nosological feature of PTSD and ASD, that of Criterion A.

The pivotal role of the stressor

Criterion A, the identification of a stressor, is an outstanding characteristic in the classification of trauma and is crucial in our understanding of the management of workplace stress and trauma. Identification of a stressor can on one hand provide a focal point for intervention, but it can also mask the interaction between ambient and cumulative stressors within the ecological context of the mental health environment.

As constructed within the DSM, PTSD and ASD are the only disorders to which an external cause is attributed. Criterion A requires a witnessing or involvement with a life-threatening event, with a reaction of intense fear, helplessness and horror (APA, 1994). Other Axis I diagnoses such as other anxiety disorders, psychoses, and mood disorders do not have this relationship with the outside world, and this is therefore a milestone in the paradigm shift influencing mental health (Breslau & Davis, 2002; Kleber, Figley & Gersons, 1995). It is significant to note that there is now considerable research and current interest in the aetiology of other Axis I disorders such as schizophrenia, where links are being made between the development of a disorder and early exposure to trauma (Read et al, 2001; Read et al, 2004). From an ecological perspective this is, therefore, of fundamental and emancipatory importance. It suggests an intellectual and epistemological acceptance of the interconnectedness between people and their environment, one which I argue may act as a benchmark not only for the development of more appropriate responses to traumatised people and communities but also for the growth in ecologically-based interventions for other mental health disorders, and the development of sane and healthy functioning within organisations. From an epistemological basis, it is recognition that the knowledge bases of medical science (genetics and neurology, for instance) need to dialogue with the environmental and social sciences located within complex and dynamic contexts. It opens up the opportunity for ecological, autopoietical constructions of response.

Two key debates are important to the argument of this thesis. The first concerns the nature and severity of the stressor and its relationship to the identification of traumatic impact; the second to the categorisation of traumatic impact as resulting from one-off or cumulative events.

In early conceptualisations of PTSD, inquiry often attempted to interpret the relationship between event and impact as lineal in nature, the more severe the event, it was argued, the greater the impact (the 'dose-response' model

described by March, 1993). This conceptualisation, similar to DSM-I's attempt to categorise mental illness on a single continuum, is now challenged by the awareness of more complex relationships and issues of meaning. The focus on the stressor itself, Shay argues, can introduce inappropriate attempts to scale the likely impact:

> Veterans call it 'pissing contests' when one veteran denies the validity of another veteran's war trauma. Different survivor groups eagerly start these competitions as well, each claiming that their experience is the only significant one. [...] These pissing contests only serve the interests of perpetrators, all perpetrators. [...] No person's suffering is commensurable with any other.
>
> Shay (1994;205-6)

The definition of the stressor, changed in DSM-IV to allow for secondary traumatisation, has now expanded to include many social and interpersonal events not envisaged within the original DSM-III construction, whilst retaining awareness that there will be some events that are likely to overwhelm most people.

The jury is still out on what sort of stressor may cause more harm (McFarlane & de Girolamo, 1996). There is some evidence that man-made and person-induced traumatic stress, especially intentional injury, is more traumatogenic and more likely to cause mental health problems than natural disasters (Breslau et al, 1991; Smith & North, 1993; Weisaeth & Eitinger, 1993). Janoff-Bulman's (1992) research suggests that survivors of human-induced victimisation have a greater degree of negative assumptions about the goodness of the world. It is suggested that if an offence is within a context (for example, date rape rather than rape by a stranger) then it is harder to deal with and reporting it is less likely (Gould & Ryback, 1999). Freyd's (1996) concept of betrayal trauma describes the influence of attachment relationships upon the forgetting and recall of abuse within dependent relationships. Dyregrov and Mitchell (1992) observe that emergency workers frequently mention that certain incidents are especially traumatic, such as those involving children, multiple deaths, and threats to one's own life. This suggests that complexity in relationships configures impact in a significantly different way, a factor emerging as highly significant in the narratives within this thesis.

It should be noted that not all the evidence points to this importance of man-made impact: some studies continue to reflect a dose-response, or trauma severity, outcome (Carlier et al, 1997; Favaro et al, 2004; Ikin et al, 2004; Rubonis & Bickman, 1991). However, it appears that context often plays a significant

part in the determination of impact, a factor explored with the participants in this thesis study.

Whatever the qualitative difference in the stressor, the central characteristics of its impact are consistently issues of helplessness, powerlessness and threat to life (Herman, 1992a). Stressors are often defined as positive, in the sense of being present. However the impact of negative stressors can in itself be major. Davis (1999) cites the case of the Australian Port Arthur shootings, where it was the expectation of an event, the 'not knowing' where the gunman was, that was as traumatic as being shot at or the witnessing of murder. The key here is the level of powerlessness that a person can experience. Davis goes on to point out that the recognition of a stressor as traumatic is compounded by public and social attitude, as in the social construction of sexual abuse as fantasy, the denial of the impact of warfare on returning veterans, or the patina of professionalism in the workplace that prevents acknowledgement of harm.

Debates over the nature of the stressor introduce the second element for consideration, that is, whether the stressor is identified as a one-off or as a cumulative process. On a simple cause and effect basis, DSM-IV defines a stressor largely around threat to life. McFarlane and Yehuda (1996) speculate that this may be a feature of western society and its focus on the individual. They critique Criterion A in the DSM-IV for its focus on the effects of violence and suggest that property damage or loss may be a better predictor of long term psychopathology after natural disasters in that this effect is ongoing and more damaging to people's lives. In some cases traumatic experience may be the rule rather than the exception, an argument reinforced by the human rights elements in trauma studies (Adjukovic & Adjukovic, 2003; Becker, 1995; Kagee, 2004; Martin-Baro (in Summerfield, 1995); Simpson, 1993).

Studies within human rights contexts suggest that a simple temporal relationship between stressor and impact is often not the case, and may indeed be flawed (Young, 1995). In Green's 1997 study of the effects of toxic exposure, the psychological symptoms of trauma began only when the exposure became known, as opposed to when it actually occurred. However, McNally (2004) argues strongly that delayed onset PTSD is rare or non-existent, an argument that suggests that the development of a complex model of traumatic impact is still underway.

Terr (1997) introduced an important ecological element in her distinction between Type I and Type II events. By distinguishing between short term events that have the quality of surprise and may be isolated in occurrence, and

prolonged events which may be sustained or repeated in nature, she argues that the quality of the experience may alter the outcome of the impact. Type I stressors may become indelibly etched in memory, may more likely lead to the PTSD-like symptoms of intrusion, avoidance and hyperarousal, and may have a quicker recovery than the complexities suggested by chronic or multiple events. Type II events, she suggests, may be more likely to be of human origin and intentional and may produce a sense of helplessness, confused recall, and characterological attempts to adapt and cope with a hostile world. Events occurring in the workplace context may at times suggest the continual engagement with stressors suggested within the Type II categorisation, and potentially suggests that the isolation of the stressor from its context may remove much of the meaning of the event, and may reduce the effectiveness of interventions that focus solely on a single stressor.

Ultimately, the DSM focus on the nature and severity of the stressor may need to be reconceptualised in the face of growing ecological knowledge about individual difference, resilience, and environmental and cultural processes. Opponents to this would argue that it represents a 'conceptual bracket creep' (McNally, 2004:3) that undermines the centrality of a trauma diagnosis and introduces too many environmental variables such as the cultural interpretation of an event. My argument, enlightened by the debate over the evaluation of Debriefing in Chapter Six, is that grading the impact of trauma according to the perceived severity of the stressor is not sufficient for our understanding of traumatic experience within the workplace. As Shalev (1996) has indicated, the line between trauma and stress is a blurred division. Valent (2003) challenges the use of the term 'traumatic stress' as restricted, confused and tautological. Erickson (1994) argues this from the sociological understanding of the impact of chronic stress, which he sees as having overridingly similar characteristics to a one-off event.

Contributing to this debate, Weisaeth and Eitinger (1993) suggest a matrix of factors that assist in the understanding of the impact of trauma, with impact determined by an individual mix of high risk events (the stressor), high risk reactions, and high risk individuals. From an ecological perspective I would add high risk environments. The complexity of these arguments has significance for assessing the impact of incidents in the workplace. The emphasis on the stressor may underplay individual resilience or vulnerability. Acute and delineated stressors may lead to relatively uncomplicated traumatic reactions, where cumulative stressors may lead to recruitment of other disorders such as depression and panic disorder. Chronic and unpredictable stress may be more likely to create a set of enduring personality changes and

disruptions to the basic sense of trust. Issues of complexity are addressed below.

A reality check: Cross cultural issues in the construction of trauma and PTSD

Te matauranga o te Pakeha
He mea whakato hei tinanatanga
Mo wai ra?
Hei patu tikanga
Patu mahara
Mauri e
The knowledge of the Pakeha is propagated
For whom?
To kill customs
To kill memory
To kill our sacred powers
Tuini Ngawai, Ngati Porou composer, c. 1950, in Sachdev (2001:15)

Previously argued in this chapter and as the waiata above suggests, knowledge constructed in one cultural setting can have negative impact when imposed on another culture. Most research regarding the conceptualisation and classification of trauma has been conducted by American, European, Israeli and Australian researchers. In an epidemiological review, de Girolamo and McFarlane (1996) report that only 6% of 135 studies reviewed were located in developing countries. The application of concepts in cross-cultural settings is a further argument for the consideration of complexity.

Friedman and Marsella (1996) use similar illustrations to van der Kolk and McFarlane (1996), arguing that societies that emphasise individualism respond to trauma differently than societies that reflect passive acceptance of fate. Summerfield (1995) refers to Kleinman and Good's notion (1987) of the 'category fallacy', suggesting that similar symptoms (for example, recurrent nightmares) may be interpreted variously as irrelevant, deserving of mental health intervention, or as messages from ancestors. Cultural norms may sanction dissociation (described in Chapter Five) as a coping strategy. Hearing voices may be a culturally accepted process of spirit possession or communication with ancestors. There is likelihood that some cultures will report more somatisation features of the trauma response[24]. In Maori, for example, somatoform symptoms are used as metaphors of distress, using linguistic reference to the site of emotion within parts of the body, for instance, *pukuriri*, angry. Cross-cultural and gender appraisals of stress may differ. Some

[24] Somatisation is described as a process of converting, transforming, or diverting emotional distress into somatic symptoms (Kirmayer, 1996).

cultures, and genders within them, may be stoic, unemotional and socialised not to display feelings.

From cross-cultural studies we can learn that trauma symptoms, whilst perhaps distressing, may play out in different intensities, combinations and contexts. Summerfield and Hume (1993) report that 75% of their subjects in Nicaragua who met PTSD criteria were basically well adjusted and functioning. A trauma worker from Mozambique speaking at the ESTSS conference in 1999 commented that intrusive symptoms of PTSD were more apparent amongst rural civilians at times when they were less busy with harvest (van Dijk & Igreja, 1999). Characteristics of the impact of extreme stress are explored in depth in the following chapter.

Measurement and description of trauma reactions within cultures requires the development of emic instruments, that is, tools that are consistent with the indigenous views of distress within that culture. Problems arise when we need to compare these cross-culturally. Draguns (1996) considers that the development of emic interventions in the (western) trauma field is uncharted territory.

The question whether PTSD is an etic[25] phenomenon or is culturally-bound is ongoing (Al-Issa, 1995). Chakraborty (1991) suggests the latter. Kelly's review (1999a) of the literature suggests that there is evidence to say that traumatic stress reactions may be universal in their neurobiology but (in our understanding of the concept of emergent properties) there may be cultural variations in the construction of social reality and the definition of what constitutes a traumatic event and appropriate responses to it. Marsella et al (1996) conclude that the re-experiencing symptoms of PTSD appear to be biologically located (and therefore more likely to be an etic phenomenon). On the other hand, they state that there is less evidence to support a biological basis for avoidant or numbing symptoms. For this reason, they believe that this symptom cluster may be most susceptible to culture-specific influences. They suggest factors such as concept of personhood, social support systems, concepts of health and disease all can play a part here, further highlighting the contextual basis of our understanding of trauma.

Significantly, many of these debates about the cross-cultural application of the concept of trauma remain framed within the lens of the impact on the individual. Acceptance that an environment can be traumatogenic, in the case

[25] Somervell et al (1995) utilise the term 'etic' to refer to an external frame of reference that links experience of mental disorder to a purportedly universal, scientific system of thought.

of colonisation, for example, shifts the lens to viewing the impact on families and communities (Adjukovic & Adjukovic, 2003; Duran et al, 1998; Raphael et al, 1998; Summerfield, 1995; Tomas, 2004). The term 'post colonial stress disorder' has emerged (Turia, 2000). This has political implications that many appear unprepared to absorb. As part of an exercise in the preparation of a conference presentation, I asked the international community of the Traumatic Stress internet list whether they thought that the term 'Post Colonial Traumatic Stress Syndrome' had any significance beyond its use within our own bicultural context (Adamson et al, 2003). Of significance was that responses indicating familiarity with, and acceptance of, the application of a trauma model to culturally located generational violence came only from professionals familiar with bicultural frameworks of understanding, or from those who had explored cross-cultural issues within multicultural settings. Indirect and generalised impact of trauma is as significant within this perspective as direct and observable psychological symptoms. Illustrative of this, Tomas (2004) presents a Maori definition of trauma as an undermining of the relationships that a person has formed with the environment, mediated through the psychological processes of *mauri*, *mana* and *tapu*[26]. This perspective presents a very real challenge to a narrow medical definition of trauma, one that resonates in the issues faced by mental health workers working within the bi-cultural dynamics of mental health (Smith, 2003).

Pathways to prevalence

Given the contextual and cultural challenges to the conceptualisation of trauma within Western medical frameworks, this chapter now develops the argument for a consideration of complexity in relation to incidents within the workplace, through a consideration of measures of frequency and co-morbidity. The epidemiology of PTSD is explored and the suggestion is made that a trauma diagnosis may be but one available pathway to the manifestation of distress. (Due to its relatively recent inclusion, the epidemiological base for ASD is still being charted.) The key argument is that a focus upon the medical diagnosis of PTSD and its criteria, and an under-emphasis on the contextual, temporal and cultural aspects of experience, will distort any interpretation of incidents occurring within the workplace, and may remove from attention the full extent of the distress experienced, thereby limiting the opportunities for successful intervention.

---

[26] Tomas (2004) defines *mauri* as the life and vitality we observe in other people and things; *mana* as prestige and authority inherent in a person, group or thing; and *tapu* as the inherent sanctity that all things possess.

Breslau (2002) suggests that methods used to judge exposure to trauma, and the definition of the stressor, will influence estimates of the prevalence of PTSD. An emphasis on context determines that epidemiology cannot be used as a predictive tool, but merely as a launching pad to ask questions, such as why some people are affected to the point of a PTSD diagnosis and why others emerge comparatively less damaged. This raises important questions for the validity of evaluation studies (as discussed in Chapter Six) and for the thesis argument concerning the importance of organisational context.

On one level, issues of incidence determine a perception of how common a potential diagnosis of PTSD may be. Some environments or exposure to experience appear to carry high risk. Studies of the psychological impact of warfare intuitively link massive exposure to stressors to traumatic symptomatology and diagnosis. Grossman (1996) cites Swank and Marshall's study that suggests that after 60 days of continuous combat, 98% of all surviving soldiers will have become psychiatric casualties, the other 2% having a predisposition toward what he calls 'aggressive psychopathic personalities'[27]. He reports that in the 1973 Arab-Israeli war, almost one third of all Israeli casualties were psychiatric and that in the 1982 incursion into Lebanon, psychiatric casualties were twice as high as the number of dead.

Other professions and occupations appear to expose themselves to risk of traumatisation. In an international study of prostitutes, 67% met the criteria for PTSD, with no difference in incidence between those working in (presumably safer) brothels or those on the streets (Farley & Barken, 1998). Prostitution appears intrinsically traumatising. Another possible explanation that has a bearing on this thesis is that those entering the profession have a predisposition or prior exposure to trauma, for example through a personal abuse history.

Gender appears to be an important variable (Breslau, 1999; Fullerton et al, 2001; Stein et al, 2000). For instance, North et al's Oklahoma City study (1999) reveals that 55% of women, as opposed to 34% of men, had post-disaster psychiatric diagnoses. In gendered warfare such as rape, the incidence of PTSD may initially be high. Tomb (1994) reports that the prevalence of PTSD amongst rape victims may be as higher than 50% during the first month post assault, but this drops to 5% after several years. Studies reflecting a gender difference may reflect different lifetime exposure rates to trauma, as well as different coping styles.

---

[27] In other words, war drives you mad, and if it doesn't, you were mad already. *Catch-22* was right after all (Heller, 1962).

In the general population it appears that full-blown PTSD is seen as one of the most frequent diagnoses of psychiatric disorders. Solomon and Davidson's (1997) review of the epidemiology of trauma revealed the extensiveness of traumatic experience. They found that most Americans experience at least one traumatic event in their lives, with 5% of men and 10-12% of women suffering from PTSD sometime in their lives, with the incidence rising to 60-80% for victims of traumas such as rape. For at least a third of people with PTSD, it is a persistent condition, and over 80% experience other psychiatric disorders. Other estimations of lifetime prevalence of PTSD suggest occurrences of 3.3% (McFarlane, 2000), 7.8% (Kessler et al, 1995) and 9.3% (Breslau et al, 1991).

From an ecological perspective, however, the key argument here lies not with numbers but with recognition that PTSD (and ASD) is but a construction of distress, and that variation in environmental context may produce variation in the impact of experience. Co-morbidity is one manifestation of this, and important for the recognition of the impact of extreme stress in the workplace. High rates of co-morbidity suggest the porousness of diagnostic boundaries (Breslau et al, 1991; Davidson et al, 1991; Yehuda & McFarlane, 1995). This raises important questions about the fundamental soundness of the categories thus far conceptualised.

In the US National Co-morbidity Study cited above, Kessler et al (1995) determined that 88% of men and 78% of women with PTSD met criteria for another diagnosis. Seventy two percent of people after a natural disaster developed criteria for other diagnoses (McFarlane, 1992b). Carlier et al (2000) found that depressed patients are highly likely to have experienced traumatic events and intrusive traumatic recollections. Co-morbidity with depression and suicidality is often reported (Tarrier & Gregg, 2004). The connections between physical symptoms, depression and PTSD are manifest in studies of chronic pain (Roy-Byrne et al, 2004).

Many research studies suggest a link between trauma experience and drug and alcohol use (Jacobsen et al, 2001; Kulka et al, 1990). Levels of drug and alcohol use appear to go up after high stress or traumatic incidents (Davidson & Fairbank, 1993; North et al, 1999; Vlahov et al, 2002). There is a well-established relationship between high-risk occupations, the experience of occupational stress and levels of alcohol use (Kelly, 1999b; Stewart et al, 2004). McFarlane and Yehuda (1996) argue that a focus on trauma may mask the presence of other disorders such as depression and substance abuse, and conversely, Davidson et al (2004) comment that co-morbid depression and somatisation could mask symptoms of PTSD. Cloitre's study (1997) looking at women with a

history of sexual assault and childhood abuse found an average of three DSM-IV disorders comorbid with PSTD, listing depression, social phobia, generalised anxiety and panic as the most common. A third had a diagnosis of past substance abuse. She frames this up in a discussion about the complexity of PTSD, arguing that the DSM criteria do not adequately capture the traumatic impact of common chronic life traumas among women.

The presence of other psychiatric disorders appears to make people vulnerable to the development of post-traumatic symptoms (Bowman, 1999; Breslau & Davis, 1992; McFarlane, 1992a). Co-morbidity with other disorders is not unexpected given the nature of the pathways between the event and a traumatic reaction, and the developmental stages at which trauma occurs. It is also to be expected from a nosological perspective, in the sense that PTSD describes a cluster of symptoms, many in common with other diagnoses, the combination of which may change over time (van der Kolk, Pelcovitz et al, 1996). Self-harm features as a risk factor, and has been the highest cause of death amongst Vietnam veterans (McFarlane, 1992b). McFarlane also suggest that the next highest, motor vehicle accidents, may also be suicide but could also be due to problems with concentration. It has been suggested that 58,022 Americans died in Vietnam, but more than 50,000 have killed themselves since (Pilger, 1986).

These issues of co-morbidity suggest that there is considerable overlap in the experience and manifestation of distress, both within the current framework of classification, and for those attempting response within ecological perspectives. Whether comorbidity is seen as a coincidence, or is suggestive of more fundamental processes that the act of classification masks, may depend on the intellectual position taken. From a perspective that recognises ecological complexities, this thesis argues that the traumatic experience is best constructed as having many possible emergent properties.

The preceding discussion, in acknowledging the complex and ecologically-based relationship between experience and the diagnosis of a disorder, suggests that whilst the prevalence of traumatic impact is common, there is no direct link between stressor, impact and disorder and therefore little merit in the assumption that PTSD is a *normal* reaction to extreme stress (McFarlane & van der Kolk, 1996b; Yehuda, 1999). The question of normality is addressed here as a preamble to further discussion of issues of complexity, and the consideration of the debriefing debate in Chapter Six.

The epidemiological studies cited above indicate that whilst trauma reactions, and PTSD in particular, are not uncommon, they are not the automatic pathway that a person will follow after experiencing a traumatic event. Shalev (1996) suggests that PTSD cannot be construed as normative since many people do not get it, and attention to comorbidity studies suggests that multiple manifestations of distress are possible.

There may indeed be is a political purpose to the normalisation of impact, which has to do with the original principles of front-line intervention, that is, that early identification of and response to traumatic impact will assist the fighting or work unit in its recovery and return to pre-incident functioning (Salmon, 1919; 1929). Burt (1935, in Showalter, 1997) commented on Great War's contribution to unmasking the artificiality of the distinction between the normal and the abnormal.

Similarly, the first definition of PTSD in DSM-III in 1980 suggested that the disorder was a normative reaction to a traumatic event, a marked philosophical shift from the perspectives embedded within previous editions of the DSM, which although acknowledging the impact of external stressors, had nonetheless suggested that the degree of impact depended on the level of vulnerability within an individual (Yehuda & McFarlane, 1995). It is possible to suggest that the normalising process of DSM-III was in part a political response to the overwhelming impact of the Vietnam conflict and a significant attempt to de-pathologise traumatic experience. The ICD-10 definition of PTSD perpetuates this, stating that the disorder is a:

> ... response to a stressful event or situation (either short- or long-lasting) of an exceptionally threatening or catastrophic nature, *which is likely to cause pervasive distress in almost anyone.*
>
> World Health Organisation (1992); my italics

In the organisational and political climate in which Critical Incident Stress Management (CISM)[28] has evolved, the catchphrase developed out of Frankl's (1964) work, 'a normal reaction to abnormal events', has been used to legitimise the existence and use of staff support programmes, and to reduce the individualising and pathologising of a person's stress reactions (Laws & Hawkins, 1995; Tunnecliffe, 1997). The purpose has often been to assure the victim that what they are experiencing, however abnormal or distressing in their own experience, is part of a normal (and therefore understandable) reaction to extreme stress. This is a different use of 'normal' than can be

[28] See Chapter Six for further exploration of this concept.

construed from the epidemiological studies, and one that reflects an interface with contextual considerations.

Yehuda and McFarlane (1995) suggest that acknowledgement of such contextually dynamic interactions between person and environment has led to an identification of a conflict between the original conceptualisation of PSTD and current knowledge about its manifestations. They argue that seeing PTSD as normal has a social and political purpose as well as a mental health one. Ideologically this is advantageous, and is an empowering stance for which I have some empathy. It provides the rationale for normalising the experience, for providing support to a worker, for example, and reduces the risk of pathologising the symptoms and placing blame on the victim. It does, however, create the risk of masking those environmental variables that may serve to mitigate the occurrence and impact of incidents (McFarlane, 1995), a dynamic that lies at the heart of this thesis.

Variance and complexity: the future for trauma

The development of conceptualisations of trauma has been charted here, with the diagnoses of PTSD and ASD becoming established as the main clinical and epidemiological markers of distress.

Whilst ASD began a process of extending pathways into traumatic reaction, notions of complexity have not yet been fully diagnostically incorporated into the DSM. A cursory reading of the Criterion A event in both PTSD and ASD might suggest that trauma has a primary relationship to single events. This is patently not obvious, as a study of the context of many incidents both inside and outside the workplace will reveal. The current PTSD diagnosis often does not describe the severe psychological harm resulting from prolonged or repeated trauma (Jongedijk et al, 1995; Mechanic, 2004). As previously described, the ICD classification acknowledges that chronic exposure to stressors may produce characterological change. The DSM has been slower in its ability to recognise this.

DSM has its roots in the biological dose-response model of causality, where there is not an emphasis on the interconnection of various factors. In a dose-respondent model, the subjective interpretation of the individual is irrelevant. Distortion to the dose-related model comes in DSM-IV with the widening of the stressor definition to include indirect exposure (secondary injury), thus allowing for the awareness of things like secondary traumatisation and compassion fatigue, concepts described in Chapter Five (Dutton & Rubenstein, 1995). Other forms of extreme stress can give PTSD-like symptoms but are not

considered as PTSD because the stressor does not meet the criteria. Scott and Stradling (1994), for instance, proposed a diagnostic category called Prolonged Duress Stress Disorder, or PDSD.

Psychiatry now makes some acknowledgement of systems theory and complexity and has abandoned its total reliance on reductionism. However when under pressure, diagnosis conservatively reverts to medical assumptions. Where legal issues intrude, for example in issues of compensation, the legal system needs clear-cut answers. The need to prove experience of a stressor favours identification of single events rather than cumulative experience, issues addressed in Chapter Six.

Two variant options of PTSD have been put forward for the DSM-V Working Party, features of which may be included in future acknowledgement of the effects of complex or chronic exposure. These are *Complex PTSD*, and a category referred to as *DESNOS*.

The attempt to frame up a diagnosis that includes these complexities within the scientific paradigm of the DSM is still in part denied the status of official diagnosis. In the DSM-IV it is incorporated under the 'Associated Features and Disorders' section. The ICD-10 has created a distinct category which addresses enduring personality change after traumatic experience. However 'complex PTSD' has entered practitioner language in the same manner as the notion of complicated grief (van der Kolk, 2001). It is an acknowledgement that when we talk of people who are traumatised we are not describing a homogenous group, but rather those who just happen to have had a traumatic experience. The outcomes for each person will demonstrate incredible variation and complexity, according to the variables described in the following chapter. Thus those who have had solid attachment experiences in early childhood, who have reached adulthood with functioning and positive social networks and who live with other supportive features in their ecology, may journey through an experience of a traumatic event on a far different path than someone with a lengthy and debilitating history of child sexual abuse, for instance (Roth et al, 1997). It is because of this complexity of exposure and reaction that the notion of 'simple' and 'complex' PTSD classifications is important. It has implications for thorough assessment of those affected, for instance, and provides a further rationale for an ecological approach to the understanding of trauma.

Herman uses the term Complex PTSD to refer to the effects of chronic trauma (Herman, 1992a; 1992b). She describes a progressive form of PTSD with features of continual hypervigilance, anxious and agitated presentations, and

possible bonding with the perpetrator. This latter feature provides a conceptual link to that of traumatic attachments, attachment theory, hostage theory and the aetiology of personality disorders such as Borderline Personality Disorder (Witten-Hannah, 2001). Van der Kolk (1996b) suggested a category of complexity for inclusion in DSM-IV, that of 'DESNOS', an acronym which delightfully means 'Disorders of Stress Not Otherwise Specified' (Ford, 1999; Pelcovitz et al, 1997). This was not accepted but instead was listed as a proposed additional criteria set (www.codt.org).

The significant features of these proposals lie in the blending of physiological, behavioural and social manifestations of trauma experience over time, and have an important bearing on the theoretical arguments within this thesis. For the purposes of the discussion, the proposals for the recognition of complexity within classification systems are henceforth referred to as Complex PTSD/DESNOS.

Valent (1999b) locates some of the arguments about complexity within the debate that has dominated the acceptability and inclusion of PTSD within the DSM. He suggests that PTSD itself had to earn its acceptance into the official nosology according to what he terms the 'hard science' paradigm by stripping itself of the soft emotional and moral concerns, and demonstrating its existence by internal mathematical proofs. The tensions that emerge from squeezing symptoms into predefined boxes has forced what Valent terms the 'ripples that radiate from trauma' (p3), which may be connected through their existence within an individual but unconnected in the DSM, to be called co-morbid, that is, co-existing, diagnoses. This classification framework ignores the obvious interaction of symptoms and experience within the human condition. These views are reinforced by Freedman's analysis (2004) of the values and social and emotional characteristics of emergency responders after the September 11 bombings in the USA. The concept of PTSD was felt to be too narrow a formulation to account for the development of resilience, an argument of relevance to understanding the embedded nature of workplace incidents. A single lens on PTSD, it is argued, will obscure the holistic experience of incidents that occur in a service delivery context, and will therefore reduce the impact of responses designed to provide staff support.

Conclusion

The move towards complexity in the scientific classification of extreme stress illustrates the current status of the formal response to trauma and potentially to workplace incidents. It represents a tension between classification's historical

roots in positivism, and the current environment of contextual and ecological knowledge. The inclusion of acute stress reactions within the official nosology signals the continuing adaptation and evolution of our construction of traumatic experience, and the inclusion of contextual features within the debates over the future shape of classification opens up considerable opportunity for the shaping of staff support systems. Clearly, if environmental factors of time, space and relationship can influence the experience of events, then the environment in which they occur may have an important role in determining our response to critical incidents.

In order to comprehend this notion further, the ecological basis of traumatic impact is now explored.

Chapter Five: Body, Mind and Soul: the ecological impact of extreme stress and trauma

This chapter reviews the research literature concerning the impact of trauma and extreme stress. This knowledge is essential so that construction of staff support systems is trauma-informed, and able to respond to the variable manifestations of impact that may be revealed in a workplace context. Mindful of preceding arguments concerning the tensions between current conceptualisations of trauma and an understanding of complexity, an ecological perspective is chosen to illustrate the complex manner in which trauma can become embedded in neurobiological, psychological, social, existential, cultural and political levels. Binding this together is the argument that for workers within mental health, their recovery from critical incidents and traumatic events will be determined not only by the impact on their own body and mind, but on their inter-relationships, social and professional functioning, and on an organisational and political will that recognises responsibility for response.

The framework employed is an adaptation of *Te Whare Tapa Wha* (Chapter 2; Durie, 1994) and is developed in Table 5.1 below. Whilst holistic frameworks can take various forms, a recognition of their response to complexity, this was felt to be the most applicable to an analysis of the impact of trauma upon body, mind, relationship and spirit, as (unlike the ecological framework in Table 2.1, for example) *Te Whare Tapa Wha* incorporates dimensions of both physical and mental processes. The focus of the chapter moves from a consideration of trauma in terms of its impact upon our physical being (*tinana*), through psychological responses (*hinengaro*), the playing out of impact in relationship with others (*whanau*), through to the cultural and spiritual implications of complex impact over time (*wairua*). The argument that trauma's impact is simultaneously personal and political, physical and metaphysical, is underscored by consideration of the importance of a political dimension termed *whenua*[29], a concluding section in which structural issues of colonisation

[29] In Maori, *whenua* means both land and placenta, semantically connecting people to their homeland. For this thesis, whenua thus becomes a powerful statement of the complex and nurturing interconnection between a person and their environment, bearing political connotations of both identity and responsibility for wellbeing.

and human rights are addressed, and in which elements of the workplace context are located. As a model, the elements of *Te Whare Tapa Wha* combine in a manner recognisable to many indigenous communities worldwide (Durie, 2003).

Table 5.1: The Ecological Impact of Trauma

Trauma is personal

TINANA The fear response Arousal, intrusion and avoidance The effects of chronic stress	**HINENGARO** Traumatic memory Dissociation Trauma and learning Trauma, emotional expression and language
WHANAU Attachment and alienation Guilt, blame and scapegoating Secondary traumatisation	**WAIRUA** Trauma, culture and belief Trauma and time Posttraumatic growth
WHENUA Trauma and colonisation Trauma and human rights	

Trauma is physical

Trauma is meta-physical

Trauma is political

Tinana, the body blow: the neurobiology of trauma

Knowledge about the neurobiological impact of trauma originates from scientific investigation. Understanding gained here provides much of the rationale for the inclusion of PTSD as a mental health disorder, one distinct from other experiences of stress (Herman, 1992a). From our appreciation of ecological context and complexity, we can expect that the neurobiological effects of traumatic experience will develop emergent properties within cognitive, emotional, behavioural, social, cultural and spiritual dimensions. Not only can trauma have a 'ripple-out' effect on those within our work, home and community environments, but these contexts, it will be argued, can provide the environment where the individual impact can be addressed.

Key aspects of the physiology and neurobiology of trauma to be considered are the fear response; the processes of arousal, intrusion and avoidance; and the long-term and physical effects of prolonged and extreme stress.

The fear response

The fear response is a key to the understanding of traumatic reactions at psychological, behavioural and social levels of functioning and lies at the heart of the DSM diagnoses of acute and posttraumatic stress.

The brain structures that we have most in common with other animals are those that evolved earlier; that is, the cerebellum (responsible for automatic movements), the brain stem (which has responsibility for survival processes), and the limbic system (which governs a person's mental and emotional state). The surrounding area (the cortex) is, on an evolutionary basis, the last brain structure to have developed and its relative size and ability is what creates the distinction between human beings and other mammals. The cortex has control over our reason and logic processes, and has responsibility for the development and use of language-based functions.

Fear responses to danger are instinctive, composed of electrical and chemical changes within the brain, transmitted throughout the body via the sympathetic nervous system. Neurotransmitters and hormones produce massive responses that allow for the increased heart rate, blood pressure and respiration necessary to run or fight. It is the limbic system that is activated under conditions of fear and alarm. Of particular interest here is the amygdala, an inch-long structure that records and regulates emotions associated with sensory experience, and which therefore has a crucial role in our experience of trauma (Layton & Krikorian, 2002). By attaching emotional significance to an event, it can override later language-based learning when the event has been of traumatic significance.

The left brain houses such functions as language (in Broca's centre), context and time (in the hippocampus), and logic (in the cortex). During periods of extreme stress, the brain suppresses activity in the left brain (Herskovits et al, 2002; Joseph, 1992; Rauch et al, 1996; van der Kolk & Fisler, 1995; van der Kolk, Burbridge & Suzuki, 1997). As a result, what the positivist paradigm has termed PTSD is characterised by a high degree of sensory arousal (in particular, visual flashbacks) in the right brain, with a parallel inability to put the experience into words (APA, 2000). Recollection of an event is accompanied by physiological arousal replaying details and intensity of the original experience.

Research evidence suggests that in contrast to the processing of danger stimuli by the amygdala, processing of pleasure or disgust stimuli is a cortical activity (Damasio, 1999; Paradiso et al, 1999). This assists in explaining the human tendency to react negatively towards new stimuli. Our alarm response is, in evolutionary terms, an older and less malleable response than those based within cortical activity.

Research concerning the 'HPA axis', the functional relationship between the hypothalamus, pituitary and adrenal glands, reveals that under extreme stress, the body does not shut off the alarm reaction characterised by high levels of arousal hormones (adrenalin and noradrenalin), and nor does it implement the release of cortisol which works to stop this alarm reaction and return the body's arousal to normal (Rothschild, 2000; van der Kolk, 1996a). Endorphins, neurotransmitters for communicating stress within the brain, function as endogenous opioids and serve an analgesic function to allow for a flight or fight reaction by reducing anxiety, depression, anger and fear (Bremner et al, 1993; van der Kolk, 1996a). Endorphins are important in explaining attachment responses, as social support has the effect of increasing our supply of endorphins.

'Fight, flight and freeze': the processes of the fear response

The limbic system governs the brain response under conditions of extreme stress, controlling an organism's basic mechanisms for survival such as the need to defend itself by aggression, to run away from threat, or to maintain stillness in order to hide from a predator (van der Kolk, 1996a). The three mechanisms of fight, flight and freeze have become the standard descriptors of the fear response that governs human and animal behaviour when survival or integrity is threatened.

Nijenhuis (1999) talks of 'freezing' under threat. The act of keeping quiet, of removing language and other noises from the response repertoire, enables an animal to remain undetected from a predator. Nijenhuis argues that this may well have a survival function that assists the individual to respond, along with other distancing processes such as analgesia and visual changes. Grossman (1996) and Tunnecliffe (1997) suggest that these physiological reactions impact upon learned patterns of social relationships under conditions of extreme stress, such as posture and submission positions. In the workplace, a potential assault may provoke a conciliatory positioning as a protective stance that is often interpreted as a failing or as a dysfunctional response because of our usual reliance on language to communicate and understand. Behaviourally and

socially it may be overlaid with attributions of guilt associated with inaction in the face of danger.

The concept of learning, independent of consciousness, has become a standard interpretive tool to explain these physiological reactions to trauma, thus suggesting integration between the biological and behavioural components of experience (Freud, 1919/1954; Janet, 1889). The introduction of the psychological dimension is framed through the medium of learning theory, the pairing of stimulus and response, and the distinction between unconditioned and conditioned aversive stimuli. As learned behaviour, the implication is that it can also be unlearnt (Foa, Steketee & Rothbaum, 1989). This argument forms the basis of many bio-physical interventions for trauma such as somatic therapies and Eye Movement Densitisation and Reprocessing (EMDR) (Rothschild, 2000; Shapiro, 1995; Yule, 2001).

These processes explain the learning associated with Criterion A, the stressor in the diagnosis of PTSD (Chapter 4). As an unconditioned stimulus, the stressor produces extreme levels of arousal, and non-threatening elements in the environment - for example, smells or sounds - become psychologically fused to the unconditioned stimuli, thus becoming conditioned stimuli. Individuals react to them in the way that they originally responded to the unconditioned stimuli (Young, 1995).

'Tend and befriend': gender perspectives on the fear response

'Fight, flight or freeze' has become the standard evolutionary model for reactions to sudden and acute stressors, with factors such as size, speed of movement and position on the food chain determining the response made. Emergent processes that attempt to incorporate a human's gender and social role have been proposed. In particular, I find Taylor et al's research (2000) linking physiological and social gender responses to stress in women to be helpful. This research suggests that although fight-or-flight may characterise the primary physiological responses to stress for both males and females, responses by females to stress are marked also by a pattern of 'tend and befriend.' Tending involves nurturing activities designed to protect self and offspring, thus reducing stress and attempting safety. Befriending is the creation and maintenance of social networks that may aid in this process. Significantly, Taylor et al (2000) point out that many of the animal studies on stress have been conducted with male subjects. Until recently, the human literature was little different, the inclusion of women in human stress studies heavily dependent upon the specific topic under investigation (Gruenewald et

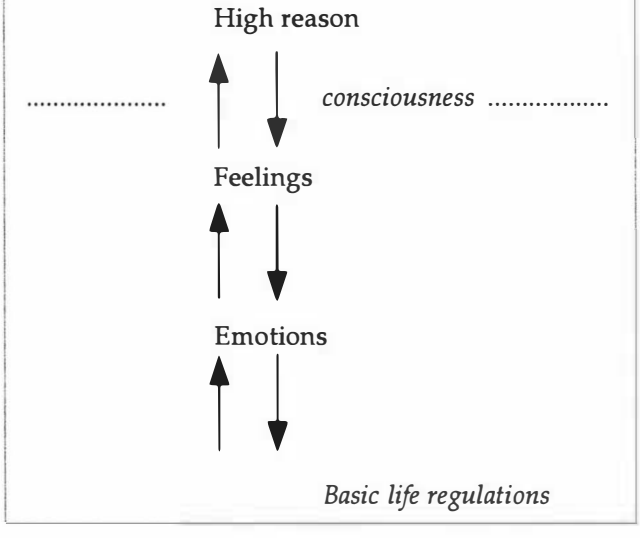
al, 1999). These authors argue that women are overrepresented in studies of affiliative responses to stress, and men are overrepresented in studies of neuroendocrine responses to physical and mental challenges. Taylor et al's (2000) research appears to suggest that attachment theory has a biological as well as a behavioural base, and that aggression (the 'fight' response) may be moderated by gender, as is the 'flight' response. They report the stress-reducing benefits of nurturing under stressful conditions, and suggest that females in particular affiliate and are more likely to mobilise social supports under stress.

This hypothesis clearly has implications for the management of stress in mental health settings with large proportions of female workers, and where workers' motivation may be informed by principles of caring and nurturing derived from both gender and cultural perspectives.

Consciousness and the fear response

The alarm responses described above are sub-cortical in terms of their evolutionary origins and are not language-dependent. The physiological impact of trauma will not immediately be put into words. Damasio (1999) provides a useful schema for the understanding of the cognitive, emotional and linguistic processes of the brain, through his consideration of the concept of consciousness. Cognitive and emotional processes, he argues, are biologically based and concern the regulation of internal states and the body's preparation to react.

Table 5.2: Levels of Life Regulation
(adapted from Damasio 1999:55)



An inability to leave the trauma behind is a characteristic of trauma survivors (van der Kolk & van der Hart, 1989; van der Kolk, 1996a). It is conceptualised as a problem of memory and of learning that has both biological and psychological features. When the body is unable to verbalise an experience because stress hormones have interrupted the verbal processing, then storage and organisation of the memory will not become a cognitive process.

Cognitive and emotional experiences of acute stress and trauma are therefore the bridge between our biological being and our accessible consciousness, and a

key point of intervention for those experiencing traumatic events in the workplace. The rationale for many interventions will be the bringing into consciousness (and therefore conscious control) of our traumatic memories, and the evaluation and critique of psychological debriefing (Chapter 6) hinges around the ability and wisdom of strategies that require a re-experiencing through linguistic recall of events.

Characteristic of traumatic stress is an apparent battle being waged between the brain's attempt to remember and an equal drive to forget the traumatic event. The three following physiological and behavioural processes provide the core of the B, C and D criteria of the PTSD diagnosis (APA, 2000). Whether these symptom clusters together represent the complete 'trauma picture' is, of course, open to critique from clinical as well as cultural perspectives (Chapter 4). They are presented here as reflective of some of the physiological manifestations of trauma impact.

Arousal: losing volume control

> He knows damn well he's still at war,
> just that the snipers aren't Japs anymore.
> from *Snipers*, McGough, in Marshall (1975:73)

The cluster of symptoms around the concept of hyperarousal (criterion D of the PTSD diagnosis) relates to the body's diminishing ability to cope with the overload of responses called into being by threat and is therefore part of the physiologically normal response to extreme conditions (Southwick & Yehuda, 1997). This is especially true for conditions of chronic or intense stress. Under these conditions, a person will remain in a highly aroused state, their body remaining triggered for a fight or flight response as described above (van der Kolk & McFarlane, 1996). The capacity to modulate a stress response, our 'volume control', becomes impaired (Bloom, 1997). As a result, traumatised people have difficulty evaluating sensory stimuli and mobilising appropriate levels of physiological stimuli. They may move from stimulus to response without conscious appreciation of the trigger. Thus a person who has become hyperaroused because of a past threat will have a similar physiological reaction when a physical or emotional stimulus *appears* to threaten. Their body will react *as if* challenged although these triggers may be completely benign. The generalisation of threat may result in sleep problems and difficulties with concentration. Within the workplace, reactivity to particular cues or situations may provoke alarm reactions, blunting the appraisal of new situations.

Intrusion: parasites of the mind

Criterion B of DSM-IV, intrusion, is the sensory recall of the traumatic event, one that will be present in most people immediately afterwards (McFarlane, 1992a). This is not limited to traumatic recollection but such memory imprinting under conditions without high levels of arousal will quickly fade and may be replaced by language-based memory. Intrusion is a necessary process so that learning can occur, and over time, the brain processes the information through all the layers from biology through to culture (Herman, 1992a). Intrusive imagery can be an indication of traumatic stress responses though not necessarily of PTSD (McFarlane, 1993). Van der Kolk and McFarlane (1996) suggest that intrusion leads to sensitisation, and instead of being processed into comprehension (stories that change over time), repetitive replaying (often visual flashbacks) etches itself deeper into the brain. This body memory manifests without narrative or context (Bloom, 1997). It should be noted, also, that not all features of an experience will be remembered, and the process of dissociation, addressed below, may also mediate recall or intrusion. Unassimilated traumatic experiences, stored in active memory, are resolved only when the survivor develops a new mental schema of understanding (Horowitz, 1986). McNally (2004) suggests that confusion about the nature of intrusion undermines the construction of Criterion B within a PTSD diagnosis.

The implication for this thesis is that normally safe environments may come to feel dangerous. Intrusions do not necessarily go away spontaneously and demand a behavioural response; hence people get into maladaptive coping strategies in order to cope with what Charcot called 'parasites of the mind' (van der Kolk & McFarlane, 1996). A mental health worker experiencing intrusive imagery as a result of a critical incident in the workplace may alter their behaviour in order to reduce the power of intrusive recollection, thus introducing the notion of avoidance.

Avoidance: healthy coping or maladaptive denial?

> I soon found out this much: terror can be endured so long as a man simply ducks; but it kills, if a man thinks about it.
>
> Remarque (1929:94)

Avoidance, Criterion C in the DSM-IV diagnosis, is the third characteristic of traumatic reactions and has profound significance for the management of workplace incidents. The concept links with the notion of numbing, and with dissociation, discussed later in this chapter.

In response to the threat of being overwhelmed by arousal and intrusion, the physiological, psychological and behavioural processes of avoidance and numbing represent attempts to protect, resulting in a 'push-me-pull-you' ricochet between the brain's attempts to integrate and then manage the arousal associated with the recall of sensory images and sensations (Horowitz, 1993). Whilst numbing and avoidance are placed together in DSM-IV, numbing probably has a different psychopathology to avoidance, as it is construed as an avoidance of any stimulation, pleasurable or not (van der Kolk & McFarlane, 1996; van der Kolk, 1996a). This may be a factor contributing to the cultural variation of Criterion C (Chapter 4), with numbing a physiologically-based phenomenon (linked to the release of cortisol, a stress hormone that has an amnesiac effect), and avoidance its behaviourally and socially-determined derivative.

Numbing can be interpreted as a protective device to shield the person experiencing a traumatic reaction from the full emotional impact that may overwhelm them (Bloom & Reichert, 1998). Forgetting reduces arousal and avoidance (Raphael et al, 1996). Denial often gets a bad press, but it has an adaptive purpose, facilitating our ability to put some discomforting emotions on hold to enable a person to continue functioning and place their attention elsewhere. This process lies at the heart of the debriefing debate (Chapter 6). Numbing may result in the loss of ability, termed anhedonia, to break out of emotional numbness into an appropriate affect state, whilst still experiencing arousal (Van der Kolk, 1996a). The related concept of alexithymia refers to the loss of ability to identify and communicate emotions that guide a person's actions and decision-making (Krystal, 1978 & 1988; Nemiah & Sifneos, 1970). Van der Kolk (1996a) points out that this ability to make connections between feelings, body states and language begins in early childhood, and that trauma can interrupt this process throughout the lifecycle.

In a workplace context, suppression of flight or fright reactions through emotional numbing can be considered a healthy process that is encouraged by training and acting in role. However this may become maladaptive if these processes continue under conditions of enduring stress, preventing processing of the arousal and intrusive memories into language (Bremner, 2002). The longer that avoidance continues, the harder it is to access and modify the traumatic memory. Avoidance and denial are also seen as increasing the likelihood of a delayed posttraumatic reaction (Horowitz, 1993; Kelly, 1999a; Wilson & Raphael, 1993) and can become processes of dissociation, as discussed below (Putnam, 1991; van der Kolk & van der Hart, 1989) In a social and political context, avoidance can overtly or covertly create or perpetuate

silence in the acknowledgement of traumatic impact by those engaging with the traumatised person (Reid & Hoffmann, 2000).

The neurobiological impact of trauma therefore has both short and long term implications. In the immediate aftermath of an incident, the human response will be harnessed around arousal, intrusion and avoidance, and the prime focus for intervention will be the establishment of stability and safety, and a return to physiological balance. Responsibility for this may lie as much with the environment (from where the initial threat emerged) as with the individual. Research suggests that these neurobiological mechanisms are protective and adaptive features for short-term survival, and a key question for workplace support is therefore how these experiences can be managed without safety and stability being further compromised. The discussion now turns to issues of the long-term effect of these neurobiological processes.

Strung out over a distance: the long term effects of stress

> We used to think that changes in human physiology or brain structure were caused only by disease or congenital defects. The idea that they can occur as a result of something that you see, feel, and experience is new.
>
> Bremner, in Larkin (1999)

The section above suggests that there are both adaptive and maladaptive consequences of states of high arousal, intrusion and avoidance. Research suggests that maintenance of such stress reactions may produce a long term legacy of physiological and behavioural change (Bremner, 1995; Charney et al, 1993; Creamer, 1996; Kolb, 1987; van der Kolk, 1996b). This has major significance for the wellbeing of workers within environments with continual or high frequency stress (a factor linking to the discussion of the health and safety legislation in Chapter Six).

The power of the environment in causing physical symptoms and physical illness is now recognised. Life events have long been known to have a negatively cumulative effect on health and wellbeing (Holmes & Rahe, 1967). This is now clearly illustrated in the effects of traumatic stress on the immune system. Adrenalin, corticosteroids and endorphins released during the stress response all play a role in suppressing immunity, and may lead to the emergence of high rates of medical morbidity (Friedman & Schnurr, 1995; Kawamura et al, 2001; Sapolsky, 1994; Yehuda et al, 1997). Many studies make the bio-behavioural link between mental health disorders and the experience of physical illnesses (Boscarino, 1995, 1996, 1997; Boscarino & Chang, 1999;

Buckley & Kaloupek, 2001; Grossi et al, 1999; Harber & Pennebaker, 1992; Keel, 1998; Krantz & McCeney, 2002; von Känel et al, 2001).

The link between high stress levels and the development of addictive and risk-taking behaviour is clearly made, with research suggesting that in chronic and prolonged stress, the body can become habituated to the analgesic, opiate qualities produced by high endorphin levels (van der Kolk & Greenberg, 1987). Removal of the stressor can in fact create opiate withdrawal. Our knowledge of the notion of tolerance and withdrawal from addiction studies informs us here. It is argued that some chronically stressed people may become addicted to their own circulating endorphins and when this stress is relieved, withdrawal makes them feel worse rather than better, and they may resort to seeking out more thrill seeking or abuse, or chemical forms of relief such as alcohol and drugs (Putnam, 2003). This creates an understanding of the high rates of alcohol and drug use, violent acting out, risk-taking activities, sexual activity, exercising, excessive eating, vomiting, over-involvement in work, and other displacement or numbing activities amongst trauma survivors who may find it hard to engage in relaxation and meditation in their recovery (Hendin & Haas, 1984; Kulka et al, 1990). Occupational stressors and alcohol are closely linked, and part of this coping strategy may relate to this need to numb sensation, or what Stewart et al (2004) term 'alcohol use-to-forget'. These are processes familiar to many of those interviewed within this thesis.

These are crucial issues for the consideration of the debate over workplace intervention, and one of great significance to the role of mental health workers, whose therapeutic and support role with consumers may extend beyond an incident with both consumers and colleagues, and who may therefore be unable to 'stand down' from an incident. A mental health worker affected by the long-term effects of trauma may be compromised both on this neurobiological level, and by the adaptive (or maladaptive) responses used as a result. The compounding effect of early experience on the adult worker is addressed later in this chapter.

Attention now turns to the cognitive and emotional processing of trauma.

Hinengaro: the cognitive and emotional processing of trauma

> Thought made it possible for trauma to be dealt with in the external world. Thought could also mitigate trauma which could not be dealt with, giving hope and coherence through myths and religion.
>
> Valent (1999a:2)

Cognitive and emotional processes link our brain function to our behaviour and social interaction. In this section, the knowledge gained from neurological research informs an understanding of traumatic memory and of dissociation, of the effect on learning, and ends with a discussion about the relationship between trauma, emotional expression and language. A working knowledge of the means by which behaviour at a social level is influenced by processes of thought and emotion is crucial to the later discussions in this thesis concerning the appropriateness of interventions within an organisational context.

Traumatic memory: extremes of retention and forgetting

> Those who cannot remember the past are condemned to repeat it.
>
> Santayana (1863-1952)

Exploration of the nature of memory is of crucial importance to the understanding of trauma, connecting neurobiology, the integration of experience and its communication to others (van der Kolk, McFarlane & Weisaeth, 1996). The characteristics of traumatic memory, the extremes of retention and forgetting (van der Kolk & Fisler, 1995), are likely to affect interventions and workplace support systems, through the ability of workers to access their past experience, to process and to learn from it.

Neurobiological research suggests that there are two types of memory, explicit (or declarative and language-based) memory, and implicit (non-declarative, procedural and sometimes, traumatic) memory. Explicit or declarative memory can be sensory rather than language-based but it differs from traumatic memory because of its accessibility and ability to be coded into language (Nakazawa et al, 2002).

It is implicit memory that operates in situations that require a quick sensorimotor reaction and where unconditioned emotional and language responses would slow reaction time. Controlled from the amygdala, it is sometimes termed 'emotional' memory (van der Kolk, 1996a). In evolutionary terms, as previously discussed, it is an earlier construction. In developmental terms, it appears to become operational earlier than our language centres. Children can remember pain, for instance, long before they have a language to describe it. This sort of memory can be visual, auditory, olfactory or kinaesthetic, and it is this that accounts for the intrusive images in PTSD.

In implicit memory, sensory information is often behaviourally expressed as actions and responses, the control of which is not necessarily voluntary and in cortical control. Freud identified this process of trapped memory as a repetition

compulsion (in van der Kolk, 1989). Triggers may provoke involuntary re-enactment of the original response (de Silva & Marks, 1999). What may have been a situationally-appropriate coping strategy may in another context become an inappropriate reaction that, in the case of the apocryphal stories about war veterans using their killing skills on partners and acquaintances, can be potentially dangerous (Burkeman, 2001). People with histories of trauma may cope well, most of the time, but after exposure to emotional or sensory triggers, the initial traumatisation may be re-experienced (van der Kolk, 1996c), a factor resonating in some of the narratives within this thesis.

The replay of memories without volition is not in itself pathological and does not automatically lead to a diagnosis of PTSD. Such rumination may well serve the purpose of moderating and adapting the emotional connotations of the memory, to build tolerance and to lessen anxiety (Horowitz, 1986; van der Kolk, 1996c). However, the location of memory as non-verbal imagery may prevent the longer-term integration of traumatic experience into explicit memory (Van der Kolk, 1989).

The key to identifying traumatic memory is, in the language used above, the difference between implicit and explicit memory. It is about the degree of control over the recollection of memory that a person will have, and the manner in which a person's life can be shaped and organised by trauma. Explicit or declarative memory, as an active and constructive process, absorbs discrete items of memory into schematic wholes, is available to narrative and therefore to emotional, cognitive, psychological and spiritual processing. The ability to distinguish between declarative and implicit memories, and the understanding of the nature and accuracy of implicit memory, will shape the effectiveness of any intervention where a posttraumatic reaction has occurred (Chapter 6). It is the ability to integrate the experience and to begin its journey. Recognition that a person may not be able to access or process implicit memory into a narrative suggests that a staged treatment intervention that establishes control over arousal and intrusion may be necessary (Herman, 1992a), and it is this issue that underpins discussion in Chapter Ten.

Significant for this thesis is the impact that unintegrated traumatic experience will then have on the behaviour and skills of a worker, who will remain vulnerable to re-enactment of trauma reactions within the mental health work place. Of further significance is that non-processed memory may become part of a pattern of behaviour - avoidance, for example - that is characterised as 'trauma-organised' behaviour at a systems level as well as at an individual level (Bentovim, 1992). This suggests that interventions founded on the

neurobiological knowledge of traumatic memory will need to be aware of systems-level interventions as well as person-centred strategies.

The Recovered Memory Debate and traumatic memory

> You never forget something; you just don't always remember it.
>
> Jessica Haddock

M'panji, a poet in Malawi imprisoned for three and a half years without access to the tools of his craft, memorised lengthy poems and retained them in his head. He said that 'you use memory to survive without a pen' (M'panji, 2001). Recall, both implicit and explicit, is the brain's way of storing information for further use in survival, social and aesthetic processes. It is the recall of implicit, emotional memory that is controversial, and which places the management of trauma squarely in the organisational and political arenas.

The current debate in regard to the accuracy and veracity of recovered memory has a two-fold relevance to the research question. Legal, economic and organisational reviews and inquiries may focus upon the ability to verbally report memories as evidence. Furthermore, the Recovered or False memory debate resonates, in any account of traumatological history, with the concepts of hysteria and malingering explored in Chapter Three, and can teach us much about societal reluctance to accept responsibility for traumatic harm (van der Kolk, Weisaeth & van der Hart, 1996). It is about evidence and belief.

The debate has created polarisation between those who accept the accuracy of implicit memory and those, for whatever agenda, doubt that such memories can remain unavailable and then triggered into recall with any degree of validity or reliability (Hood, 2001; Rix, 2000). It can best be summarised that the debate still rages, that research is still continuing and that the nature of traumatic memory, for those working in the field, must be regarded as a complex and still speculative arena. Bloom and Reichert consider that:

> This entire debate presents an excellent example of how political and social forces can influence scientific debate as well as judicial decisions with little regard for the complex nature of reality.
>
> Bloom & Reichert (1998:121)

For the purposes of designing appropriate staff support systems, it should be acknowledged that there is complexity in the process of recall. With implicit memory there are strong arguments for the accuracy of the images recalled (Bremner et al, 1995; LeDoux, 1994; Schooler, 1994; van der Kolk & van der

Hart, 1991; van der Kolk, 1996a). Schooler's review (1994) also acknowledges that fabrication of memory is possible, with fabrication confused with reality in cases where a person is dominated by persuasive others. Even where memory can be corroborated, discrepancies between accounts from one individual can vary (Herlihy, Scragg & Turner, 2002).

Environmental conditions such as the growing acceptance that abuse or workplace incidents happen are arguably factors in encouraging recall and potentially influencing the language of disclosure. In normal, declarative memory, recall is framed in language and the exchange of information is therefore a dynamic between the person with the memory and their audience. It may become altered by parallel or associated experiences, emotional states and what are termed 'demand characteristics' (van der Kolk & van der Hart, 1991). Our knowledge of traumatic memory makes it important to distinguish between trauma remembered all along in a person's experience, that which is spontaneously remembered, or recovered in a therapeutic intervention (which could be open to suggestion) and that which is suggested in the process of intervention (Yapko, 1994). This leaves an ethical responsibility with an intervention, to be mindful of issues concerning the recall of traumatic events.

The recall and processing of events may further be impaired by the experience of dissociation, discussed below.

Dissociation in time, person and place

This chapter has previously presented the research that an effect of trauma is to overwhelm the brain's capacity to use thought and emotion to integrate new information, dissociating sensory memories from a full exposure to the language functions that may add meaning and context to experience (Bloom, 1997). Understanding this dissociation is crucial to grappling with trauma and the management of acute and ambient stress in the workplace. In many ways, dissociation is the distinguishing characteristic that sets aside traumatic stress from the other stress reactions, and it may determine the appropriateness and viability of particular interventions. As a concept, dissociation connects brain function, hysteria, the concept of emotional numbing, and even the ability to dissociate from customary value bases (Bloom, 1997; Milgram, 1974). It is best conceived as a description of experience rather than as a discrete brain state or process (Jureidini, 2004) and, as a safety valve that enables the brain to cope with overwhelming sensory experience, is manifested in the narratives of some participants in this thesis.

DSM-IV defines dissociation as 'a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment' (APA, 1997:477). As Chapter Four acknowledged, there is currently a strong argument suggesting that rather than PTSD and ASD being classified as anxiety disorders, they are actually best interpreted as dissociative disorders (van der Hart, van Dijke & van Son, 2000), with research evidence that dissociative symptoms have a predictive relationship with later PTSD (Dancu et al, 1996; Shalev et al, 1996; Spiegel et al, 1996; van der Kolk & Fisler, 1995; Van der Kolk, Pelcovitz et al, 1996). North et al (1999) consider avoidance and numbing as dissociative traits. A study by Carlier and colleagues (1996) suggests that the relationship between PTSD and dissociation is in fact the reverse, that the presence of PTSD is predicative of dissociation. There is indication, too, that those people with acute stress disorder (the disorder that is often the temporal precursor of 'full-blown' PTSD) are more likely to experience dissociation than those with subclinical or no apparent ASD (Bryant, Guthrie & Moulds, 2001). This is a key clinical indicator for the success of particular interventions, as I shall consider later.

In human experience, dissociation may manifest on a continuum ranging from Dissociative Identity Disorder (DID) (APA, 1994) through to common processes that increase behavioural efficiency and multi-tasking, for instance, whilst driving. DID can manifest as separate identities within the same body and whilst used as a literary device in order to contain both good and evil within one personality (Stevenson, 1979; Weldon, 1995), is usually cited as resulting from chronic childhood abuse. Peritraumatic dissociation, the immediate process at the time that an event is unfolding, may produce alterations in the experience of time (a slowing or acceleration), of person (unreality that it is occurring, that the individual is the victim, a depersonalisation, out of body experiences, bewilderment, confusion and disorientation, altered pain perception, altered body image or feelings of disconnection, or tunnel vision) and of place (a sense of unreality) (van der Kolk & Fisler, 1995).

The implications of dissociation for the recall and integration of traumatic memories are profound. Memory may have split into manageable segments of time, sensations or emotion, and may be disorganised, with sequential recall not possible. Incoherence may indeed be proof that a person was traumatised. A person in a dissociated state may have a diagnosis of PTSD queried, as they may not meet the criterion B requirement of intrusive features (McNally, 2004). Dissociation is therefore a key feature of traumatic experience that has to be considered during immediate intervention after a traumatic event in the workplace, as recall of details may be absent, partial or separate from emotions,

or may be locked in implicit rather than language-based memory. Marmar (1998), writing in relation to emergency services personnel, considers that factors affecting the degree of dissociation include the younger age of the victim, higher levels of exposure during the event, a greater subjective perceived threat, poorer general psychological adjustment, poorer identity formulation, lower levels of ambition and prudence, a greater external locus of control, and greater use of escape/avoidance processes. The implications for training, selection and practice are considerable. Morgan et al (2001) present similar evidence, suggesting that whilst dissociation will occur in healthy people, those that they classify as 'stress-hardy' (in the context of their study, Special Forces soldiers) experience fewer dissociative symptoms.

Responses to traumatic stressors appear to have gendered and cultural dimensions into which constructions of dissociation are woven, further underscoring the advantage gained from the use of a holistic framework such as *Te Whare Tapa Wha*. Perry (1995) suggests that women's response to trauma may trend towards the development of dissociative symptoms, whereas male response to trauma may manifest more commonly as psychopathy[30]. It could be suggested then that women's processing of trauma is sectioned along lines of time sequence, as in dissociative disorders, whereas men's dissociative processes verge towards divisions and barriers between modalities - for example, separating feelings, thoughts and images. Culturally acceptable expressions of distress will result in variation of physical and mental symptoms. Many cultures have traditions where people deal with emotional, social or interpersonal conflicts through the enactment of multiple identities, which the medical model would identify as the extreme end of a dissociative continuum. Many have strong traditions of spirit possession (Spanos, 1994). Transgenerational transmission of trauma may not have the lineal directness of physiological impact, yet the demonstration of trauma's legacy through dissociation's cognitive-emotional, behavioural and social processes of avoidance versus integration can assist in the understanding of familial and cultural patterns of coping and dysfunction (Egeland & Susman-Stillman, 1996). Notions of the generational effects of trauma are discussed later in the chapter.

Trauma, learning and helplessness

The isolation of sensory information from processing on a cognitive level, often characterised by dissociation, therefore impacts on a person's ability to begin to

[30] A working definition of psychopathy can be a separation of actions from feelings (Mullen, 1992).

control the impact of experience. Our ability to learn from an event, to contain the impact, understand, and adapt, becomes compromised. LeDoux (1994) describes the imprinting of emotional memory that is able to activate the physiological reactions associated with the original danger. This notion of state-dependent learning suggests that it is only these reactions and responses that are available to the traumatised person, not learning made at other levels. Cues are not used to process incoming information into meaning but are more likely to precipitate flight or flight reactions. Bloom (1997) suggests that this may account for therapeutic difficulties where responses to situations are successfully rehearsed in safe environments but cannot be utilised when under conditions of environmental stress that trigger off recollections and automatic reactions. Staff in organisations with high stress levels may not be able to distinguish between affective cues to assess levels of risk, instead remaining hyper-vigilant and less able to absorb new information.

The impact on workplace practice may therefore be considerable. Learning from one stressful event, if met by successful coping and support strategies from both individual and organisation, can be generalised to another similar experience without producing the initial levels of high arousal. If the outcome of an event is repeatedly out of a person's control, as warfare, abuse or repeated bullying may teach us, learned helplessness can occur. The concept of learned helplessness illustrates that humans can generalise from a traumatic situation in which they experienced powerlessness, into others where solutions may indeed be possible but are not attempted (Seligman, 1992). The futility of resistance can produce emotional, learning and motivational changes in human performance and self-perception, and the ongoing stress can be linked, as previously discussed, with physical problems and a reduction of what in religious terms may be called 'free will'. Along with this goes impairment in self-esteem, a potential for depression and an overall sense of powerlessness in life decisions. Translated into the effect of trauma on worker performance, learned helplessness may result in defensive practice (for example, not extending clinical practice into areas of risk), professional dangerousness (perhaps, as Morrison (1998) suggests, extending into 'passing the buck' in inter-agency relationships) and distorted communication styles. Decision-making can become severely compromised. During a crisis our thinking may be characterised by tunnel vision that is restricted and simplistic, and where the holding of different levels of thought or prioritisation becomes difficult. We may not be able to envisage long-term consequences, and are geared for action, not debate. If our physiological perceptions of stress persist through experience of hyperarousal and hypervigilance, much of our decision-making activity may

evolve around avoiding triggers in the environment. We may be impelled to use short-term solutions, perhaps fight or flight reactions, to avoid the problems or anxieties. Our ability to analyse situations may lessen the integration of immediate cues into a worldview that contains moral and ethical moderators, into decision-making that is instrumental and geared to escaping or eradicating the threat (Gersons & Carlier, 1992). Analytic thought is a higher cortical function that may not get exercised in conditions of extreme stress.

Trauma and emotional expression

> It's in the feelings not the thoughts that the poison lies.
> Father Michael Lapsley, in relation to recovery from apartheid,
> *National Radio*, 10.11.04

The ability of a person to translate emotional experience into language lies at the heart of some sentinel debates in the delivery of trauma and critical incident response within the workplace (Chapter 6). Our ability to categorise these experiences creates a pathway to managing the emotional reactions and resultant behaviour.

Bowman (1999) emphasises that emotions are the outcome of a complex series of processes and as such are not directly reflective of the nature or severity of an event. In other words, there is an emergent property of psychological and environmental mediation at work. Her review of the research literature in regard to individual differences and PTSD suggests that emotionality, or emotional response styles, are trait rather than state characteristics. This view lends some weight to an understanding of individual difference and predisposition, the impact of prior experience and training, and raises socio-political issues of gender, selection and accountability in organisations.

From both a trait and state perspective, a body of research suggests that the suppression of emotional experience through denial and numbing has negative consequences for both physical and mental health that can be relieved by disclosure and communication (Harber, 1992; Kiecolt-Glaser et al, 1996; Kiecolt-Glaser et al, 2002; Paez, Basabe & Gonzalez, 1997; Pennebaker, 1990 & 1995). However the usefulness of emotional expressiveness as a coping strategy is contested, with some arguments that denial and avoidance of the emotional impact of events are also beneficial (Weisenberg et al, 1993). A gender analysis of emotional expression styles and coping strategies, such as the 'Tend and Befriend' arguments above, may provide contributory explanation for the higher rates of PTSD amongst women.

Expressed emotions on an interpersonal level may have a negative impact on the environment of recovery. Emotional contagion can occur in states of acute stress, where we are easily susceptible to emotional and physical cues from others (Bloom, 1997; Miller, Stiff & Ellis, 1988). The environment may close down on the affected individual in an attempt to control the vicarious pain that their experience may cause. The attribution of responsibility may be weighted towards the victim of the event: such pathologising and individualising of responsibility may create the social behaviours of avoidance, exclusion, and denial that may become a generational pattern (Bloom, 1997; Egeland & Susman-Stillman, 1996; Harber & Pennebaker, 1992).

The expression of emotions appears to be a double-edged sword in regard to the impact of trauma. My reading of this issue suggests that two factors assist us in understanding the role of emotion in the impact of extreme stress. Firstly, that understanding the neurobiology of stress and trauma provides the essential information that in the processing of sensory and emotional information, there will be processes of denial and avoidance that serve to keep people safe in the short term, and that it is long-term inability to bridge the gap between emotions, cognitions, language and meaning that creates the problems. A distinction needs to be made between anhedonia and alexithymia, between the ability to recognise emotions, and the appropriateness of giving vent to emotions as a response to conditions of extreme stress (Krystal, 1988; van der Kolk, 1996a).

Secondly, as Bowman (1999) points out, a blanket assumption that all emotional expression is healthy after the impact of an event is inaccurate. Some emotions (such as anger) may be harmful, and expressed emotion may create defensive isolation of a victim. An integrated approach that reconciles emotional expression and cognitive understanding may reduce these incongruencies.

The section below begins to describe the translation of experience into verbal expression and language-based communication with others.

Developing a relationship with trauma: transferring memory into language

> Since then, at an uncertain hour,
> That agony returns:
> And till my ghastly tale is told,
> This heart within me burns.
>
> *The Rime of the Ancient Mariner,* Coleridge (1970:68)

For trauma survivors, language becomes the means to begin the integration of experience, moving events from dominating the present back to a manageable past. For this thesis, it provides the link into a discussion of the search for meaning as the key to the management of workplace incidents.

Language is, of course, not mere words, but includes other communication processes of ritual, dance, storytelling, and visual arts. Collective non-verbal processes may serve an equal or perhaps more effective integrative and communication function of mimesis[31]. Geering (1994) argues that the role of language and other symbolic codes is the pivotal feature in the creation and maintenance of our sense of self, contradicting Maslow's (1998) location of symbol as an aesthetic rather than an affiliation need. Bloom and Reichert (1998) use Driver's (1991) argument that rituals in society are activities that connect individuals to the collective and which are used as a means of working through traumas and major life transitions (also, deVries, 1996). The use of such activities and symbols, through art, dance, and drama therapies, or cultural rituals, may be an access point into the processing of trauma for people who are anhedonic or alexithymic, uniting individual physiological and emotional experiences through a common expression and facilitating the growth of both individual and shared interpretations and meanings. It potentially rejoins what has been disconnected by trauma.

Language processes thus locate us in a world outside of ourselves (Friere, 1972). Well-developed mental and linguistic processes appear to have a resiliency function for us through the transformation and communication of inner experience (Cederblad & Dahlin, 1995; Masten & Best, 1990; McFarlane & Yehuda, 1996; Norman, 2000; Paton, Violanti & Smith, 2002; Rutter, 1990; Rynearson, 2001). Repetition of one's story, like Coleridge's Ancient Mariner in the quote above, serves to externalise rumination and engage with an audience. Language, too, is a great way of not being where we are, narrative distancing us from impact (McFarlane, 2000). It can be viewed as an attempt to address the intrusive, overwhelming recollections of experience, through unloading some of the aroused emotion and reframing the experience with new weightings and interpretations. Pennebaker argues this in relation to the positive effect of the development of a narrative in a verbal or written form that may or may not have an audience (Pennebaker & Beall, 1986; Pennebaker & Susman, 1988; Pennebaker, 1989; 1990; 1993). Connection between self and the world may be an individual, a socio-cultural and a spiritual process, thus linking the impact of trauma through different ecological levels. Workplace settings, reliant upon

[31] Bloom uses Donald's term 'mimesis', which he defines as 'the ability to produce conscious, self-initiated, representational acts that are intentional but not linguistic'. (Bloom, 1996:58).

communication in many different forms, therefore have the opportunity to manifest trauma's impact in many different ways.

Whilst we consider language and the ability to communicate as key indicators of health and of the impact of trauma, we must also consider the dynamics of silencing and prevention of communication as important to our understanding. We have previously seen how the impact of trauma itself can create alexithymia. We colloquially talk about being 'gobsmacked', or lost for words. Burrow, an American reporter at the liberation of Buchenwald, said simply, 'for most of it, I have no words' (in McFarlane, 2000). An intervention after traumatic experience may need to focus on assisting the integration and expression of emotions in order to overcome the enforced silence:

> Give sorrow words; the grief that does not speak, whispers the o'er-fraught heart and bids it break.
>
> Macbeth 5.1.50-1

Silencing can stem from sources other than the direct impact of an event. Environmentally-imposed silencing can have a traumatic or re-traumatising effect, as in the case of gender socialisation that encourages or suppresses emotional self-disclosure (Purves & Erwin, 2004), the socio-cultural suppression of grief, silencing through processes of shame or denial (Kessler & Bieschke, 1999), and the socio-political suppression of minority languages through colonisation, as was the case in Aotearoa New Zealand, in Wales (Davies, 2001) and with the Kurds in Turkey. Transposing this into the impact of workplace trauma would suggest that our awkwardness with the language of loss, grief, stress and trauma, allied with a social denial of the gravity of the psychological impact, compounds difficulties in recovery and healing. The breaking of silence and the use of language thus often support the transition between being victim and becoming survivor.

Discussion of the relationship of trauma with language thus suggests the centrality of communication as a focal point for workplace interventions. It links the internal experience of trauma with its effects and potential resolution in the social and organisational environment. With this understanding, attention now turns to the impact of trauma in our relationship with others.

Whanau and the social world

Within the framework of *Te Whare Tapa Wha*, the focus on *whanau* emphasises the importance of our social connections, a crucial dimension in our comprehension of workplace incidents. A biomedical emphasis within the conceptualisation of extreme stress and trauma has tended to underemphasise

the importance of the social context in both absorbing and shaping impact and response, despite exposure to trauma not always being a private experience. Events within a work setting are variously challenged and strengthened by crisis and trauma, making a personal experience public, and impacting on social and cultural dynamics within an organisation. Attention to the social impact underscores the ecological argument that the environment has a major role in the determination of outcome. Attachment, systems and constructivist perspectives can all be utilised here (Nadeau, 2002).

In this section, issues of attachment and alienation are first explored. Notions of guilt, blame and scapegoating are then highlighted. From within this social framework of understanding, the concept of secondary traumatisation, central to the experience of many of the participants in this thesis research, is discussed.

Attachment and alienation: stretching the trauma membrane

> Identity is ... a construct derived from the nature of relationships with the external world.
>
> Durie (2001:172)

As social beings, our survival and well-being are intimately connected to others (Caplan, 1974; Durkheim, 1951; Falloon & Fadden, 1993). Ecological acknowledgement of interconnectedness reinforces Summerfield's (1995) contention that traumatic experiences need to be conceptualised in terms of the dynamic interactions between the person and people in their environment. This places the impact of trauma not just in a static physical location within the individual but in a complex social and employment relationship that continues to evolve meaning of an event. The western emphasis on individualism and the biomedical focus on the individual is merely a question of balance rather than a denial of interconnection. Notions of the importance of attachment appear to be universal in human society (Boscarino, 1995; McFarlane & van der Kolk, 1996a). Characteristics of a workplace environment may determine whether the impact is either centrifugal or centripetal, either disconnecting people or strengthening their bonds (Erikson, 1994). This potentially protective process of social support is what Lindy (1985) terms the 'trauma membrane'.

The research literature suggests that positive social support can positively affect stress and arousal levels, and the immune system (Cohen & Wills, 1985; Coyne, Ellard & Smith, 1990; Croll, 2000; Morgan, 2002). Conversely, emotional contagion can create vicarious arousal when individuals are presented with empathy-inducing stimuli (Eisenberg & Fabes, 1994; Larsen, Diener &

Cropanzano, 1987). Concepts of attachment apply also to workplace situations, where colleagues provide a social support network of informal as well as formal connections. A heightened need for affiliation and peer support may be a rationale for the use of peer support in workplace interventions (Chapter 6). Ecological and Strengths perspectives, and a meso-level analysis, illustrate that it is the strength and positive nature of these bonds that will provide affinity and support.

There are also negative aspects in the relationship between trauma and social support, which focus upon trauma's ability to split a person from support, and the environment's ability to provide what is necessary for healing.

A key effect of a traumatic event is to challenge a person's ability to be intimate with others, through a process of alienation from trust relationships that undermines unspoken assumptions about safety and protection (Turner, McFarlane & van der Kolk, 1996). Trauma has the power to skew the social world so that the traumatic event becomes a player in the interactions, social supports becoming co-dependently enmeshed by the need for stability in what Bentovim (1992) refers to as a 'trauma-organised system'. Accommodation without successful intervention can in extreme form become identification with the aggressor (Hearst, 1981). Often termed the 'Stockholm Syndrome', this process has been described within child protection and mental health agencies and inquiries as a process of professional dangerousness, the practitioner identifying with the threatening or bullying figure in order to ensure their safety or survival (Morrison, 1998; Strenz, 1982).

There are clear implications for support systems within mental health, where person-inflicted trauma may have a qualitatively different impact on a person than by a non-human source such as a natural disaster (Breslau et al, 1991; Gould & Ryback, 1999; Janoff-Bulman, 1992; Smith & North, 1993). A worker may feel that no one can relate to what they been through, or that the quality and the meaning of the event cannot be communicated without a sense of betrayal (Freyd, 1996). Social withdrawal and alienation may increase the vulnerability for self-destructive behaviours and substance abuse. The task of recovery and healing is to reinstate a larger human connectedness that transcends the discontinuity and dissociation that a traumatic event may bring.

Another aspect of social support is that the environment itself may be abusive or 'toxic' in some way, for instance where the perpetrators of a traumatic event are within the group, or a worker remains clinically involved with a perpetrator or primary victim (Bloom, 1997). Kleber et al (1995) cite examples of how

communities have not sustained groups of trauma survivors through a lack of recognition of their experience and by destruction of their support systems, the most cited example being the return of Vietnam veterans to the USA and Aotearoa New Zealand, who were seen as perpetrators rather than victims (Grossman, 1996). RSA[32] organisations closed their doors because the conflict in Vietnam was not given the status of a 'real' war.

Such a social gulf between victim and community is clearly more obvious in the context of warfare than in the management of workplace incidents, and judging by the attractiveness of the concept of traumatic alienation to literature and film, there is now a degree of sympathy for the veteran (Cimino, 1978; Heinemann, 1987; Stone, 1989; Zemeckis, 1994). Alienation through other processes (male dominated society; colonisation; or workplace violence, for instance) may not achieve the same profile, but may result in a similar separation of the person from support and a sense of future (Doka, 1998; Shay, 1994). It may also result in the formation of social groups that are characterised by exclusion from the mainstream (Gibson, 1994). Defensive alliances may be forged out of necessity (Frankl, 1964; Remarque, 1929). It can be posited that continual high levels of occupational stress may contribute to a closure of boundaries between some workers and the world outside, a phenomenon particularly frequent within institutional settings such as secure units.

Survivor guilt and the blaming of others

Survivor guilt, and the blaming and scapegoating of survivors and their managers for their survival and subsequent behaviour are key social responses to trauma that need to be explored in order to create an understanding of the environment into which intervention may occur (Kubany, 1998; Lindemann, 1944). Both are manifestations of the need to locate the self in relation to the event, and to attribute causation and responsibility.

Feeling guilty for having survived or for having reacted in a particular way is a common process linked with our attachments, location in the social world, and attempts to create meaning. Lifton (1988) refers to the 'failed enactment', survivor guilt emerging from the sense of helplessness experienced at the time of the event, which is compared with standards of ordinary life processes and roles. The feeling that one could have done something may overshadow the fact that one's actions may be constrained and limited by the characteristics of the extraordinary event. Shay (1994) argues, within the contexts of Vietnam and the *Iliad*, that it is the nature of the bond created by serving alongside comrades

[32] Returned Servicemen's Association in Aotearoa New Zealand.

in warfare, the mutual dependency and raised awareness of responsibility and duty that leads to a blurring of the boundaries between the self and others. This process could be reflected within workplace dynamics within some mental health settings.

Bloom lends an interesting interpretation to the notion of scapegoating. Alongside the guilt that a person may experience for having survived a traumatic event, others may attribute blame for the event on their actions or inactions through what she calls 'one of our oldest cultural motifs'[33] (Bloom 1997:51). The use of people as 'poison containers' for our own unacceptable feelings can be seen as an externalisation of guilt and responsibility. The fact that a traumatised person may appear to invite further abuse because of their passivity and seeming compliance makes the power dynamics of trauma very sensitive within the workplace, a process made stronger if the victim is already culturally devalued by belonging to a particular gender, age or occupation that is considered inferior (Matsakis, 1994). Victims may get viewed as somehow having contributed to their own distress, or exaggerating their sufferings for purposes of compensation, sympathy or as an excuse to avoid responsibility. This links with the conceptualisation of traumatic impact as malingering (Clark, 1991; Young, 1995).

The work environment of mental health, with its evolving professional identities, unique stressors, media attention and repeated enquiries and restructurings, is an environment in which issues of responsibility for incidents may often become enmeshed with the impact of trauma itself. Attention to the needs of the worker (often the secondary victim in the focus upon consumer need) may be overshadowed by both clinical and organisational imperatives.

It is to the issue of secondary traumatisation that this chapter now turns.

The impact of secondary traumatic stress

> I try to eradicate the past. I live with the memory of all those frightful images of human conflict while the negatives are neatly filed away in my study. Now I create my own days in my garden shed, assembling still life subjects that please me [...]. The real struggles now take place in my darkroom, where I try to resist the temptation of printing my pictures too dark.
>
> McCullin, war photographer (1994:198)

The social impact of trauma emerges as starkly important when we look at the secondary effects on those exposed to the traumas experienced by others. The

[33] She is, of course, referring to North American culture.

concept of secondary traumatisation allows us to access the impact of experience of diverse groups such as jurors (Hafemeister, 1993), journalists (Brayne, 2003), translators (Reynolds, 1998) and transcribers in evidential units for child abuse. Mental health work, by the nature of the issues facing its consumers, may expose staff to much that is vicarious. What follows is a conceptual description of secondary traumatisation and related experiences. A fuller account of the various descriptors of experience is included within Appendix Four, as a broad understanding of the manner in which the literature addresses secondary stress is crucial to the thesis argument. These relational concepts are key to the understanding of the ecologically embedded nature of traumatic experience and their organisational response.

Secondary effects of trauma are acknowledged within DSM-IV, which includes the impact of witnessing or learning about an event or serious threat (APA, 1994). Classification of trauma within the positivist framework of the DSM is being stretched by our growing comprehension of the effects of cumulative exposure to other people's distress, and how this compounds when we become victims in our own right. Direct exposure is therefore not a mandatory criterion within the paradigm. Terr et al (1999) introduced the concept of 'distant-traumatic' effects, and Taylor (1996) created a framework for understanding the multiple levels of impact.

Secondary trauma enters the experience of workers through the social world, and raises some interesting questions for issues of legislation, compensation and support, and for research inquiry into the nature of the traumatic experience. The fact that a person can be badly affected not only by direct experience but by exposure to that of others should not lead us to assume that the impact is any less great. It is important to view secondary traumatisation as a process of traumatisation, not as a reflected, watered-down version. McCann and Pearlman (1990b) acknowledge this, arguing that therapists working with trauma survivors will experience lasting alterations and impact on cognitive processes and schemas, and on their relationships. Whether this impact has a positive or negative impact, they suggest, will depend on whether the therapist is able to engage in a parallel process of integrating and transforming the experiences.

The power of the organisational environment to generate ongoing high levels of stress and potential for retraumatisation would suggest that the integration process will be slowed or halted by a person's inability to detach or remove themselves from the effects of an incident. Work in the human services can be life changing, as in a study of social workers in rape-crisis work, which suggest

that there were emotional and existential consequences such as a diminished level of trust and belief in the goodness of society (Clemans, 2004). Avoidant behaviour might result, or work with clients may be altered to protect the worker (Pope & Garcia-Peltoniemi, 1991). These writers also suggest that the voyeuristic opposite may occur, and that clinicians too can experience guilt, about not having done enough. Ruzek (1993) argues that that strong emotions are a natural part of the work and I would add to this the argument that how these emotional reactions are addressed is not only an issue for the individual worker but for the organisation in which they work.

Secondary traumatisation may of course extend ecologically beyond an organisation into the home lives of its workers. Significant levels of family distress and damage are described in the research related to military personnel and their families, for instance, Solomon et al's finding that wives of soldiers with PTSD are much more likely to suffer from levels of mental disorder and social dysfunction than those with partners without PTSD (Solomon et al, 1991). Kulka and colleagues (1990) have reported levels of long-term effects amongst American Vietnam veterans. The impact on family life and relationships emerges as a major feature of the narratives within this thesis. The impact on children growing up in an environment where family members are traumatised, perhaps as secondary victims, is a significant contribution to our knowledge base. It provides motivation for prevention of family damage through events in the workplace, but it also underscores the importance of training and support of workers in their work-life balance.

The introduction of relational elements in the experience of trauma and extreme stress extends consideration of impact out of the focus upon an individual and into the contextualised levels of dynamic interaction. By so doing, the theoretical influences of systems and constructivist approaches add to our knowledge base, bringing with this change of emphasis a greater awareness of meaning and of relationship. It is to the concepts surrounding *wairua*, the spiritual dimension, that the attention of this chapter now turns.

Wairua, time and the spiritual dimension

> But, after the fires and the wrath,
> But, after searching and pain,
> His Mercy opens us a path
> To live with ourselves again.
>
> Kipling, *The Choice*

Wairua, or the spiritual dimension identified in the model of *Te Whare Tapa Wha*, represents the existential and meaning-making dimensions of the impact

of trauma over time that are omitted by the positivist paradigm (Littlewood, 2001). An ecological approach suggests that such metaphysical issues lie at the heart of the experience of critical incidents and traumatic events, challenging our assumptions of safety, identity and belief about the world we live in, and involving us in a meaning-making activity that identifies us as human. A constructivist perspective provides an understanding of this human ability to regenerate and reconstruct. Through constructivism, we can acknowledge not only trauma's power to damage our powers of comprehension, but some of the recovery processes that may validate a person's experiences (Gusman et al, 1996; McCann & Pearlman, 1990a). The thesis question explores the nature of the meanings that the participants place upon the events that they recount.

This section address the issues of assumption and meaning, discusses trauma's impact through culture and belief, and addresses how trauma can become embedded in person, family and culture over time. It concludes with the acknowledgement that the experience of trauma can result in posttraumatic growth.

Trauma and our assumptive world: searching for meaning

> Men are disturbed not by things, but the views which they take of them.
>
> Epitectus, fifth century BC

The question of meaning is fundamental to any discussion of the impact of trauma and extreme stress within the workplace. Using the cognitive and emotional processes of language and communication that enable connection with others, construction of meaning assists us to incorporate experience into some bigger picture that extends outside of the trauma and into other more stable parts of reality. We acquire a sense of reality from the accumulated experience of others (van der Kolk, McFarlane & Weisaeth, 1996). The search for meaning can be seen as a process that links a traumatised person or population with their past and with the hope of an untraumatised future.

The epidemiological and diagnostic issues discussed in Chapter Four raised crucial questions concerning why a diagnosis of PTSD is acquired by some people, in some circumstances, and not by others. There is a strong argument against a 'dose-related' interpretation of the impact of trauma, research evidence telling us that interpretation of events (and thus an emphasis on individual, social and cultural difference) is an important part of the matrix of our understanding (Bowman, 1999; Wortman, 1992). Beliefs and cognitions act as moderating and mediating influences. Ecological interpretations of

experience underpin the discussion here: Zohar (1997) argues that core values and a meaning for life are fundamental to human existence and organisational functioning, and that we cannot prioritise and separate physical, social, personal and spiritual needs (as Maslow (1998) does, for example).

The acquisition of meaning is very much a process rather than a steady state, and a group as well as an individual process, as it develops through complex interaction with the environment. Linking with attachment theory, we gain an understanding of the world from our early interactions (Antonovsky & Sagy, 1987; Bowlby, 1980; Freud, 1935). Janoff-Bulman (1992) describes three major assumptions that she believes lie at the core of this sense-making: that the world is benevolent; that the world is meaningful; and that the self is worthy. We prefer to believe that we do good and tend to deny our capacity to harm or offend others. Anxieties about safety and risk are kept at a distance by the sense of ontological security that attachment theory suggests is provided by secure childhood relationships. Trauma may transform this sense of trust into distrust of systems and environments as well as relationships (Erikson, 1994).

This reorganisation of purpose and role lies at the heart of many experiences of critical incidents in the workplace. Miskiman (1990) writes that the individual's perception of invulnerability is one of the factors in whether an incident is critical for them or not. Hence the meaning of an event is different for a person employed in a crisis context than for a layperson (van der Kolk, van der Hart & Marmar, 1996). As adults, exposure to trauma and acutely stressful situations can provoke many of those familiar emotions of vulnerability, fear, isolation, guilt and responsibility for having caused the distress. Internalisation of these messages develop as 'dominant stories', perpetuated by further experiences and outside agency, and contribute to the development of negative identities characterised by the sense of hopelessness and lack of competence previously described as learned helplessness (Salmond, 2002; Seligman, 1992; White & Epston, 1990). This highlights the importance of stress-inoculation processes through training, education and supervision and brings us back to the central importance of context and time in this research.

One aspect that is at the core of many traumatic experiences is that of the presence of death, an event that severely compromises a sense of control, and which is identified in the DSM criteria as lying at the core of traumatic experience. A threat to life opens up the presence of death in a profoundly existential way. An event may not involve the death of someone for a victim to consider their own mortality or ontological security. Lifton (1988) argues that the presence of death is often ignored within the post-traumatic literature, in

terms of both a conceptual and a (western) cultural resistance to acknowledging it. Our discussion about the guilt of the survivor is not complete without an acknowledgement that they have survived something that others have perhaps not. Consideration of the nature of interventions, likewise, may not be effective without acknowledgement, in some way, of the mortality with which we all live. Meaning in this context links the attachment notions of ontological security to the existential questions of spirituality and belief, issues that are now considered.

Trauma, culture and belief

> I was sitting there with this one priest and said, 'Father, I don't understand this: how does God allow small children to be killed? What is this thing, this war, this bullshit? I got all these friends who are dead' ... That priest, he looked me in the eye and said, 'I don't know, son, I've never been in war.' I said, 'I didn't ask you about war, I asked you about God.'
>
> Herman (1992a:55)

The construction of traumatic impact within the biomedical model of the DSM is made with a passing acknowledgement of the cultural variation that may influence all disorders, with little or no incorporation of spiritual and religious values, and with a claim to be value-free. Yet, as the quote above suggests, the search for meaning after traumatic experience is a very real factor and potential determinant of outcome, and within the field of mental health, may manifest in the diverse realities of cultural identity and expression, religious motivation and agency purpose, and in the processes that individuals and group employ to come to terms with the meaning of events. The emergent properties of physiology, emotion, thought, behaviour and language all coalesce around the search for meaning, which in the case of mental health workers will occur within organisational and political environments that are also termed 'cultures'.

From an ecological perspective, culture provides us with an identity and a sense of belonging that defines our values, our sense of connectedness and much of our explanations for events, behaviour and meaning. We can talk also of organisational 'culture' in an attempt to describe codes of behaviour and loyalties within professional and environmental locations, for example, in the organisational literature (Thompson et al, 1996). Culture is the lens through which we are taught to see the world and which we internalise throughout our life. Explanations for critical incidents and traumatic events will always be sought within cultural frameworks. Whilst we can make cross-cultural comparisons of reactions and understandings, we do so as members of our own particular cultures with our own inherited wisdoms (Goode, 2000; Littlewood,

2001; Sachdev, 2001). The imposition of one perspective onto that of another culture runs the risk of 'trauma tourism', colonisation, and potential re-victimisation.

Cultural narratives mediate both the manifestation of trauma and the responses made both to individuals and communities in the wake of a traumatic event. They may provide protection but can also alienate if a person's experience is not legitimised, or if the entire culture is itself threatened. Commentators suggest that the perception of trauma as afflicting individuals otherwise in control of their own destinies is a modern western construction, arising out of social changes (and possibly the decline in the power of organised religion) occurring within Western society, and is not in fact a universally agreed articulation of experience (deVries, 1996; Gillard & Paton, 1999; McFarlane & van der Kolk, 1996b). Elsewhere in the world, deVries argues, religions such as Islam and Hinduism structure responses to trauma within an acceptance of fate. Many non-Western cultures feature high levels of somatisation rather than psychological effects. Assumptions cannot be made that an intervention constructed for use in one cultural environment will apply and be as effective in other cultural settings, a cautionary note to carry into the discussion regarding the construction of support systems (Williamson, 1999). For Maori workers, both within Western and Kaupapa Maori systems of mental health care, such cross-cultural tensions may be part of the dynamic of trauma response, with collective appraisals of health and wellbeing taking primacy over individual perspectives (Durie, 2001).

Culture defines a person's relationship with the world, and may determine the form that this takes. Trauma can disrupt this relationship, or it can strengthen it (Turner, McFarlane & van der Kolk, 1996). There may at times be dissonance between explanations of experience. Taylor, for example, highlights a fundamental clash of values between religious and scientific interpretations of events after cyclone damage in the Pacific (Taylor, 1998 & 1999). A similar conflict may arise in the acceptability of particular responses and interventions within organisations, such as the use of prayer. Religious belief may be challenged by trauma (McFarlane & van der Kolk, 1996a). As workers, we have motives for entering and remaining in the helping professions, and for the professional environment to turn around and bite us may precipitate existential and spiritual dilemmas (Bloom & Reichert, 1998).

On the other hand, religion, a cultural expression of spirituality, can provide:

> ... a sense of purpose in the face of terrifying realities by placing suffering in a larger context and by affirming the commonality of suffering across generations, time, and space.
>
> McFarlane & van der Kolk (1996b:25)

As a social institution it can act as a protective layer, a structure for shielding a traumatised person from some of the anarchy that trauma and stress may produce (Darling, Hill & McWay, 2004). Organisations that have a Christian basis to their mission statement may provide such a protection for their workers, and spiritual belief can transform and transcend (Benigni, 1998; Keenan & van der Kolk, 2000).

Forgiveness figures prominently in accounts of recovery from traumatic experience (Wiesenthal, 1997) and may allow a worker to move on from the personal impact of an incident towards the development of a profound understanding of its meaning. Whether this framed as a religious process or not, at its core lays the separation of the event from the person, a cognitive action that signifies the location of traumatic experience within a frame of reference:

> Because he loves off-duty policemen and their murderers
> Christ is still seen walking on the water of Lough Neagh.
>
> *The Fishing Party*, Longley (1995:42)

This frame of reference often includes political and cultural dimensions of justice, and attests to the linkages between meaning, belief, organisational functioning and human rights that conclude this chapter. Attention now turns to the relationship of trauma and time, an issue that underpins the discussion surrounding the complexity of response to incidents within workplace settings.

Trauma and time

> The future is 'kei muri' (behind), another way of saying that the future is largely determined by the past.
>
> Durie (2001:77)

Discussion now follows that explores the concept of time in relation to trauma. Time is a vehicle of transmission of impact. Incidents that occur at one point of a person's experience can resonate and repeat their effects at later stages, and the behavioural patterns that are created in family and community can create vulnerabilities in the lives of generations to come. Located within the holistic concept of *wairua* or spirituality on the framework of *Te Whare Tapa Wha*, the discussion illustrates the embeddedness and pervasiveness of traumatic impact across lifespan and reinforces the ecological assumption that worldview and belief systems, interlaced with structural and systemic elements, will shape

individual experience of trauma within the workplace. The framework for understanding this process is holistic, and the temporal influences are not lineal or direct, being what Durie (2003) terms 'long distance' rather than 'short distance' relationships. Durie (2001) suggests that for Maori, there is an implicit recognition of intergenerational knowledge and processes that accepts the intertwining of past and future in a way that challenges positivism's emphasis on reductionism. The focus of attention for the thesis is the degree to which the impact of extreme stress can embed and manifest itself in the lives of mental health workers, with resonating effects over considerable periods of time.

The importance of knowledge about traumatic effects and time in relationship to staff support systems is twofold. Firstly, successful interventions and support will aim to prevent or minimise harm, so as to strengthen a positive relationship between the present and the future. It suggests that whilst individuals directly affected may be the prime focal point, others in their immediate system may also bear the impact over time, and that any intervention must be aware of the lengthy process of recovery that incidents may require. The occurrence of critical incidents and extreme stressors in the work environment should not be an entry point for trauma into the lives of workers and their families.

Secondly, the vulnerability of workers who have family or cultural histories of trauma adds another dimension to this. Belief systems and traditions, interaction patterns and behaviours are often the fruits of traumatic experiences. In education, when students are asked to make links between their personal and family histories, it is a process that for many is often the first step of a process of articulating the unspoken experiences of past generations (Nash, 1993; Prasad, 1988). Critical incidents and traumatic events in the workplace may not be the first experience of trauma for an individual, and the impact of a new event may resonate and coalesce with existing responses. Adaptation to trauma over the lifespan may blur an obvious connection between the traumatic event and the subsequent cognitive, behavioural and social consequences (van der Kolk, 1996b). Potential for such triggers may be unanticipated within the organisation, and this raises issues of selection, training, preparation and support of workers selected to work in areas where it can be expected that buttons may be pressed, and where the risk of retraumatisation, secondary traumatisation and burnout are an occupational hazard (Figley, 1995; Pearlman & Saakvitne, 1995). These implications are both practical and political, as it raises the spectre of pre-selection on grounds of perceived psychological vulnerability. There are good grounds for concern, given the use of medical specialists in World War I in order to establish which

servicemen were malingering, and it also represents a denial (personal or organisational) that some occupational circumstances are highly likely to be highly stressful if not traumatic to many workers, regardless of resiliency factors.

It is to this issue of prior experience and retraumatisation that discussion now turns.

Time plays a major role in the dissemination of the impact of trauma throughout all ecological levels and dimensions. An ecological understanding of the complexity of traumatic impact pays attention to the ontological burden carried by many within the mental health workforce. Faced with the experience of critical incidents occurring in the course of their employment, many may also carry the legacy of prior experience in childhood or earlier in adult life. Brown and Bourne (1996), referring to social work and supervision, suggest about twenty percent of professionals who work with children have been sexually and/or physically abused themselves as children, with a higher percentage for women than for men. Given knowledge from the previous discussion about the effect of trauma on brain development, it can be hypothesised that a considerable proportion of mental health workers will also carry with them the scars of early traumatic experience.

Adding weight to this is the considerable research evidence linking early trauma experience and adult vulnerability to traumatisation. The experience of multiple events involving assaultive violence in childhood made more likely the development of PTSD as a result of a subsequent trauma (Breslau et al, 1999). A similar result has been found in studies of adolescent reactions to a natural disaster (Garrison et al, 1993) and worker's tolerance of stress (Izutsu et al, 2004). High rates of childhood trauma have been reported in combat veterans from the Vietnam War (Bremner et al, 1993; Davidson, 1991; Kulka et al, 1990; King et al, 1996; Zaidi & Foy, 1994). Links can be made between previous rape victimisations and adverse effects on the processing of a later trauma (Foa et al, 1993; Resnick et al, 1992).

There is considerable research in the field of child abuse that attests to the significance of early experience on adult behaviour. This comes in the form of the neurobiological impact of trauma on brain development (addressed earlier in this chapter), from attachment studies, from research that assesses the impact of living in violent environments, and from consideration of the generational transmission of impact.

Attachment styles may influence workplace relationships and responses to crisis. Given our knowledge of the environmental and family influences on child development and well-being, there is a strong imperative from the attachment literature to reduce the effects of traumatic events on the parent-child relationship. Attachment will have enduring significance both for the formulation of resilience against extreme stressors for a child, and for the ongoing ability to handle and respond to stressors in adult life (Lieberman, 2004; Maunder & Hunter, 2001; van der Kolk & van der Hart, 1989). Poor or damaged attachments increase a person's susceptibility to stress, increase the likelihood that a person may recourse to external regulation of affect (for example through the use of relationships, substance abuse and so on) and may alter their help-seeking behaviour. Parental detachment, or in an extreme form, rejection of their children because of pressures on their own stability and identity has an intergenerational influence on grandchildren (Main & Goldwyn, 1984; Main & Hesse, 1990).

Van der Kolk, van der Hart and Marmar (1996) argue that coping with stress entails the development of skills in self-care, accessing social support, and using the environment as a protective shield against potentially overwhelming events. The developmental level at which a person experiences trauma, along with the event's duration and severity, will determine how such impact manifests (Perry and Pate, 1994; Perry, 1995; Pynoos, Steinberg & Goenjian, 1996; Teicher et al, 2000). Adult survivors of childhood abuse may learn strategies of survival that are avoidant in nature (Kisiel & Lyons, 2001). Such relationship styles may protect from distress but may also reduce opportunities for the development of positive attachments (Putnam, 1997). A secure attachment history (with care-takers assisting in the construction of an experience) allows for this development and utilisation of skills in the current work environment (van der Kolk, 1996b). Where a worker operates in an occupational setting such as mental health that relies on communication, language and which is predicated upon a high level of autonomy, these skills are essential. Trauma symptoms may be provoked by the job requirements of cooperation and trust. Those workers whose own attachment relationships have been fraught may respond differently when under pressure themselves, using different internalised models of functioning even if the current working relationships are open and benign in nature (Crittenden, 1985).

In addition to influencing attachment styles and communication patterns, past experience can potentially determine a worker's response to threats and acts of violence. Environmental exposure to violence and aggression as a child can over time create vulnerabilities for adult functioning that are distributed

throughout body, mind, social connections and spirit (Marmar, 1998; van der Kolk & Fisler, 1995; van der Kolk & van der Hart, 1989). Motivation to work in human services may well be fuelled by personal history of violence within the home, and this carries attendant vulnerabilities for the mental health worker. Within the workplace, childhood or inherited patterns of verbal or physical violence, or a person's response to this, may determine the outcome of a critical incident. Early social relationships may create internal representations or patterns of relational behaviour, which may be shaped by experience of abuse or neglect; for example, the possibility of modelling power and control behaviour (Graham-Bermann, 1998). In these situations, the protective and recuperative features of the family, which we may employ to cushion the effects of a traumatic event, may well be absent or actively toxic (Jaffe, Wolfe & Wilson, 1990).

A direct link between childhood experience and adolescent and adult behaviour can be made, suggesting that exposure to violence as a child may lead to adults engaging in aggressive behaviour as a means of eliciting a predictable response (Perry, 1997). Zuckerman's (1999) description of the 'Stress-Diathesis' model of disorders suggests that episodes of abuse in childhood stimulate stress hormones that eventually become acutely sensitive even to benign stimuli, and therefore work overtime as a person grows into adulthood. Within a family system, children may be exposed not only to direct violence but also to the witnessing of adult partner violence. Where a child is both primary and secondary victim, the impact is greater (Hughes, 1996; Jaffe, Wolfe & Wilson, 1990). Graham-Bermann and Levendosky (1998) found that a significant number of children exposed to the abuse of their mothers suffered symptoms associated with PTSD, suggesting that the unrelenting distress of witnessing alone can have a profound cumulative effect on the child. The implications for vulnerability in workers can be profound.

This discussion suggests that whilst early trauma may result in problems in adult life, its course is neither uniform, lineal nor particularly predictable (van der Kolk, 1996b). The subtle interweaving of resilience and vulnerability factors underscores the need to take a multi-causal perspective in our understanding of the effects of trauma and chronic stress in the workplace. It cannot be assumed that the presence of a toxic past contributes directly to current levels of vulnerability to the effects of trauma. Nor can we assume that there is a cumulative effect of traumatic events, as do, for instance, the Life Events models of Holmes & Rahe (1967) and Brown & Harris (1978). Adult abilities may reframe the meaning of past experiences in either positive or negative ways (Green, 1997). The complexity of the person-in-environment development

provides the imperative for us to study resilience as a protective factor, and the overall benefit of learning from experience, and is perhaps an ideological stance to take in the selection and training of mental health workers. What is important to carry out of this discussion is awareness that prior experience can be a major factor in determining a person's reaction to a new environmental threat (Ford & Kidd, 1998).

In addition, work environments such as mental health may repeatedly put workers at risk of exposure to new traumatising incidents. It is a thrust of this thesis that a lack of support for workers within service environments in which, by the nature of the job, traumatic events may occur, can contribute to a cumulative retraumatisation with long-term individual and organisational consequences. Thus both prior and cumulative experience may severely undermine coping ability.

Without negative past experiences, retraumatisation may still be a reality for mental health workers. Incidents do not often occur as single events (I was once asked to conduct a 'debriefing' in a residence whilst the skirmishes were still continuing outside the door) but rather as a process whose impact reverberates through personal, social, political and cultural dimensions (Erickson, 1994; Straker et al, 1987). Events within mental health systems will have organisational and legal responses that further impact on the wellbeing of those concerned. Operational reviews, coronal inquiries and perhaps even debriefings with staff support in mind, may contribute to further revictimisation. Interventions themselves, working as they do in the sensitised ground of traumatic impact, may be mis-placed, mis-timed or unwisely conducted (Bloom, 1997; Silver, 1986). It is knowledge such as this that places the design of staff support systems under an ecological obligation to include systemic, structural, organisational and human rights factors within their construction.

Introduction of these 'bigger picture' processes within the impact of trauma are highlighted by the growing knowledge of the inter-generational transmission of the effects of trauma and extreme stress, which Bloom (1997) terms a psychic abscess dissociated from the original trauma. The concepts of complex trauma/DESNOS and the long-term impact of trauma on characterological development, described in Chapter Four, suggest that physiological effects on the individual develop into the emergent properties of behavioural and social dynamics, all play out within cultural contexts but are largely ignored in most clinical assessment and treatment (Kira, 2001). These 'long distance' effects, as Durie (2003) terms them, are often researched through the impact of major

events on the world stage, such as the effects of the Nazi Holocaust (Berger, 1988; Danieli, 1985, 1997 & 1998; Kellerman, 2000; Rowland-Klein & Dunlop, 1998; Steinberg, 1989; Yehuda et al, 1998a & 1998b) and the Vietnam War (Galovski & Lyons, 2004; Harkness, 1993; Rosenheck, 1986) and in Aotearoa New Zealand, through debate concerning the impact of colonisation (Chapter 4). Growing knowledge about the neurological, behavioural and social transmission of the effects of child abuse and domestic violence also suggests that the impact of incidents within the workplace may be played out in accordance with large-scale patterns and processes (Egeland & Susman-Stillman, 1996; Oliver, 1993).

Whether the impact of trauma across generations is transmitted through biological vulnerability or environmental influence is still under investigation (Kellerman, 2000; Muller, Hunter & Stollak, 1995; True et al, 1993). Yehuda (1999) leaves open the issue of whether trauma actually interferes with heredity on a genetic level, acknowledging that such biological alteration may be environmentally determined. Transmission is complex rather than lineal and my reading of the research literature suggests that it is likely that there are multiple and indivisible contributions to traumatic impact, further underscoring the importance of using a holistic framework of understanding that can address complexity.

The possibility of posttraumatic growth

A review of the impact of trauma suggests that as the impact expresses itself through the dynamic interaction between ecological levels, so too can the impact transform itself according to its environment, whilst still retaining a fundamental relationship with its neurobiological and cognitive features. With this transformation comes the mediating power of the environment, which can potentially assist the mental health worker to develop new learning and to grow from the experience.

Illustration 5.1: *Danger and Opportunity*, the Chinese pictogram for crisis

Cultural beliefs outside of a Western perspective have long incorporated the possibility of posttraumatic growth. Buddhism, for example, predicates the development of wisdom upon the experience of suffering (Tedeschi & Calhoun, 1995). The Chinese pictogram for crisis (Illustration 5.1) represents both danger

and opportunity. Scientific descriptions of traumatic impact and research into PTSD have tended to focus on the massive negative aspects of physiological and behavioural change, and on pathology (Joseph, Williams & Yule, 1993; Tedeschi & Calhoun, 1995; Violanti, Paton & Dunning, 2000), despite signalling of the potential for positive outcomes within humanist psychology and a Strengths perspective (Gilliland & James, 1997; Joseph, 2004; Saleebey, 2000; Wolin & Wolin, 1993).

Literature from the Strengths, Recovery, thriving and resilience fields since the 1980s has suggested that the impact of adverse events can be mitigated by personal and environmental factors such as a strong sense of self and of future (Henry, 2001); the notion of emotional expression (as suggested by Pennebaker's work addressed earlier in this chapter); better family functioning (Tiet et al, 2001); family embeddedness in community (Gilgun, 1999); and in social support (McMillen & Fisher, 1998).

Research within the trauma field has, within the last ten years, begun to reflect a similar perspective. Research evidence suggests that some positive change may occur in between fifty to sixty percent of traumatic experiences (Tedeschi & Calhoun, 1995). Recovery bears an ecological face, using cognitive and constructivist processes that have a dual role of managing the physiological stress response, and developing narrative (Calhoun & Tedeschi, 1998 & 1999; McMillen, 1999; Saakvitne et al, 1998; Tedeschi & Calhoun, 1995). Tedeschi and Calhoun describe positive change that occurs in five areas: more intimate and emotionally open relationships; the recognition of new possibilities in life; a deeper appreciation of what life offers; a greater sense of personal strength; and spiritual or religious development (Calhoun, 2003; McMillen & Fisher, 1998; Tedeschi & Calhoun, 1996). Thus those affected by trauma reform their shattered assumptions (Janoff-Bulman, 1992; McCann & Pearlman, 1990a). Ursano et al (1996) describe the 'psychic glue' that may organise experience and reorient values and goals. Saakvitne et al (1998) formulate their ideas under the created description of 'constructivist self development theory' and emphasise that adaptation to trauma is a complex interaction between personality, history, event and context over time, arguing that to comprehend how someone may thrive after adversity, an intrapersonal perspective and theory base is required.

The determination of recovery also lies to a great extent on the receptiveness of the environment to validate a person's experience (Bloom & Reichert, 1998; Tedeschi, 1999). The general assumption of the literature is that growth occurs over a lengthy period of recovery, and may not be so evident in the immediate aftermath of an event. However, windows of opportunity may be present

within the posttraumatic environment, and especially in the immediate period post-incident, which may work with victims to develop an orientation towards the possibility of positive change (Calhoun & Tedeschi, 2000). This ecologically informed approach suggests that there is environmental responsibility for the management of incidents and developing resilience (Paton, Violanti & Dunning, 2000; Paton, Violanti & Smith, 2002). An approach that recognises the importance of the interconnectedness of human experience is of great significance to our response to traumatic events in the workplace, where the complexities of individual response and organisational context interact over time.

On the basis of this approach, the holistic framework of this chapter concludes with acknowledgement of the systemic and structural foundations of experience, as exemplified by consideration of the importance of justice and human rights issues.

Whenua, the ground we stand on

The use of the holistic framework of *Te Whare Tapa Wha* illustrates the potential for the impact of trauma to become embedded in all aspects of human life, from the neurobiological to the cultural and spiritual. There is a complex interrelationship between the impact of events on the individual and the social and organisational environments in which they function. A shift in focus, from the impact on the individual to that of the impact on the person within the environment, suggests a parallel shift in responsibility and opportunity for the provision of support for events within a workplace context. With this knowledge comes an imperative for action within structural and political dimensions of justice and human rights, elements also accorded weight within the Western ecological model described in Chapter Two.

Collective rather than individualised responses have emerged in some political contexts (for instance, Truth and Reconciliation Commissions, and the reparation and accountability processes of the Waitangi Tribunal[34]), and Critical Incident Stress Debriefing, discussed in the following chapter, represents a movement towards this within a workplace context. Collective responsibility - having the ground to stand upon in identifying the traumatic cultural and political impact of events - is a far more complex strategy to take, and one that is challenged by the forces of silencing, minimisation and denial,

[34] The Waitangi Tribunal was established in 1975 in order to hear Maori grievances and to investigate claims based on historical land confiscations and other breaches of the 1840 Treaty of Waitangi, which established a relationship between Maori tribes and the Crown (Walker, 1990).

an argument that can apply equally in the workplace as it does within global politics (Bloom & Reichert, 1998; British Medical Association, 1992; Davies, 2001; Summerfield, 1995). Accepting that acts of violence and patterns of response may in part be determined by historical and cultural forces suggests that restoration of well-being and equilibrium needs to occur not only at the immediate physiological and behavioural level, but also within the systems of service delivery and the political and human rights policies of national government and health organisations (Kagee, 2004).

There remains resistance within 'mainstream' society to accept the use of a trauma model, to make a connection between political and cultural abuses and current social problems, or to take collective responsibility for events impacting on individuals (Bloom, 1997; Polakow-Suransky, 2003; Tomas, 2004; Turia, 2000). These dichotomies resonate within parliamentary debates and also within the 'debriefing' literature, Kelly arguing forcefully that:

> To be effective, responses to acute trauma need to be situated in a framework of collective and cumulative traumatisation over several generations.
>
> Kelly (1999a:38)

Summerfield argues that there are too few studies that bridge the gap between 'individual psychological responses and the sociopolitical dynamics of marginalisation and persecution' (Summerfield, 1995:26). This thesis is intended as a contribution towards redressing this balance.

There are, however, models of trauma treatment that acknowledge the multi-systemic and transtheoretical dimensions of the experience of extreme stress: these, through ecological necessity, contain the wisdom that any response to trauma must respect the autopoietical principles of identity, structure, relationship and change.

Ecological frameworks of trauma response

> And if there ever is gonna be healing
> there has to be remembering
> and then grieving so that there then can be forgiving
> there has to be knowledge and understanding
>
> O'Connor (1994)

The trauma literature is dense with description and evaluation of interventions for those experiencing post-traumatic symptomatology. Much of this is relatively context-free in terms of its derivation, application and evaluation, and as such, does not match intervention with environment in the way that an

ecological imperative requires. Pharmacological treatment, reflective of its medical identity, uses the physical body as its domain and aside from issues of compliance, does not pay significant attention to the environmental conditions in which trauma occurs. Many psychological techniques and tools, for instance, focus on specific difficulties (for instance, somatic or anxiety symptoms) that a person may be facing during part of their recovery. The inherent logic that recovery may take time and that it progresses through different stages with different needs is, however, embedded within both the trauma and crisis literature, and within popular culture (Lindemann, 1995b; O'Connor, 1994, as above).

Several theorists and practitioners have attempted to draw together descriptions of the interventions and supports necessary to assist someone in their entire journey through recovery from traumatic experience (for instance, Chu, 1998; Herman, 1992a; van der Kolk, McFarlane & van der Hart, 1996). The creation of such frameworks, described as phase or stage models of recovery, are conceptually similar to the critical incident stress management approach (Chapter 6), although less tied to contexts such as the workplace. The recognition that people go through stages in recovery (and that different interventions will be required at each stage) introduces an ecological awareness of context. Bloom's writings, for instance, suggest a strong humanitarian and political agenda that includes the need for primary initiatives aimed at prevention or harm minimisation (Bloom, 1997; Bloom & Reichert, 1998).

Of the generic frameworks for recovery, Herman's (1992a) three-stage model is widely utilised, the stages being safety; remembrance and mourning; and reconnection with ordinary life.

The safety aspect of the framework suggests that the person affected by trauma must become safe from further or recurring stressors (van der Kolk, van der Hart & Marmar, 1996). Work on the actual trauma may be deferred until control over somatic, psychological and social effects is gained, which implies a range of possible interventions spanning relaxation and body work, pharmacological support, cognitive-behavioural exercises, attention to addiction and substance use, and psycho-social interventions such as housing, income and family work (Figley, 1990). Underpinning all of this is that those conducting the intervention process must manifest aspects of safety themselves: that is, they must be acceptable, congruent and able to establish and maintain trust and rapport (Pope & Garcia-Peltoniemi, 1991).

The middle stage of Herman's model refers to remembrance and mourning, and the work done here represents the therapeutic and practical tasks surrounding dealing with traumatic memory and experience. Interventions in this stage, because of their trauma-focus, are often seen as the true 'trauma work' as opposed to the safety focus of the first stage and the reconnection goal of the third. Here we may find processes geared at identifying, containing and coping with traumatic memory and imagery, moving the experience from being pre-narrative into a linguistically-based reconstruction able to be manipulated through therapeutic intervention, and thereby beginning to address the emotions such as rage, anger, grief, blame and guilt that emerge. Mindful of the retraumatisation that can occur through the evoking of memory, strategies employed in the first stage of safety will continue to be of importance whilst monitoring distress. This second stage, utilising individual and group-focused processes, corresponds to the processes embedded within defusing and debriefing within the workplace, and also with the formal political processes of testimony such as are enshrined in truth and reconciliation processes (Agger & Jenson, 1990; Mater, 1999; Noble, 2001; Reid & Hoffman, 2000; Swartz, 2000). For many victims of trauma, this stage marks recognition that others can recognise the impact, and perhaps have shared similar experiences.

The third stage of this model transforms the trauma victim into a survivor, and focuses on reconnection strategies with the non-trauma focused world (Janoff-Bulman, 1992). After coming to terms with the past, the survivor must create a future by learning to live in a changed reality. Such reconciliation, restitution and reconnection may take different paths, and some people emerge with a renewed or changed vision of their life's purpose, a political or professional imperative or a change in the nature of their relationships through estrangement or forgiveness. Re-engagement with the rest of life does not imply an abandonment of the previous stages. Key situations and triggers may require implementation of safety strategies, for instance, or a re-working of some of the 'trauma work' of the second stage. Sgroi (1989) suggests that these phases should be envisaged, therefore, as a spiral rather than a lineal progression, with an ever-present need to be able to re-visit previously encountered processes of recovery at a higher level of integration. This ensures that the traumatic impact is not forgotten, a common occurrence, perhaps, within the short-term memory of organisational.

There are thus strong arguments for a framework of recovery and support from the clinical and research literature, and whilst the processes suggested by these various models include psychological treatments (for example) that do not apply to workplace settings, it is the process suggested by them that resonates

strongly with the models of critical incident stress management described in the next chapter. What emerges from this consideration is an endorsement of a matrix of intervention strategies that includes, but which is not limited to, the provision of treatment or intervention strategies focused on the incident and its immediate aftermath. As the following chapter suggests, however, much of the critique of workplace supports has been focused on the efficacy of psychological debriefing as an isolated intervention.

Conclusion

This chapter is, like the thesis itself, founded upon ecological principles that offer a theoretical and practical process of unifying interpretations of research and experience from a variety of perspectives and paradigms. The use of *Te Whare Tapa Wha* has bound together the knowledge located within the positivist paradigms of neurobiology and psychiatry, and structural, systemic and interpretivist perspectives that link the individual's experience to that of their social and cultural participation. There is a growing body of evidence leading to the conclusion that workplace intervention should not exclusively occur on an individual level but should operate in social, cultural and organisational domains (Ozer & Weiss, 2004). The implication of this complexity suggests that responses to critical incidents and traumatic events in the mental health workplace will be multi-level, transtheoretical, and environmentally embedded. It is to the issue of workplace incidents that attention now turns.

Chapter Six: Critical Incidents: their response and evaluation

Introduction

This chapter maintains the emphasis on the importance of an ecological approach to understanding trauma and extreme stress. As previously argued, ecological frameworks of understanding have, at their core, an embedded assumption that individual incidents are best understood by means of an awareness of the environment in which they occur. Frameworks such as *Te Whare Tapa Wha* and the ecological perspective first articulated by Bronfenbrenner (1977; 1979) emphasise the contextual dynamics and relational aspects that responses to incidents must take into account. Such perspectives promote the application of autopoietical notions of structure, relationship, identity and change in any response and its evaluation.

The chapter begins with a discussion in regard to the contextualised nature and incidence of critical incidents within workplace settings, and briefly considers the policy and legislative context of health and safety in Aotearoa New Zealand. The chapter then introduces the concepts of psychological debriefing and critical incident stress management around which much of the current debate about staff support systems revolves. In order to understand the strands of the ensuing debate over debriefing, the theoretical foundations of evidence based practice, the tool currently utilised in its evaluation, are explored. Consideration of the issues raised by the debriefing debate forms a case example that underpins the voices of the participants in this thesis research, and assists in the determination of appropriate response to the occurrence of critical incidents.

Crisis and Critical Incidents: definition and nature

By reviewing the impact of trauma and extreme stress, it is clear that prediction of outcome cannot assume that any one event will become critical. Rather, as Gilliland and James (1997) suggest, it is the perception of a threat to needs fulfilment, safety, or meaningful existence that may harm. The inclusion of the notion of crisis within this research lies with the recognition that the criticality of an incident plays out over time after an incident, and its impact becomes

embedded within the personal, professional and organisational characteristics belonging to that unique situation (Janosik, 1984). Recognition of the role of self-definition and the environment produces an interactive or dynamic definition of criticality and critical incidents, very much reflective of constructivist elements within an ecological approach (Miskiman, 1990). Within the theoretical stance taken within this research, the criticality of incidents for those interviewed was left up to each participant to determine.

Whilst the knowledge base of crisis (and of crisis intervention theory) can be traced from the initial articulation within psychodynamic processes of human development (Lindemann, 1944), more recent research studies and reviews reflect these ecological conceptualisations (Seymour & Moore, 2000). In Everly, Flannery and Mitchell's (2000) review of the origins of crisis intervention, they note the shift from looking at the impact of critical incidents on individuals to the effects on groups of victims, and begins to define incidents not only in terms of the impact on the individual but on the individual within the environment. The notion of crisis brings with it the understanding that the experience temporarily overwhelms usual coping strategies; the notions of intervention and incident introduce context.

Within the debriefing literature and evaluation, there is, however, a tension that emerges between the perception of incidents as being critical, and as being traumatic, a confusion that is as much about theoretical positions as it is about choice of terminology, and one that I have learnt is symptomatic of this field. The terms 'crisis', 'emergency' and 'trauma are often juxtaposed (Everly, 1999 & 2000; Miskiman, 1990). Indeed, the terms have been used in relationship with each other within this thesis title as a deliberate conjunction of knowledge bases that requires clarification and resolution prior to the establishment of appropriate staff support systems. This inclusive description, 'critical incidents and traumatic events', although acknowledging the potential for some incidents to have traumatic impact, also reveals the core of much of the debate over the appropriateness of particular interventions and support for workplace incidents that is addressed later in this chapter.

The nature and incidence of critical incidents

> There seems to be better and easier places to work than mental health.
>
> Annette King, Minister of Health (2002)

It is to the understanding of the dimensions of critical incidents that attention now turns. Mental health services are, of course, not the only location for events

that are perceived as critical, and whilst a hypothesis about the high proportion of incidents in this sector that are of a person-to-person nature can be made, consideration of incidents occurring in other sectors can serve to illustrate general patterns and to signal key issues.

Other human services share the concerns of the Minister of Health, as above. Both Beckett (2003) and Luparell (2004) refer to the use of military and battlefield terminology to describe human services workplaces. Teachers and tertiary educators are subject to physical assault as well as 'grade rage'[35] and other forms of emotional abuse, with significant implications for job satisfaction and tenure (Luparell, 2004; Staffwriter, 2004). Police both here and abroad are particularly vulnerable (Addis, 2002; Buchanon, 1994). Social workers both in Aotearoa New Zealand and internationally have described high levels of physical violence, threats to their safety, and situations of bullying and verbal abuse (Beddoe, Appleton & Maher,1998; Bibby, 1994; Johnson, 1988; Rey, 1996; Smith, McMahon & Nursten, 2003; Stark, 2001). Agnew, Dawson and Elliott (1998), in their list of critical incidents experienced in the child protection environment in Aotearoa New Zealand, name situations that reflect potential for traumatic impact, but also more general perceptions of crisis, emergency and, significantly, cumulative stress.

Health service environments appear to be particularly vulnerable to the experience of critical incidents, with statistics tending to omit those incidents not resulting in physical injury. Breakwell's early study (1989) indicates that health social workers were twenty six times more likely to be assaulted and seriously injured than the general public. A survey in the British National Health Service (NHS) found that almost one in ten health workers had been attacked at work in the previous year (BBC News, 1998). In the US, too, the health service figures prominently in critical incident reporting (Bloom & Reichert, 1998). Kelly (1999a) suggests that exposure to threatened or actual violence to self is a common experience among rural health practitioners in Australia. Eighty two percent of a national sample of remote area nurses reported that they had been exposed to verbal aggression or obscene behaviour in the previous twelve months, with nearly half reporting exposure to physical assault.

Mental health appears to have its own particular vulnerabilities, the US Bureau of Justice (1997) reporting that it is one of the most dangerous environments. One early study listed 24% of psychiatrists, psychologists and social workers being assaulted by one or more patients in a one year period (Edelman, 1978).

[35] A term for which I thank Liz Beddoe at the Centre for Social Work, University of Auckland.

In 2000, 17% of psychiatrists in a British study had been assaulted by patients in one year, and one third threatened with violence (BBC News, 2001). Sixty two percent of clinical staff reported experiencing a critical incident involving a serious threat to the life or physical safety or witnessing a serious injury or death (Caldwell, 1992).

A local newspaper reported that in three months in 2003, 277 acts of patient violence were reported in Capital and Coast DHB[36] (Macdonald, 2003). In the first quarter of 2004, 36 of the same DHB's staff were injured in attacks, and 141 threatened by verbal abuse (Boniface, 2004). Almost all incidents occurred in mental health or geriatric services. The Board's then Clinical Director for Mental Health, McGeorge, was reported as saying:

> It's an occupational hazard [...]. In some ways it's remarkable how they deal with these types of situation. They are very dedicated. Mental health becomes a life mission.
>
> Macdonald (2003)

Certainly, mental health environments carry their own unique risks in terms of client self-harm and suicide (Mental Health Commission, 1997; Mullen, 1996). Gilliland and James (1997), arguing in an American context, attribute an increased risk to deinstitutionalisation. People receiving treatment for mental illness are no more violent or dangerous than the general population and more likely to be victims of violence, especially self-harm (Duckworth, 2002; Mulvey, 1994; Simpson et al, 2003) and homicide (Hiroeh, Appleby, Mortensen & Dunn, 2001). However with a drug and alcohol presentation, the risk of violence becomes far greater (Steadman et al, 1998; Tiihonen et al, 1997). Thus mental health workers may be victims of direct violence, but may also be indirectly affected through the secondary traumatisation of violence or distress. Added to this will be the sensitising effect of working with people in environments where stigma and discrimination debilitate and undermine recovery processes (Ferriman, 2000; Jorm, 2000; Link et al, 1999; Phelan et al, 2000). Staff attitudes and prejudices play an active part in either perpetuating or ameliorating these stereotypes (Balsa & McGuire, 2003; Sartorius, 2002).

The economic cost of workplace incidents and stress

The economic cost of incidents and cumulative stress is another factor that illuminates the issues of critical incidents. There is considerable evidence in the occupational health literature of the financial cost of workplace stress, which then provides a rationale for the inclusion of cumulative as well as critical

[36] The District Health Board that covers the Wellington region.

incident stress within preventative systems and health and safety legislation. Evaluation of the impact of incidents alone is rare, and suggests that in contextualised employment settings, isolation of the initial event from its ecological impact is not feasible. The quantification of the impact of stress and incidents is clearly dependent upon the tools used to measure and evaluate, factors such as sick leave, absenteeism, recruitment and replacement costs and (in the North American environment in particular) the costs of litigation all emerging as measures (USA Today, 1995). The standard costing for staff turnover is, according to Douglas (undated), a year's salary to fill a vacant position. This is factored from things like advertising, training, and speed to effective functioning. Other commentators suggest that in turn, vacancies and under-staffing add to the stress levels of existing staff members, by increasing their hours, responsibilities and by souring the relationships between workers and their management (Kadis, undated; The King's Fund Mental Health Inquiry, 2003).

According to the US National Safe Workplace Institute, the average cost to employers of a single episode of workplace violence can amount to $US 250,000 in lost work time and legal expenses (Anfuso, 1994). Early and ill health retirements by police officers in the UK in 1997 cost the taxpayer £330 million (Field, email to Traumatic Stress list, 30.9.98). Field, a writer on workplace bullying, described the figure as the 'medicalisation of dissatisfaction'. In 1998-9 in Workcare (the Australian funding for workplace support), the average cost for occupational stress claims was four times the average across all forms of claim. Within mental health, a British study suggested an annual turnover rate of nurses at between 11-21% across agencies surveyed, with vacancies at any one time averaging 13-23% (The King's Fund Mental Health Inquiry, 2003). Similarly, one in eight consultant psychiatric positions were vacant at any one time (Sainsbury Centre for Mental Health, 2001). Within Aotearoa New Zealand, the cost of workplace stress has been addressed within various human service settings. Huddleston (2002) reports that the cost of recruiting and training a police officer was about $144,000 in 1998, with costs of voluntary retirement being $23,000.

Huddleston (2002) cites an American report that validates early intervention in cost terms (Friedman, Framer & Shearer, 1998). Here, the average cost for an early intervention in traumatic stress was $US8,300 and when detection and intervention were delayed, the cost rose to $46,000. Delayed intervention quadrupled the amount of time taken off work and litigation rose sevenfold. Similar benefits of implementing early intervention or comprehensive programmes of staff support have been noted (Cornell & Kirwan, 1997,

Flannery et al, 1995; Mitchell, 1995b; Western Management Consultants, 1996). It should be noted that several of these studies have been conducted within a frame of reference of critical incident stress management, which is addressed later in this chapter.

Reflective of the decentralised and diversified nature of the mental health workforce in this country (Chapter 3), no overall statistics appear to be kept by the Ministry of Health in relation to the cost of recruiting and retaining mental health workers. The number of unfilled fulltime equivalent (FTE) posts in 2003-2004 was nine percent (Hatcher et al, 2005). A tentative extrapolation from the studies reported here suggests that there is a vicious circle of attrition and staffing losses, under-staffing and occupational stress, all of which can create environments of risk in which further incidents may occur.

The Ministry of Health and 'Sentinel Events'

The Ministry of Health and its Mental Health directorate has recently taken responsibility for the gathering of information about serious incidents that they term 'sentinel events'[37]. However, these refer only to those incidents that have a serious impact on consumers (Sentinel Events Project Working Party, 2001). The Sentinel Events report acknowledges the existence of other events, some of which they term 'close calls', and other incidents that they view as undesirable, but which the Ministry views as each board's internal operational responsibility to report for quality improvement and risk management purposes. The Ministry does not centrally monitor or determine the nature or impact of critical incidents and traumatic events on the workforce (personal communication, Director of Mental Health, 3.6.04). Within mental health services there is not a universally agreed definition of critical incidents. Each District Health Board maintains its own statistics and, within the terms of the health and safety legislation discussed below, has responsibility for the shape and efficacy of staff support systems. The emphasis on severe incidents affecting consumers is clearly necessary but not sufficient for an understanding of workplace incidents and support.

Within the report cited above, there is however a significant shift in policy thinking which is encouraging. On a philosophical level it reflects a strong endorsement of systems and non-lineal complexity. In its description of 'root cause analysis', for example, it encourages employers to consider the root

[37] Sentinel events are defined as 'those events that must be reported centrally 'and which 'result from the systems that deliver care/treatment to consumers'. They are seen to 'have a significant effect on the consumer, result in permanent disability or death and result from management of the consumer's illness, disease or condition' (Sentinel Events Project Working Party, 2001).

causes of sentinel events, and acknowledges that at times the root causes get to the heart of how an organisation operates. It focuses on systems effectiveness and change as requirements of a response to events, and acknowledges that cause-and-effect attribution is not always possible. For the argument within this thesis, comments such as the need for a profound culture change in organisations (p12) represent a considerable shift in thinking towards recognition of the importance of job context.

Job context and job content: the interface with workplace stress

This thesis argues that reactions to workplace critical incidents and traumatic events are determined by the dynamic relationship between person and environment. It argues that critical incidents and traumatic events, damaging as they potentially are, are possibly highlighted at the expense of those background stressors more firmly embedded into organisational life, and less readily attributable to immediate and short-term intervention. The interface with levels of ambient stress within the workplace is therefore crucial to an appreciation of the appropriateness and effectiveness of staff support systems responding to incidents.

Rose and Tehrani (2002) suggest that there was a lack of literature prior to the 1980s that considered the impact that working with traumatised people has on workers. Ream (1999) cites a study by Brodsky (1982) as one of the earliest analyses of employees' experience of stress from an organisational and cultural perspective. The development of support systems following incidents, allied perhaps by necessity to the trauma literature and a biomedical paradigm, has ignored or at best underplayed the importance of organisational stress, and has until recently not attempted to consider the importance of context in the construction and implementation of responses. Measure of outcome, as considered later in this chapter, has not focused on the environment in which incidents occur.

Yet organisational issues appear paramount in the determination of worker wellbeing and performance. Valent (1999) suggests that morale, one of the major concerns of trauma literature from World War II, has been underplayed in the current focus on trauma. The issue of morale, connected as it is to the fabric of the life of an organisation and its employees' wellbeing, is crucial in our understanding of stress and its relationship to the management of incidents. Valent (1999a) argues that, like the military, mental health professionals in trauma (and perhaps management in organisations) may be

unwittingly forced to underplay the issues in order to keep up the image of corporate productivity, efficiency, public service and public safety.

Job stability, satisfaction and morale are clearly linked in many studies and commentaries regarding organisational health (Bassett, 2001; Chalmers, 1998; Douglas, undated; Mason, Johnston & Crowe, 1996; Voss et al, 2001). Probst and Brubaker (2001) connect these to higher levels of workplace injuries and accidents. Several studies highlight the negative impact of bullying (Matthiesen & Einarsen, 2004; Newsroom, 2002; Sheehan et al, 2001; Summerskill, 2002; Tehrani, 2004). As distinct from harassment, which often takes a physical, racial or sexual form, bullying is often embedded in the power structures of an organisation.

An emergent feature of stress in the workplace is that of the degree of control held by a worker. Wilkinson (1996) argues that social institutions set up in order to deliver health services and to reduce social inequalities, in fact end up perpetuating the inequalities because they mimic the same divisions in society. His argument is connected with the notion of social capital, suggesting that levels of social capital within an organisation will influence wellbeing and protective layers, played out through issues such as extent of networks, degree of trust, shared norms, mutuality and reciprocity. In a philosophical review of the theories of institutions and their social and psychological processes, Jones and Fowles (1984) trace basic themes in relation to the nature of mental health institutions, aspects experienced by consumers and staff alike: loss of liberty and autonomy, social stigma, depersonalisation and low material standards.

From a social work perspective, Morrison (1998) talks about working in an anxious environment. He argues that because it is often interpreted as unprofessional to be anxious, this emotion is suppressed through flight or fight mechanisms. Staff are undermined in their confidence to experiment with new practice, show a resistance to sharing ideas, expressing feelings and so on. Emotional defensiveness, task avoidance, and denial follow. Morrison's concern is that this can result in the depersonalisation of clients, detachment and denial, ritual task performance, constant counter-checking, redistribution of responsibility, reframing and minimising and clinging to the familiar. Similar processes may manifest in mental health. Workplace conditions may jeopardise the ethical obligations of mental health workers (Green & Bloch, 2001).

Under-reporting of incidents appears to be embedded in the workplace context in which incidents occur. Murray and Snyder (1991) found that five times as many assaults on health care workers occurred than were reported. Few

incidents of assault were reported to management in Beddoe et al's 1998 study of New Zealand social workers' experiences of violence. Crampton (1999) suggests that under-reporting is in part due to lack of formal reporting structures. A contributing factor may also be the complex relationship between job context and job content, in which significant stressors may be experienced that do not emerge as discrete events measurable by reporting or data gathering systems.

Research evidence reinforces that the causality for distress is not a lineal relationship between the experience of stress and an incident (Bloom, 1997; Finlayson et al, 2002; Huddleston, 2002; Smith & Paton, 1997). Analysis of the impact of job context (the environmental conditions in which the work is conducted) and the job content (the actual experiences) reveals some significant weighting surrounding the effects of the environmentally located organisational stressors. Examples can be found within studies within police, welfare and health organisations. Huddleston's study (2002) of the impact of traumatic and organisational stressors on New Zealand police recruits suggests overwhelmingly that it is the organisational issues that provide the major source of stress for young police officers, rather than the exposure to trauma. Her findings provide substantial argument for the development of organisational support systems. Violanti and Aron (1995) suggested that organisational stressors were 6.3 times more powerful than incidents in the New York police. A study of reactions to body handling by police officers after an oilrig tragedy in Britain suggests that the high morale within the group was sustained by a clear definition of duties, a feeling of being valued by management, helpful feedback about the tasks performed, and good relationships through both horizontal and vertical layers of the organisation (Alexander & Wells, 1991). Educational sessions that I have conducted with site managers[38] and supervisors for the Department of Child, Youth and Family confirmed that whilst the content of the work and the sometimes painful incidents encountered in child protection created stress, the majority of examples of sources of stress were located within the context of organisational functioning. These views were reiterated by grassroots staff in the Department's Baseline Review (Department of Child Youth and Family Services, 2004).

Mental health services are not exempt from these pressures, the 1996 inquiry raising concerns about the workforce in Aotearoa New Zealand (Mason, Johnston & Crowe, 1996). A joint union submission in the report suggested that

[38] Site Managers have the overall responsibility to manage the staff, policies and practice in the various geographical sites in this country.

burnout was causing open antagonism in previously cohesive teams and that levels of violence against staff were increasing.

Mindful of this interrelationship of context and content, the development of the health and safety legislation within Aotearoa New Zealand is now considered.

The Health and Safety environment

Bloom and Reichert (1998) suggest that the foundations necessary for the study of psychological trauma are the existence of a political will or movement. Support for mental health staff experiencing stress and trauma in the workplace will only become viable if there is organisational ownership of the risks. Without this, a culture of denial will exist alongside suppression of organisational initiatives to assist staff members. The current health and safety legislation may perhaps be interpreted as a framework illustrative of consensus regarding cause, effect and responsibility in regard to the management of workplace stress.

Legislation governing health and safety in the New Zealand workplace initially evolved in the intellectual environment of positivism, which enhanced the natural conservatism of the courts through requirement that a lineal relationship between an event and its impact be established before legal liability was proven. Compensation for damages through the courts required a tort, that is, an injury resulting from a wrongful (intentional or negligent) act of omission or commission, which potentially entitles the victim to compensation. Conservatively, legal systems have resisted these sorts of claims unless some form of damage could be proven (Brown, 1999).

A diagnosis of PTSD was previously essential for compensation, as a direct cause could be found in a lineal fashion. The further from the diagnosis one strayed, the more speculative and tenuous the attribution became (McNally, 2004; Pitman et al, 1996). One difficulty is that it is harder to determine culpability in terms of what Brown (1999) calls 'nervous shock' as opposed to physical injury or damage to property. This perhaps parallels the emphasis on tangible, physical proof in empirical science and the emphasis on actual physical violence in the statistics.

The same paradigm shift that has enabled a greater appreciation of issues of complexity in the conceptualisation of trauma has led to sophistication in the application of health and safety law. Preceded by a decade of test cases in this country and similar jurisdictions, the legislative framework in Aotearoa New Zealand was amended in 2002 to include notions of cumulative stress, thus

severing the directly lineal causal link between an immediate environmental event and outcome. Several testcases both in Aotearoa New Zealand and overseas attest to this process of change (Brown, 1999; The Guardian, 17.11. 94, in Brown & Bourne, 1996; Clarke, 2000; Weekend Herald, 10-11 June 2000).

The Health and Safety in Employment Amendment Act (2002), whilst still using the notion of 'hazard' that suggests risks of physical injury incorporated the knowledge that cumulative stress and exposure to the traumas of others can significantly impair health and wellbeing through both physical and psychological harm. It thus reflected the changes in knowledge base surrounding environmental stress and trauma, and loosened the direct causal connection between event and impact. It outlines a gradient of intervention that gives preference to the elimination of hazards. Only if this is not practicable should such risks be isolated, and if this is not possible, then minimisation of the likelihood of harm should occur.

Such a hierarchy of harm prevention acknowledges that there are some workplace environments that are inherently stressful, and that accumulation of stress, rather than single identifiable events, may lead to harm. Furthermore, it suggests that in some environments, where there are consistent reports of distress and adverse health outcomes, it may not be possible to eliminate the hazards and the task of the employer-employee contract is therefore to minimise the damage done. The state Occupational Safety and Health website (www.osh.govt.nz) acknowledges that occupations particularly at risk are ambulance services, health care personnel, police, prison services, social work and teaching. Significantly, all of these are occupations involving human interaction, many of which operate in potentially crisis situations. Occupational Safety and Health (OSH) observes that in these occupations, employers need to be proactive in considering and evaluating the potential for harm to occur.

Of major significance to this research study is the incorporation of cumulative stress into the responsibilities and compensation field. The clinical differentiation between traumatic stress, acute stress reactions and cumulative stress, fraught at the best of times and often achievable by retrospective diagnosis, receives less of an emphasis. Although clearly still important in terms of long-term individual outcome, it is replaced in the legislative spotlight by an emphasis on the rights and responsibilities of those within the organisation. Employers have a responsibility (the 'duty of care') to ensure that all practicable steps are taken to ensure a healthy and safe workplace; employees have a duty to signal, through organisational means such as

supervision, the degree to which the workplace environment has become stressful.

Resistance to this paradigmatic shift has come from forces representative of commercial interests, such as the Employers' Federation. Such managerial advocates have expressed concern that the notion of cumulative stress will contribute to the growth of a litigious environment. Some evidence for this can be located within the North American legal system, whose adversarial system has resulted in a PTSD 'industry'. French (2001) quotes Lees-Haley (1986) in saying 'if mental illnesses were rated on the New York Stock Exchange, post-traumatic stress disorder would be a growth stock to watch'. French's discussion is in a context of assistance to mental health professionals who are called upon to provide expert evidence in court cases surrounding employer negligence.

It is perhaps erroneous to compare the legislative environments of North America and Aotearoa New Zealand, and too early to be able to assess the full impact on stress claims and compensation, and on any improvements to workplace systems. Nevertheless, the legal climate signals an important conceptual shift in a recognition of complexity, and one that is of particular relevance to the understanding of response to critical incidents in the workplace.

Attention now turns to an exploration of the shape of critical incident response.

Responding to critical incidents: psychological debriefing and critical incident stress management

Support systems for workplace incidents have evolved relatively recently in the understanding of extreme stress and trauma. Only in the last three decades has the workplace been acknowledged as a forum for potential harm and correspondingly, interventions have emerged combining characteristics of positivist, systems and constructivist interpretations, and reflecting the tensions between these perspectives. The dominant model for staff support after critical incidents is that of psychological debriefing, or Critical Incident Stress Debriefing (CISD), and its related processes within the programme termed Critical Incident Stress Management (CISM)[39]. Unlike other workplace systems such as Employee Assistance Programmes (EAP), industrial chaplaincy initiatives or supervision, debriefing processes have been specifically designed for the support of staff after critical incidents and traumatic events.

[39] 'CISM' is pronounced "sizzum". 'CISD' is spelt out - C.I.S.D.

Whilst debriefing has not universally been adopted within mental health agencies, and was not experienced by all of the participants in this thesis, its characteristics and the ensuing debate over its evaluation provide a central platform for the development of appropriate, ecologically-informed, staff support systems. Criticism of this model has tended to generalise into any early intervention initiative, and this thesis argues that an understanding of the elements of existing staff support systems and their evaluation is essential in order to build for the future.

Clarifying the nomenclature is important. CISD and CISM are terms in use within a specific model (often termed the 'Mitchell Model' after the American paramedic who led its development), around which much of the debate about workplace support after critical incidents and traumatic events centres. 'Debriefing', often prefaced by 'psychological', is a wider description of an intervention that is usually, but not exclusively, a group process, and which may or not conform to the prescriptions of the models of CISD and CISM proposed by Mitchell, Everly and others, descriptions of which follow. I have come across no other phrases that refer to a comprehensive range of supports within the workplace other than that of 'CISM', and it should be noted that this acronym is still associated strongly in the debate with the work of Mitchell and colleagues. This confusion and affiliation of terms with one particular model or other is perhaps reflective of the stage of development of workplace support for critical incidents. Wherever possible within the text, therefore, I intend to signal if 'CISM' refers to the specific programme with Mitchell origins or to a generic description, and tend to use the full term of 'critical incident stress management' to refer to all processes serving this purpose.

The origins of critical incident stress management, CISD and psychological debriefing

Everly is the chief executive officer of the International Critical Incident Stress Foundation (ICISF[40]), founded by Mitchell and Everly in 1989, and one of the major proponents of the orthodox 'Mitchell' model of CISM. He defines CISM as:

> ... an integrated, comprehensive, multicomponent crisis intervention system.
>
> Everly (1999:77)

[40] International Critical Incident Stress Foundation.

He traces three evolutionary phases of intervention, starting with traditional individual crisis intervention approaches (Caplan, 1964; Lindemann, 1944; Lindemann, 1995a); single factor group psychological debriefings, or CISD (Mitchell, 1983); and then multicomponent critical incident stress management models (Everly, Flannery & Mitchell, 2000). He describes these first two approaches as univariate, whereas CISM has a range of interventions and components, organised in a systematic manner that spans preventative and preparatory strategies as well as peri- and post-incident responses.

Both Everly and Mitchell's writings link CISM and CISD with the history and theoretical foundations of crisis intervention and emphasise the fact that the practice models that they propose are not in a unique field, despite operating within workplace contexts. Mitchell and Everly (1996), for instance, use the research on crisis intervention to confirm the rationale for the introduction of CISM and CISD, and Everly, Flannery and Mitchell (2000) cite characteristics of a crisis intervention approach (namely primary prevention through early intervention) as the model's theoretical roots.

The second phase of development into what is now known as CISD is what is termed Mitchell's group psychological debriefing model (Everly, Flannery & Mitchell, 2000; Mitchell & Everly, 1983). Designed originally to assist emergency services personnel in severely stressful situations, the goals of debriefing are similar to crisis intervention procedures in the attempt to prevent maladaptive responses to critical incidents but it uses the group format as opposed to individual attention as a mode of intervention. This is particularly relevant to the location of these initiatives within highly organised emergency teams that rely on role allocation and performance, and a military precision in their operations (Mitchell, 1995a). Such a group focus appears to allow for more of a psychosocial approach, as Everly et al (2000) explain that it seeks to restore the support network of caring attachments and the victims' sense of meaning in life as well as to stabilise the situation and provide symptomatic relief. It is therefore alert to the context in which incidents occur within the emergency services.

Mitchell (1983) describes his model as based on the principles of immediacy, proximity and expectancy, derived from military experience in World War II (Bloom, 1997; Grinker & Spiegel, 1945; Kardiner & Spiegel, 1947). Underpinning the intervention is the understanding that support given immediately and with one's peers will enable a speedier return to a level approximate to pre-incident functioning (Hanson, 1949; Solomon & Benbenishti, 1986). The principle that the intervention should be brief has also emerged from this military focus

(Artiss (1963) in Rose & Tehrani, 2002). Mitchell and Everly do not talk about the rap groups originating from the military experience in Vietnam but it is important to include these here as part of the historical and theoretical movement towards group rather than individual responses. There is theoretical congruency here with the knowledge of the social impact of trauma and acute stress, that victims and survivors will communicate with others who have been through the same or similar experiences and with whom they speak the same language. It also emphasises that for the delivery of some services, the functioning of the group takes precedence over that of the individual (Hamling, 1996).

CISD, then, is a model derived from military and para-military environments, and has as a prime focus the restoration of function, rather than the prevention of PTSD, to which some of the literature also alludes. This is a subtle but important distinction to make for the debate over appropriate response to workplace incidents.

It is relevant to note here that the generic model of psychological debriefing, the precursor of CISD, is described here as being a phase of development and that debriefing procedures are currently now described as a component of a more comprehensive programme to manage critical incident stress (CISM), the third phase to which Everly (1999) and Mitchell (1993a) refer. Mitchell (1995a) is at pains to point out that CISM preceded his model of CISD in its development. This is a sequence that is challenged within the literature (Kenardy, 2000), and which Everly's writing at times appears to dispute. Re-writing the sequence of history is one of the accusations thrown at Mitchell and his colleagues by critics of CISD within the debate over the effectiveness of debriefing.

Robinson (1997) traces the development of organised CISM approaches in Australia from Cyclone Tracey in 1974, from the 1977 Granville train disaster, and the Ash Wednesday bushfires in 1983 described by McFarlane (1990). From 1984 on, programmes designed for emergency services were extended through to defence forces, hospitals, banks, petroleum companies, industries such as mines, welfare and youth services, rehabilitation services, and high-risk sports. Psychological support for emergency workers began to surface as a topic in stress and trauma conferences from 1986 onwards. Robinson records the first Combined Emergency Services Debriefing Team was set up in 1987 in Victoria followed by Peer Support programmes the following year. ACISA (the Australasian Critical Incident Stress Association) and ASTSS (the Australasian Society for Traumatic Stress Studies) were both founded in 1990. There was initial close association between the two organisations, with a joint conference

(alongside NALAG, the National Association for Loss and Grief) in Sydney in 1997.

Awareness of critical incident interventions within the workplace arrived in Aotearoa New Zealand largely through the Fire Service. The 1990s saw the rapid development of peer support initiatives within fire, ambulance and to a certain extent the police, the prison service, child protection and youth justice, and health. Occurrence, uptake and maintenance of the programmes varied, as did adherence to the model known as the 'Mitchell' model, which provided the template at training sessions and conferences in the mid to late 1990s. Small regional meetings preceded the first Critical Incident conference (CRICIS '95), organised by the Auckland Fire Service Peer Support Team in 1995.

I turn now to a description of the characteristics and components of Critical Incident Stress Management, CISD and psychological debriefing.

Components of the CISM model

Everly and Mitchell outline seven key components of their Critical Incident Stress management model:

Table 6: Components of Critical Incident Stress Management

1. Pre-incident education /mental preparedness training
2. Individual crisis intervention support/on-scene support
3. Demobilisation after disaster or large scale events
4. Defusing
5. Critical Incident Stress Debriefing (CISD)
6. Significant other support services for families and children
7. Follow up services and professional referrals when necessary

Everly (1999); Mitchell & Everly (2000:5)

CISM is depicted as a range of interdependent interventions, as a model which reflects primary, secondary and tertiary characteristics compatible with the World Health Organisation guidelines (1984) and which appears to address an ecological perspective through its focus not only on the individual but on work groups and sites, and on the family and community. Mitchell and Everly (1993b) define the CISM team as a partnership between professional and peer support personnel, all of whom have received relevant training.

The individual components of CISM are underpinned by pre-crisis preparation. Everly (1999) describes examples such as stress management education ('stress inoculation'), stress resistance and crisis mitigation training for both individuals and organisations.

Demobilisation and defusing are often termed 'psychological first aid' and are terms that resonate strongly with crisis intervention theory and strategies aimed at a practical and supportive level (Gilliland & James, 1997; Raphael et al, 1996; Trauma Intervention Programs Inc., 2001; Tunnecliffe, 2001). 'Demobilisation' is a military term that may not sit comfortably within a mental health environment without deconstruction. It is sometimes termed 'front line' or forward treatment, another term that reveals its genealogy and focus on the removal of a group of victims/survivors from an ongoing incident through a process of triage. Noy, an international expert on traumatic stress in a military context, defined this principle:

> Frontline treatment (Salmon's principle) is allowing respite within the parameter of the support group and returning the soldier promptly to coping and to the support group.
>
> Noy (2002); personal communication

It focuses on short-term respite, a standing down that links respite from acute stress with a return to functioning at an early stage (Salmon, 1919; 1929). The term is defined within an Aotearoa New Zealand social work initiative as:

> ... a structured meeting conducted by the site manager or senior staff member to assist staff make the transition from a physiologically aroused state following the incident to a more normal state.
>
> Children, Young Persons and their Families Agency (1999:15)

The emphasis here is on immediacy, practical assistance and reduction or prevention of further impact. The CYPFA[41] report suggests that this should be conducted as a matter of course, the peer group providing the forum for emotional ventilation with the emphasis on safety and the reduction of impact and arousal, with no attempt at processing the experience. Characteristics of this process may be practical assistance with food, drink, clothing, shelter and psychological reassurance, reminiscent of the foundation rungs of Maslow's hierarchy of need (Maslow, 1998). An underlying assumption in demobilisation is that those affected are no longer involved in the incident, an issue that is potentially problematic in fields such as mental health, which involve relationships over time.

As depicted in Table 6, a process known as defusing occurs following demobilisation. The term 'defusing' is often confused with the process of

[41] Organisational restructurings can be marked by the passage of acronyms through documents such as this: CYPFA was once CYPS and CYPFS and is now CYF, the Department of Child, Youth and Family, the government department with mandated responsibility for child protection and youth services.

debriefing. In Mitchell and Everly's schema (Everly, 1999; Mitchell & Everly, 2000), the processes are quite distinct, and the act of defusing may be all that is sufficient as an intervention (McHugh, 2001). Everly describes defusing as:

> ... a three phase, structured small group discussion provided within hours of a crisis for purposes of assessment, triaging and acute symptom mitigation.
>
> Everly (1999:77)

The aim of defusing is to review known facts about what has happened, to answer questions, to provide information, to deal with immediate issues, to give advice on self care and stress management, to assess needs and to plan for any necessary next steps. The three-phase structure is that of introduction, exploration and information. The introduction serves to lay down guidelines for the meeting, and significantly, encourages people to 'actively discuss the traumatic experience' (Mitchell, 1995a:80). Various descriptions of defusing suggest that it is a short informal process (perhaps an hour or less), guided by the needs of those involved, and that it should occur ideally within twelve hours of the resolution of the event (CYPFA, 1999; Mitchell, 1995a; Ream, 1999). Mitchell and Everly (1996) consider that a group process reduces the 'fallacy of uniqueness' that affects people after acutely stressful incidents, by allowing people to share and observe the impact of the event on others. This is clearly congruent with understanding about the isolating impact of high levels of stress and of trauma on social functioning, but the emphasis on the development of a narrative and the promotion of ventilation and catharsis as a purpose may raise concerns in regard to the levels of traumatisation (including aphasia, high arousal and dissociation) associated with a traumatic event.

The next stage of the CISM model, debriefing, is now described.

'Stabilise, mobilise and restore to function': characteristics of psychological debriefing and CISD

This next stage of the CISM model, debriefing, is key to the arguments within this chapter, as it is often viewed and evaluated as a discrete intervention. It is presented here as part of a larger stress management programme. Critical Incident Stress Debriefing (CISD) has been tailored to reflect organisational contexts and professional identities whilst attempting to maintain the para-military functioning or employer-driven purpose of enabling a work unit to function again.

In his keynote address to the first Critical Incident conference held in New Zealand, 'CRICIS 95', Mitchell described debriefing as:

> ... a peer driven, clinician-guided, group discussion of a traumatic event.
>
> Mitchell (1995b)

Everly (1999) describes CISD as a seven phase, structured group discussion that is usually provided one to fourteen days post crisis. The formal CISD model constructed by Mitchell is the template for the bulk of training, conference presentations and research evaluations of debriefing encountered during the course of this thesis. As such, it is a major model of intervention, made prominent both by its importance within an overall CISM framework and also as the focal point for the debate over its effectiveness. CISD refers explicitly to the seven-stage model outlined in Appendix Five.

Consideration of the stages of the CISD model reveals its strategy for response to a critical incident. Issues of safety and boundaries are established prior to an exploration of the facts of the incident as perceived by those present. Only after some structure has been created does the process move through a hierarchy of cognitive, emotional and physical symptoms and experiences, emerging back into a structure of fact and education before its termination. The methodology of CISD reflects a more structured and lengthened process than defusing and psychological first aid, and a greater emphasis on ventilation of emotional responses.

Everly, Flannery and Mitchell (2000) cite research literature that reinforces the wisdom that talking about one's experience is a very human imperative after a critical incident (for instance, Pennebaker (1995); Shalev (1994). Mitchell and Everly (1996) use Pennebaker's argument that catharsis (the safe ventilation of emotions) can be provided by CISD. According to Mitchell, CISD gives the opportunity to verbalise, alleviates stress and strain on homeostatic mechanisms, reduces rumination and helps to make sense of the trauma.

The psychological construct that provides explanation for this is explained by Gordon (1997), who argues from a social constructivist point of view that preliminary meanings or interpretations of an event are still unstable immediately after a critical incident, and that a group debriefing process providing support and a contextualised discussion can assist in the formation of constructs that support a healthy perception of the incident. This learning, he argues, cannot be achieved once the cognitive schema have consolidated.

Framing ventilation and catharsis within a larger structure of cognitive and factual accounts of the experience provides a rationale for CISD's claim to actively assist in building coping strategies. CISD, according to Mitchell and

Everly (1996), provides a behavioural structure that is superimposed upon the chaos of the impact of the event, psychologically aiming to provide shape and control. Everly, Flannery and Mitchell (2000) talk in terms of participants learning more adaptive cognitive and behavioural coping skills.

This argument resonates with the research literature on the development of cognitive and narrative understandings of traumatic experience. However knowledge of the impact of trauma also raises the concern that for some, the traumatic impact immediately following exposure prevents the development of language, as evidenced by the research concerning dissociation, aphasia and traumatic memory (Chapter 5). A key question is therefore whether psychological debriefing is a suitable intervention for those who are actively traumatised by their experience and how a group-based intervention can in the early hours after an incident distinguish between levels of impact within the group. These issues are discussed in the consideration of the debriefing debate.

The end stages of the CISM model, family support and follow-up for individuals, appears under-acknowledged within the literature, and I suspect are processes assumed by the literature to be subsumed within organisational functioning and serviced perhaps by existing systems such as supervision and welfare operations focusing on the individual. The lack of an apparent interface with the crisis-oriented processes of critical incident stress management is a potential issue in the light of knowledge over the long-term effects of extreme stress and trauma.

The development and adaptation of CISM and debriefing

CISM and psychological debriefing have developed further than their origins in the emergency services. Both Everly and Mitchell have argued for a general applicability to crisis and disaster situations for all individuals and they illustrate the wide range of different settings (industrial, commercial, educational and community) that have adopted the model (Everly, 1999; Mitchell, 2000). This argument is not without flaw, in that the uptake of an intervention tool by an organisation is not in itself an indication that it is either suited to the new environment, or is effective in its purpose.

In my review of the literature, there are many descriptions of debriefing processes and models, but few of complete CISM programmes, a fact that suggests to me that both intervention and evaluation remain focused on the part rather than the whole. One of the few is that of Flannery et al, who describe the development of a CISM approach for psychiatric health care providers that includes individual crisis counselling, CISD, a staff victims'

support group, employee-victim family counselling and professional referrals (Flannery, 1991; 1995)[42]. In addition to Flannery's example, cited above, two Australasian models of critical incident stress management emerge.

Kiwi Experience: the Child, Youth and Family model

The following example is the only New Zealand model of CISM and CISD located during this thesis research, and as such, its adoption and adaptation illustrates many of the issues that resonate within the findings of the thesis.

The Department of Children, Youth and Family in Aotearoa New Zealand instituted a debriefing and peer support programme in 1997 after a client death and request from staff for support (Elliott & Agnew, 1999). This coincided with their National Office directive for managers to support staff in work-related situations of risk (the Dangerous Situations Memorandum), which became a CISM process (Children, Young Persons and their Families Agency, 1999). Whilst the major emphasis in this programme has been the defusing, peer support and debriefing elements, other parts such as pre-incident training and education (for both managers and staff) about CISM, promotion of the service, and training of peer supporters and facilitators are all stressed. There is a focus on integration with existing policies and guidelines.

A literature review conducted by a team managing the process found that the 'Mitchell model' was the most common form of practice (Elliott & Agnew, 1999). Training for this was sourced from Australia. CISM and critical incident stress information was given to all staff to heighten the awareness of the service. A National Advisory Group consisting of managers and clinicians from around the country (and myself as an external consultant) was formed to provide support for this process.

Agnew, Dawson & Elliott (1998) describe this initiative as based on the Mitchell model but with significant variations such as the application of the debriefing process to support individuals affected by a critical incident, a necessary characteristic of any support provided for staff that do not always work in teams or units. Cultural adaptation was required to respond to Tangata Whenua and Pacific Island processes, in particular the use of karakia (prayer). Elliott et al (1999) comment that CISD as a trained peer support model fitted in with Maori and Pacific staff concepts of warmth and support, an acknowledgement of group processes and a locus of healing that lies within the environment rather than solely within the individual. Similar cultural

[42] Flannery is often one of Mitchell and Everly's co-researchers and writers, and is on the staff at the ICISF.

adaptations are noted in Canada, for instance in Saskatchewan (McCord & Associates, undated).

Learning from Australia

The Council of Remote Area Nurses of Australia has produced some informed and pertinent literature describing the rationale for the model that they have adopted for supporting remote area practitioners (Kelly, 1999a; 1999b). Whilst the scale of the isolation faced by these practitioners is unique to Australia, characteristics of their experience and their recommendations for critical incident support resonate with issues faced by mental health workers within Aotearoa New Zealand. Within our own country, some mental health agencies operate in effective isolation or in a potentially insular manner, de facto remote if not geographically. This may be especially so for tangata whenua and iwi agency agencies whose natural communication patterns are directed towards a relatively small geographical area rather than a wider regional, national or internationalised system of information and support. The impact of events may be experienced in quite a different manner than in those agencies based in urban or suburban communities.

Kelly (1999a) suggests that in these rural areas, work-related traumatic events are likely to be more complex experiences than in urban areas. Exposure may be at a high level and prolonged. Practitioners may face an extension of their professional roles beyond the scope of their training or expectations, with communities lacking of what Kelly terms 'circuit breakers' between home and work. Events may themselves be very public and may reduce the opportunity for anonymity and confidentiality that may support time out for rest and recovery. The impact of the event itself may reverberate between the workplace and the home in a uniquely porous manner. Rural settings, Kelly suggests, necessitate the development of new frameworks for intervention that reflect the communication patterns and experience of these contexts, for instance, the Bush Line telephone service which aims to overcome isolation and problems with anonymity. At the 1998 ACISA conference, Tunnecliffe also argued that cross-service peer support probably works best in country areas, for example where people know each other better, have a different sense of boundaries, and where economies of scale come into play. Ream (1999) comments that CISM teams can be a consultancy or supplementary resource for smaller agencies.

Many of the principles that Kelly (1999a; 1999b), Ream (1999) Tunnecliffe (1998) resonate with my own experience. At the ACISA conference in Adelaide in 1999, I presented an ecological model as a framework for the consideration of

critical incident intervention. I noted that the audience response was clearly split between those who nodded vigorously at times, and those who clearly looked puzzled and unenlightened. During question time it became apparent that the confused component of the audience was urban firefighters, whose professional identity was contained within tightly moulded, hierarchical roles and allegiances. An ecological framework advocating an interaction between systems, organisations and communities did not appear as relevant as it did to the rural emergency services personnel, health workers and social workers in the audience. This example further reinforced my developing argument for a matrix of intervention that is responsive to the ecological conditions of the workplace.

Diversity in debriefing

One of the issues of the 'Debriefing Debate', discussed below, is the degree to which the initial form of the 'Mitchell model' has undergone adaptation and revision since its initial inception within emergency services in North America. For this study, it raises issues of the retention or conversion of principles for staff support across different cultural and social environments. In relation to debriefing specifically, there is indication in the literature that models are under constant refinement and are adapting according both to their environmental context, and to a degree of reflectivity as a result of the debate of effectiveness of these procedures (McHugh, 2001; Robinson, 1997; Tunnecliffe, 1997).

Several reviews of debriefing models suggest an evolution of the model away from its early paramilitary and emergency services contexts, and a confusion of terms between the 'Mitchell model' of CISD and the generic term debriefing, an issue that lies at the heart of the debriefing debate and the arguments of this chapter (McCammon & Allison, 1995; McHugh, 2001; Rose & Tehrani, 2002). Tunnecliffe (1997) describes some variations on the CISD model such as the Lewis' 'paint the picture' model of debriefing and he suggests that adaptation to small group environments may be necessary (Tunnecliffe, 1998a). Dyregrov (1989), whilst a proponent of the Mitchell approach, indicates that the type of debriefing needs to fit the group participating.

Psychological debriefing is a construct now applied in settings environments outside of emergency services and with individual victims, for example with train drivers, and postal employees (Tehrani & Westlake, 1994). Parkinson (1993) has evolved a model for use with groups, couples and individuals. Schools have become a forum in the USA (Juhnke, 1997; Thompson, 1993), and in Aotearoa New Zealand (Stewart, 2001). The examples above serve to

illustrate the complex processes and adaptations of the original concept of psychological debriefing, although not all descriptions of debriefing are accompanied by evaluations.

Two other key elements of debriefing processes, peer support and external provision, are now described.

Peer Support

Peer Support emerges as a major characteristic of CISD and CISM in many models (Elliott & Agnew, 1999; Tunnecliffe, 1998a; 1999). It is an approach that utilises the skills and situational expertise of informed and trained peers within the workforce, and has developed in organisations with strong occupational identities, roles and allegiances. Tunnecliffe, for example, has extended the Peer Support model out of emergency services into industries such as mining, environments that often are located in remote areas where self-reliance and peer support may be necessity as well as choice. Peer support has the characteristic of staff having familiarity with and immediacy of access to the workplace situation. It is therefore a model that is compatible with the principles of early intervention, proximity and immediacy, and with the ecological principle of engagement with identified supports within the environment (Cooper, 1998). Peer support may be compatible with a Strengths perspective:

> In many cases, the reliance on professionals to immediately arrive and 'counsel' people after traumatic events is highly inappropriate. It reinforces the idea that most people don't have the power to cope and look after themselves and that small acts of caring are not part of the support process.
>
> Tunnecliffe (1995:4)

Tunnecliffe (1999) describes the core skills required in peer supporters, and suggests that systemic organisation is required for the use of peers to be acceptable and effective. Tensions between 'normal' job descriptions and time spent in facilitating debriefings, for instance, may arise, and the coordination role of any particular team member, perhaps different to that of their daily tasks, may need to be reinforced. Confidentiality can become a major issue where staff meet in different roles. Robinson (1997) adds her voice to cautions about the use of peer teams, suggesting that they may not work as well in non-emergency service environments. She comments that peer support requires an administrative infrastructure, forums for support and development, and are not a cheap means of providing staff support and servicing organisational responsibilities. One of the practical constraints on the use of peers in this

model is their availability. Small numbers of experienced staff may become in high demand. Some worksites or agencies may have few sufficiently skilled and experienced staff. Recruitment, retention and resourcing issues for some agencies may therefore inform the choice for use of peers in support systems.

The external provider model

An adjunct to Peer Support is the external provider model. This is adopted often by large organisations in fulfilment of their Duty of Care under health and safety legislation; for instance, many banks, commercial enterprises and industries utilise this model. It is perhaps more common outside of the health, welfare and emergency services environments, and may be selected because of the relatively low level of perceived need. It is therefore a model that has moved away from the ethos of CISM that Mitchell and Everly define. In my experience it is also a model that may be adopted as a reflection of a lack of infrastructural development within an organisation, an agency assuming that its workers' needs are met by calling upon an external provider when required, and thus removing the necessity of establishing contextually-appropriate systems of its own. It is, however, a model that has potential for adoption by small agencies for whom an individual support infrastructure is not a feasible resource.

In this model, external consultants and companies may provide a mental health service on a 24-hour basis. Because of the location of the service outside of the organisations in which the incidents occur, there are contextual issues that arise in relation to the ecological fit between provider and agency (for a full discussion, see Beale (2002) and Tehrani, 2002). For instance, most of these services are provided through a financial retainer and a fee for service by selected providers (usually psychologists in independent practice): service may be thorough but unintegrated. These services do not extend education and preparation for incidents (including anticipatory explanation of the function of debriefing) to the staff and management. Omission of stress inoculation and systems preparation may challenge the integrity of a critical incident stress management programme, as having an external provider does not imply any particular structural or systemic integration with policies and procedures that would allow for fluid management, internal organisational communication, assessment and referral, and as McHugh (2001) suggests, does not contain automatic processes for quality assurance.

There is clearly a considerable variation and emergent issues in the development of debriefing and CISM processes. These issues inform the

discussion that now turns to the debate over the effectiveness of psychological debriefing within the workplace. The major tool utilised within the debriefing debate is that of evidence based practice, the characteristics of which are now considered.

What works? Towards establishing a framework for staff support systems

Response to critical incidents within the mental health workplace is shaped not only by an understanding of the impact of extreme stress and trauma and the prevalence of incidents, but by dominant environmental, political and legal constructions. Measurement of the implementation and success of any programme designed to support workers after incidents will similarly reflect a blend of pragmatic, conceptual and theoretical influences. The following sections address the nature of processes adopted for evaluation of critical incident support, and argue for the development of more ecologically attuned frameworks.

Providing a foundation for the evaluation of psychological debriefing is Evidence Based Practice (EBP). EBP is defined and examined here as a tool for assessing the appropriateness of particular interventions. The debate over the efficacy and safety of CISD then becomes a case study for this thesis because, when critically deconstructed, the strands of the argument highlight the continuing tensions between positivist and ecologically-based imperatives for staff support. Comprehension of the theoretical and ideological perspectives within the arguments will guide the construction of effective workplace systems.

Defining Evidence Based Practice

Evaluation of psychological debriefing has largely reflected the processes of EBP, an approach which reflects its theoretical origins within a biomedical perspective and which represents the strongest voice in the debate over debriefing. The key issue for this discussion is the extent to which the current standards of measurement for best practice and outcome reflect the shift in paradigm from a reliance on positivism and reductionist measures to a more holistic, ecological and inclusive means of evaluation.

The origins of the push for an evidence base to practice date from 1972, and called for the establishment of a central international register of clinical trials, on the basis that medical clinicians made interventions and chose treatments

often without recourse to research evidence of effectiveness. Sackett et al describe EBP as:

> ... the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. This practice means integrating individual clinical experience with the best available external clinical evidence from systematic research.
>
> Sackett et al (1996:71)

Currently the Cochrane Collaboration, as the initiative has developed into, contains the Cochrane Controlled Trials register, which is aimed at being a reliable, comprehensive and accurate medical database; the Cochrane library, which includes two 'metadatabases' (the Cochrane Database of Systematic Reviews, and the Database of Abstracts of Reviews of Effectiveness); and a database on the science of research synthesis. Published articles are entered on to the Cochrane databases by members of the Cochrane Collaboration, an international network of (mostly) medically qualified volunteers who each take on the scrutiny of a particular clinical journal back to the very first issue. Using strict methodological criteria, they classify each article according to type (randomised trial, other controlled clinical trial, epidemiological survey and so on) and prepare structured abstracts.

The methodological criteria utilised provide ranking of research evidence according to a strict hierarchy, headed by systematic reviews and meta-analyses (that is, secondary research papers in which all the primary studies have been hunted out and critically appraised according to rigorous criteria) (Greenhalgh, 1997). Below systematic reviews are randomised controlled trials; cohort studies (groups of people, perhaps involved in different interventions, followed up over a period of time); case-control studies (matching of people with a particular condition, situation or disorder with people with similar characteristics but without the disorder or condition); cross-sectional studies (for example, epidemiological surveys of incidence) and case reports (descriptions of unique/individual experience). Krishnan (2004) ranks impressions and opinions at the bottom of the list, Davies and Nutley (2000) placing peer leader opinion and personal experience at the bottom.

This hierarchy determines the choice of research method:

> Evidence-based medicine is not restricted to randomised trials and meta-analyses. It involves tracking down the best external evidence with which to answer our clinical questions.... if no randomised trial has been carried out for our patient's

> predicament, we follow the trail to the *next best* external evidence and work from there.
>
> Sackett et al (1996:72), my italics

Out of the available research methods, the 'gold standard' is that of randomised controlled trials (RCTs), which Andrews (1999) describes as the benchmark for evaluating efficacy. This process describes the randomised allocation of research participants to one of two or more groups, with the intervention under investigation then provided for one and not the others. Its tools are the use of control groups and placebos. RCTs are best suited to single system designs and as argued below, may not be as easily applied in situations of complexity such as in the matrix of factors that may create response to critical incidents within the mental health workplace.

Evidence Based Practice in an ecological world

Where interventions under scrutiny have predominantly behavioural and social characteristics, the use of evidence-based tools becomes contentious. Several challenges have been mounted (Bracken & Thomas, 2001; Epstein, 1996; McBeth, 1996; Seligman, 1995; Smith, 2001). Schon (1991) suggests that in real life, problems do not tend to present themselves as single-issue or discrete, and Lockwood (2004) and Macdonald (1999) suggest that the 'objective' view of the world held by clinicians may represent a very different values base from that of their clients, and recommends the use of narrative in measures of best practice.

Challenge and critique also comes on an ethical basis from within the positivist paradigm itself, suggesting that controlled trials are not always appropriate or ethical, and that research from observational or cohort studies may inform practice as adequately (Benson & Hartz, 2000; Concato, Shah & Horwitz, 2000; Ioannidas, Haidich & Lau, 2001). Trauma, in part because of its diagnostic relationship with an environmental stressor, does not open itself so easily to this hierarchy of experimental designs and research practices (van der Kolk, 1996c.

Assessment of therapeutic safety is not always a consideration within EBP, thus reducing the clarity of decision-making in selection of intervention (Papanikolaou et al, 2004). A review of two medical databases in this regard found that only a quarter of systematic reviews included safety aspects as a secondary outcome measure (Ernst & Pittler, 2001). It argues that other methods of research should be utilised in order to consider the safety (as opposed to merely the efficacy and effectiveness) of therapeutic methods.

In practice, when clinicians and practitioners talk about 'what works', they allude to effectiveness, cost effectiveness and the efficiency of an intervention (Andrews, 1999). Clinical and managerial accountabilities are often inseparable in terms of expected outcomes. Value for money, audit systems, and threat of litigation may all become factors upon clinical decision-making.

The use of the tools of evidence based practice can therefore be critiqued in terms of their inflexibility in responding to complexity, their bias toward epidemiological as opposed to consumer-focused research, and their ethics in terms of the use of RCTs. As a mental health worker's experience of a critical incident will occur in a complex arena of personal, occupational and organisational interactions, these theoretical concerns about the foundations of EBP carry weight. As the definition of health has in itself changed, so too have ways of measuring health outcomes: it is to the development of ecologically-aware evaluation tools, characteristics of which may serve to guide the development of ecologically-sound staff support systems, that attention now turns.

The development of ecological evaluation tools

Critical incidents and traumatic events within mental health service delivery occur and are responded to within complex environments. There is thus a potential disjuncture between the experiences of workers in relation to what assistance was most effective for their needs, and evaluations that may focus upon single interventions or psychological outcomes. A more ecologically based evaluation approach may provide a more sympathetic tool with which to measure and develop appropriate response systems. Two approaches have evolved, in the form of the development of standards and guidelines, and in the call for holistic evaluation frameworks (Kingi & Durie, 2000; Mental Health Commission, 1998).

Davies and Nutley (2000) make a distinction between EBP and what they term the guidelines movement for connecting evidence to practice. They describe guidelines as top-down responses (that is, from government to service providers). In the Aotearoa New Zealand context the guideline movement is represented by the Blueprint for Mental Health (Mental Health Commission, 1997). Mackay et al (2004) provide an example of standards-based discussion around workplace stress. Examples of guidelines for critical incident support are considered later in the chapter. Guidelines (or best practice models) may be used simultaneously with EBP procedures and can be achieved out of consensual, consultative processes that can include the addition of cultural and

ethical values, thus reflecting a refinement of EBP principles to include some of the previous criticisms. Statements of what is important can define new parameters for how we measure the effectiveness and efficiency of our interventions, what we rate as priority and what information we privilege.

Guidelines provide standards and benchmarks by which to measure performance but do not necessarily provide extensive evaluative processes by which to gauge what works. Evaluation models developed through holistic or ecological frameworks offer opportunity to incorporate both scientific and contextual information. Rather than hierarchies, their structures are a matrix or framework of elements that have the potential to reflect the transtheoretical nature of complex interactions. A major strength of an ecological framework in assessing best practice is in the recognition that outcomes are as much determined by the interrelationships between systems, and between agencies: it is the complexity of a situation that may determine outcome (Mandell, 2000). This requires a different manner of working to many of the medical interventions that have been described within evidence-based research. Interventions may be so multi-systemic and interrelated that individual inputs may not be able to be identified or measured.

In this way, structural and resource issues surrounding health outcomes, and consultation and engaging of whanau and of family in decision-making and support can be included. Such frameworks can be adapted to incorporate cultural and spiritual perspectives that reorganise the relationships between people and their environment. Interventions that are favoured from this perspective are those that address the needs of each level of an ecological system; for example, multi-systemic approaches within child and adolescent and community mental health mental health (Falloon & Faddon, 1993; Henggeler, 1999; Kazdin & Weisz, 1998).

Examples of ecological frameworks developed within Aotearoa New Zealand are Hua Oranga (Kingi & Durie, 2000 & 2001), a measure of Maori mental health outcome structured around the principles of *Te Whare Tapa Wha* (Chapter 5), and Bridgman et al's (2000) model of wellness. Both are significant in their combination of clinical measures and psychological, social, cultural and spiritual factors, arguments endorsed by Bracken (2001) and Fahlberg and Fahlberg (1997).

With this perspective, the debate over the effectiveness of psychological debriefing following critical incidents and traumatic events is now deconstructed.

The Debriefing Debate

> Are people still saying it doesn't work?
>
> Tunnecliffe (1998b)

> If this was a drug, we would take it off the market.
>
> Gist, Traumatic Stress list (1998)

At the core of this chapter lies the following consideration of the issues in regard to the evaluation and critique of existing support systems for critical incidents and traumatic events. The issues that emerge within this debate contain the central themes of the clashing of knowledge bases, of two professional subcultures (Gold & Faust, 2002) and of the centrality of issues of context and complexity.

At the first Critical Incident conference in New Zealand, CRICIS '95, one of the main speakers was Heinrich, the coordinator of the Victorian Ambulance CISM programme, who described the need for adaptability of CISM models for different settings, by referring to Malucchio's term of 'ecological competence'[43]. He made many theoretical allusions to an interpretive paradigm, stressing that the meaning of the event was more important than the actual event in terms of its impact on people's ability to cope. Something about his emphasis on the adaptability of the model set up a reaction in some members of the audience, and about two thirds of the way through the address, I turned to see the majority of the keynote speakers (Mitchell and Robinson amongst them), who had not been attending the talk, assembled at the back of the room and clearly very angry. A heated debate ensued with the 'Mitchell' model supporters becoming notably irate at the apparent breaking of the party line. Significantly or not, I did not see Heinrich at any subsequent Critical Incident Stress Association conferences, and the debate over delivery of staff support systems continued to rage in conference, email and journal forums.

The debriefing debate has provided me with rich material with which to highlight the theoretical arguments of this thesis, and with which to grapple in a search for understanding about our response to the impact of critical incidents in the workplace. Its exploration has revealed complexities of arguments and passions whose origins reflect scientific, professional, political and emotional underpinnings. In my deconstruction of the strands of the debate I first intend to examine the arguments surrounding the efficacy and effectiveness of psychological debriefing. The understanding gained from this,

---

[43] Maluccio writes in the social work family and fostering literature (for instance Rine, Warsh, & Maluccio, 1993).

and from illustrations of other facets of the argument, will serve to highlight key determinants of an ecologically-based framework for staff support systems.

Evidence based evaluation and psychological debriefing

> ... there has not been an acceptable and reliable evaluation of the briefer forms of post-trauma intervention such as CISD/CISM. [...] The minimum requirement (for better or worse) for such a study to be acceptable in the scientific arena is randomised controlled design. Until protocols such as CISD/M are evaluated in such a manner and the results published in a peer-reviewed journal that has credibility (for example the Journal of Traumatic Stress, British Medical Journal) then attempts to shift the goalposts by claiming that the failure to find positive effects following "debriefing" (or even broadly following brief counselling) are a result of applying the wrong intervention will fall on deaf ears.
>
> Kenardy, Traumatic Stress list (6.6.00)

This comment from an Australian psychologist deeply involved in the scientific evaluation of psychological debriefing clearly illustrates the positions and confusions within this debate, one which can be comprehended through the discussion about the theoretical underpinnings of evidence based practice. These arguments form a crucial part of the knowledge base required for the development of ecologically sound staff support systems.

In this quote, Kenardy signals the scientific community's benchmarks of appropriate evaluation and dissemination of research, yet makes some fundamental (and perhaps inaccurate) generalisations about the homogeneity of psychological debriefing, CISD, and Critical Incident Stress Management approaches. This debate reveals disagreement over research methodology originating from two polarised schools of thought, one representing those who truly believe that CISD does what it claims to do, and one doubting its effectiveness through tackling its empirical validity (Herndon, 2002; Miller, 2003). Gold and Faust (2002) suggest that this division occurs between academic researchers and practitioners, whilst I would argue that it more accurately reflects different degrees of comfort with dimensions of context and complexity.

The historical development of this debate reflects these tensions. CISD arrived at a time when an evidence based practice approach was not adopted thoroughly by many professions or in many health and welfare settings. Much of the early evaluation was based on qualitative reporting of self-report and satisfaction measures (Robinson, 1989). Gist and Woodall (1998b) criticise CISD

on the basis that evidence is derived from data of perceptions of helpfulness rather than controlled or comparative assessment of psychological morbidity.

Debriefing's continued popularity has been sustained by factors other than positivist verification. What remained important for many practitioners was the demonstration of employer commitment to their welfare, and recognition of the impact of their work. CISM and CISD were seen as organisational and sometimes grassroots initiatives, and as social rather than scientifically determined interventions (Kelly, 1999a). Raphael and Wilson (2000) suggest that debriefing provides a socially sanctioned framework that fulfils our ethical obligations of support. Ormerod (2002) suggests that the nature of traumatic incidents themselves morally impels people to action before considered evaluation is possible.

When the scientific community did begin evaluation of debriefing, the mixed results created debate and raised issues for yet more research. Many of these studies begged the question of what was measured, what the debriefing set out to do, and what sort of debriefing it was. Some suggested that whilst intervention helped reduce acute post-trauma stress, it also predicted increased delayed stress (Carr, 1997; Griffiths & Watts, 1992; Kenardy, 2000; McFarlane, 1988). Concerns emerged over whether the model was able to prevent the onset of PTSD and other post traumatic symptoms (Avery et al, 1999; Bisson & Deahl, 1994; Bisson et al, 1997; Gersons, Carlier & Vrijlandt, 1997). Some studies found no preventive effect (in relation to post traumatic symptoms) (Deahl et al, 1994; Kenardy et al, 1996a). Others showed adverse outcomes (Bisson et al, 1997; Gist, Lubin & Redburn 1998a).

These findings were countered by various studies (Mitchell & Bray, 1990; Mitchell & Everly, 1997). Mitchell (1992) and Robinson and Mitchell (1993) claimed a scientific basis for CISD backed by systematic research, but subsequent research articles considered the model still relatively untested and some evaluations anecdotal in nature (Bisson & Deahl, 1994; Deahl & Bisson, 1995; Kenardy, 1996b; Meichenbaum, 1994; Raphael, 1995). Mitchell and Everly (1996) acknowledged that CISD had not yet been scrutinised by controlled experimentation.

Systematic evaluations and RCTs were called for by both practitioners (Davis, 1999) and researchers (Raphael, Meldrum & McFarlane, 1995), and a Cochrane review was initiated.

The Cochrane review

As described previously, the Cochrane review lies at the top of the evidence based hierarchy, enabling the meta-analysis of randomised controlled trials and therefore the pooling of research evidence across several evaluations. It has a high status within the empirical processes that underpin EBP.

The purpose behind a systematic review of psychological debriefing was to assess the effectiveness of the intervention to mitigate the effects of an incident. Rose and Bisson (1998) conducted a systematic review of the literature on randomised controlled trials only, which delivered a neutral verdict on one-off psychological interventions, with some studies showing a positive outcome, some with no effect, and some having a negative outcome. The subsequent meta-analysis produced by Wessely et al (1999)[44] focused upon the psychological state of individuals as reported within research reports, but only including studies that fitted within the parameters of EBP. The selection criteria for all the RCTs was that they should focus on single sessions, with persons recently (one month or less) exposed to a traumatic event, and that the intervention should involve some form of emotional processing or ventilation accompanied by normalisation of emotional reaction to the event. The Wessely review said that there was no current evidence that psychological debriefing is a useful treatment, raised concerns that it may exacerbate PTSD, and stated that the practice of compulsory debriefing should cease.

The debate raged on, displaying an emotional underbelly of internet flaming, expulsions from email lists, and accusations of commercial exploitation and suspect skill levels. On an organisational level, some CISD programmes were abandoned, others slowed in their implementation, and concern was raised that the entire concept of early intervention was tainted by the perceived inadequacies and dangers of the one model that had emerged specifically to respond to workplace incidents.

An analysis of the emergent issues, both methodological and clinical, now follows.

Methodological issues in the debriefing debate

An examination of the literature concerning debriefing and its evaluation illustrates that there is not consensus about its definition, nor understanding about what the intervention actually is, and for whom it is intended (Ormerod, 2002). Research has covered a wide range of settings and consumer needs, and

[44] This review is also referenced in the order Rose, Bisson & Wessely in some of the literature.

it is clear that Mitchell and Everly present a very different view of debriefing from that of many of the researchers using the Cochrane analysis and other RCT procedures (Mitchell & Everly, 1998 & 2000). The emphasis of the intervention appears to have shifted from that of an organisationally embedded programme to that of an intervention evaluated by psychological criteria, as in the Cochrane Review (Wessely et al, 1999).

Proponents of the Mitchell model, arguing that it is neither treatment nor therapy but triage (for instance, Mitchell, 1995b), can be held accountable for some of the confusion. As previously indicated, CISD was effectively the first workplace-based support system designed to be respond to critical incidents. The enthusiasm in which it was received by workplaces and workers was matched by the marketing processes used, which place the model largely out of academic and research-based endeavours, and into the entrepreneurial world of independent training providers, such as the ICISF. Some of the heat of the debate is demonstrably due to the marketing claims that debriefing is suitable for all situations (Rey, 1996). Herndon (2002) reflected upon what he terms the notion of the 'method school of acting' in reference to the insistence from within the Mitchell model that the CISD/CISM format be strictly followed.

This 'one size fits all' approach, underplayed in recent accounts of the process from CISD supporters, muddied the waters of the debate by introducing the possibility of commercial interest as a driving force behind its promotion (Gist & Woodall, 1998b; Kelly, 1999a). Gist and Woodall (1998b) talk about Mitchell in terms of his having built an empire, using words such as rhetoric and charismatic. They liken the rise of the Mitchell model to the Barnum effect, a process named after the master showman who built an empire on people's gullibility. De Soir (2004) adds his voice to the concerns about the commercial intent of some of these programmes, comparing the superficial nature of some of the training with the depth of knowledge required to work in the trauma field.

Definitional problems abound in this debate. The criteria of selection for the Cochrane review are problematic, in particular the use of single session interventions. No distinction was made between the types of events or those who had been offered assistance. Lovell suggests design faults in the actual RCTs used for the Cochrane review, in terms of standardisation, length of intervention, timing and so on (Lovell, 2000). The British Department of Health EBP guidelines echoed these concerns and queried the quality of the interventions in the studies (Department of Health (2001) in Ormerod, 2002). Ormerod also cites Yule's argument that challenges the applicability of many of

the brief interventions to the situations in which they are employed, and the use of the term 'debriefing' to describe them (Yule, 2001). Dyregrov (1997) points out some of the many complex independent variables such as the training and skill of the provider, the group history and cohesiveness, the intensity of the traumatic experience, internal group leadership, communication skills, and the timing and location of the intervention. Mitchell and Everly (1998 & 2000) challenge research such as Kenardy et al (1996a), which does not define the precise operational nature of the intervention; that is, what was actually done, by whom and what experience and training they had, as well as the timing of the study post-incident that would have ignored ecological variables. The Kenardy authors themselves point out the ambiguity around the debriefing process, and Kenardy's later review of psychological debriefing called for examination of parameters for the intervention (2000). Such variations in the descriptions of debriefing appear to have been minimised or ignored in many of the evaluation studies located in this literature review, and this, it can be argued, undermines the reliability and validity of the findings.

A similar concern can be raised in the consideration of the uses to which 'debriefing' has been put. The imposition of the seven stage CISD process (the 'Mitchell model') as a template for all situations has created concern, both within the debriefing community who see it being used for processes for which it is not intended, and with critics of the intervention. De Soir (2004) cites it as being often 'culturally blind, mechanistic and ideological'. The fact that it was not designed for scattered work sites or for individuals may have been overlooked by proponents and critics alike. This lack of responsiveness to environmental conditions is apparent in much of the literature. Culture and gender, for instance, do not seem to be assessed as important in either promotional or evaluative approaches to the subject. Some studies have been criticised for mixing the types of victims (Everly, Flannery & Mitchell, 2000). Mitchell and Everly (2000), for instance, criticise the early McFarlane (1988) study for studying a range of primary (bereavement) and secondary (property loss) victims together. Clearly, the needs of women following a difficult childbirth (Small et al, 2000) may be very different from the needs of survivors following an earthquake, or the needs of staff on a psychiatric ward after a suicide, but the contextual differences of these events may be overlooked by some methodologies.

McHugh (2001) observes that many of the randomised controlled trials that have been done have focused on debriefing individuals, for which the original protocols were not designed. Indeed, the historical roots of the model suggest

that the focus was not primarily intended to fall upon individuals, even within debriefing groups. Psychological debriefing emerged out of group process and recovery. From a military and emergency service perspective it is the group which is the vital common denominator, and its functioning as a whole is what is considered important. Ørner (1995) argues that trauma recovery in emergency workers is a group phenomenon and that its evaluation should be viewed in terms of what it does to group processes rather than focus on individuals. Mitchell (1995b) says that the wrong questions are being asked by much of the research, in the focus on symptoms rather than the return rate to work, level of sick leave and so on. He suggests putting an emphasis on the measurement of the social and organisational aspects of functioning as well as the psychological. Significantly, from the perspective of the argument in this thesis, Ormerod (2002) also suggests that factors other than exclusively individual symptom reduction be included in any review of effectiveness. She suggests that factors such as the actual intervention process, the satisfaction of participants, and work-related measures such as a cost-benefit analysis, sickness levels and job performance be considered. In a synthesis of the arguments, Ormerod suggests that the strict scientific interpretation of evidence based practice needs to be expanded to ensure that clinical experience is taken into account.

Hamling (1996) takes this argument one step further. He argues that the problem is that these studies focus on the impact on individuals, but when these individuals function as a group, to separate off the effect on each one is not possible. There are complex interactions and processes which mean that one person in a group may be more affected by the same incident than another, that a person may be affected by hearing about someone else's experience - either positively or negatively - and that the desired outcomes are interpreted through a group and organisational framework of performance and outcome, and not an individual one. In addition, because of this group identity, temporary retraumatisation may be an acceptable price to pay within such environments. Evaluations of psychological debriefing have therefore not grappled well with the emphasis on the group and on collective functioning.

In a further point of ecological critique, neither do evaluations address the location of debriefing in a wider context of the management of critical incident stress. As the quote from Kenardy (2000) that begins the discussion on the evidence based approach to psychological debriefing suggests, there is a lack of clarity in regard to whether debriefing, or CISD, is a stand-alone intervention, or part of a broader package of Critical Incident Stress Management. Capewell (1998 & 2000) has suggested that a failure of research has been to remove CISD

from the CISM context in which it should rightfully be located. Everly and Mitchell (1998) are insistent that CISD is part of a programme within CISM and that evaluation of one discrete component is not appropriate.

Proponents of the Mitchell model may have contributed to this narrow focus by an over-emphasis on the debriefing process at the expense of other components of programmes created to manage stressful events in the workplace. Mitchell and Everly (2000) themselves acknowledge a mistake in terming the multicomponent system of intervention as CISD or debriefing rather than as CISM. Critics suggest that Mitchell's location of CISD within CISM is a retrospective re-writing of history (Montgomery, 24.4.99, Traumatic Stress list).

However, it is debriefing, rather than CISM programmes, that is the intervention evaluated within the Cochrane Review and evidence based studies. EBP, located largely within a positivist approach to evaluation, prefers the single case, the one-off intervention, the discrete event as a unit of measurement, and may have also contributed to the focus on the figure rather than the ground. The implication of locating CISD within a CISM programme is that evaluations of such multi-component responses would require an entirely different methodological approach, one cognisant of ecological dimensions and interactions. Neither Boudreaux and McCabe (2000) nor McHugh (2001) found that any EBP studies they reviewed had evaluated a comprehensive approach.

Some studies report their evaluations of CISM but do not detail the evaluation frameworks utilised (Campbell, 1992; Flannery et al, 1991; Flannery et al, 1995; McHugh, 2001; Ott & Henry, 1997). These report reduced turnover of staff, less use of sick time, fewer workers' compensation claims, medical and legal expenses. Campbell's study suggests a reduction of use of alcohol, a positive adjustment to work with better work relationships. Accepting some of this evidence within an EBP framework would be problematic as the synergistic benefit of some supports is not a lineal measurement of effectiveness. Mitchell (1995b) underscores these findings in his comment that few critiques take on board the importance of structural change and good organisational systems, the bigger picture of which CISM, not debriefing, is representative.

There are therefore fundamental methodological issues that some of the research appears to miss, voiding debriefing of its relational context to focus exclusively on individual psychological impact. A crucial factor that therefore emerges is the degree to which debriefing is designed to assist the organisational goals or to mitigate potential traumatic impact. The two goals may not be identical. The focus of the discussion below concerns the extent to

which an intervention aimed at allowing for emotional ventilation and expression is actually effective, both in terms of perceived helpfulness and longer-term harm.

Clinical issues in the debriefing debate

The clinical aspects of the evaluation of psychological debriefing focus around the claims that have been made that it serves:

> ... specifically to prevent or mitigate the development of post-traumatic stress among emergency services professions and other high-risk disciplines.
>
> Mitchell & Everly (1995c:79)

Mitchell's critics suggest that his claim that CISD is able to prevent PTSD is over-optimistic, and concerns have been raised that it may, in fact, cause iatrogenic harm. Certainly many of those adopting the model have been somewhat sweeping in their certainty (Hodgkinson & Stewart, 1991; Parkinson, 1993). This belief was expressed within social work and New Zealand organisational responses to critical incidents. Bell (1985) clearly linked CISD with the prevention of PTSD. A similar belief operated within the rationale to construct a critical incident response within the Department of Child, Youth and Family in Aotearoa New Zealand NZCYPS (undated).

Mitchell (1995b) and Mitchell and Everly (1996) have retorted by arguing that CISD was never designed as therapy for PTSD[45], but to serve as a preventive device, thus placing the argument into an ecological context outside of much of the EBP-based evaluation. Ambiguity abounds: in Robinson's handouts for Critical Incident training, she compares the terminology of trauma to that of critical incidents, suggesting that their difference is merely one of language. Robinson's text does not distinguish between critical incident and trauma situations and responses, and between cumulative and one-off incidents. A similar juxtaposition between critical incidents and traumatic events is used in the New Zealand literature, for example:

> A critical or traumatic incident is a time of crisis for one or more people.
>
> Stewart (2001:41)

Indeed, both terms are positioned together in the title of this thesis as a deliberate act of inclusiveness in recognition of the overlapping (and at times,

[45] Yet the title of a book in which he states this is substantially misleading in my opinion: *Critical Stress Debriefing: an operations manual for the prevention of traumatic stress among emergency services and disaster workers* (Mitchell & Everly 1996).

indistinct) boundaries between the experiences, and because of the overriding ethical responsibility that I believe an organisation has to respond to incidents affecting its workforce. It becomes problematic, however, when an intervention is specifically conceptualised and evaluated as a treatment (as opposed to prevention) for trauma, especially given the knowledge that some posttraumatic symptoms may take some time to emerge after an incident. This muddies the question of when a debriefing should be applied, to whom, and with what expected result. It also underemphasises the role of demobilisation and defusing processes.

Of crucial importance here is the issue of the power to define and name. Gordon (1998) comments that what we define as a critical incident, an emergency or a crisis will determine the likelihood that a debriefing process is implemented. What is a critical incident for some may be an everyday occurrence for others, a situation that reflects the complex relationship between stressor, person and environment. This point raises the question of whether any debriefing should be mandatory. Clearly, the severity of some situations may themselves suggest a response, but the literature on the impact of crisis and trauma clearly suggests that much of the impact is determined by internal and contextual resiliencies and vulnerabilities. Much of the impact of evaluations, then, appears to hinge upon whether the effectiveness is defined as stress relief and social reconnection, or if it has a direct intention to prevent or mitigate the traumatic impact.

Ormerod (2002) makes a distinction between the subjective perceived helpfulness of debriefing as a measure of effectiveness, and measures that reflect a reduction in traumatic symptoms. Several studies report that participants found the process helpful (Bisson et al, 1997; Robinson, Mitchell & Murdoch, 1995a; Rose et al, 1999). However from a trauma perspective, Brewin (2001) suggests that there is no evidence to suggest what exactly in the debriefing was helpful, or whether it was the debriefing or the simple contact that was perceived as helpful.

What cannot be overlooked, however, is the considerable research evidence that appears to raise concerns about the iatrogenic effects of debriefing, and in particular, the emotional ventilation. Key elements of this argument are based in the knowledge surrounding early indicators of the development of post-traumatic symptomatology, clarity or confusion over the distinction between acute stress reactions and traumatic stress, and about the viability or appropriateness of using ventilation and catharsis with those who may have

posttraumatic symptoms and who may become retraumatised through a re-living of the initial event.

Two assumptions underpin most debriefings; that treatment must focus on the event in order to work; and that emotionality must be openly expressed and worked through (Bowman, 1999). Active confrontation of events may not be appropriate or safe. A professional focus on event-exposure and emotionality has been reported as intrusive and aversive (McFarlane, 1990; Scott & Stradling, 1997). Our knowledge of coping skills suggests that problem focused intervention may be more effective. Charlton and Thompson's study (1996) of coping after psychological trauma suggests people have a wide range of coping responses but that only cognitive reframing and psychological distancing (specifically contrary to emotional venting and coping) tend to prove beneficial. Bisson et al (1997) question the wisdom of immediate intervention, suggesting that such early intrusion may effectively inhibit the distancing needed in the immediate aftermath of traumatic disruption. Other studies also suggest that the debriefing that they considered lead to poorer adaptation (Bryant, 1994; Carlier et al, 1998; Raphael et al, 1996). Gist, Lubin and Redburn (1998) similarly question this, suggesting that the helpful part of the process may be the social construction of the problem, and the selection of solution schemata, whilst emotional catharsis maybe negative. They suggest focusing instead on essential resiliency, informal and instrumental support, 'invisible' interventions and organisational and community responses.

Litz et al (2002) say that there is little evidence to support the continued use of psychological debriefing with individuals who experience severe trauma. They further propose that psychological first aid is an appropriate initial intervention but that it does not serve a therapeutic or preventive function. They advocate, instead, screening to pick out individuals who may have difficulty recovering on their own. Kenardy (2000) cautions against using these factors to write off the entire debriefing process. De Soir reinforces this concern, in regard to:

> ... the ignorance and/or arrogance of some of the world leading trauma specialists trying to stop practitioners [...] continue their early support or intervention activities, without providing a clear substitute or alternative.
>
> de Soir (2004)

It is often the case that these critiques are made from the perspective of immediate trauma assistance and tends to obscure the understanding of the long term processes of recovery, as explored within the stage processes described in Chapter Five (Herman, 1992a). Nevertheless, significant concerns

are raised by the evaluation of CISD and psychological debriefing and significantly placed within these are the confusions and inadequacies associated with the evaluation tools employed.

Towards a framework of evaluation

> ... the trauma experience is not just a medical issue needing quick cures but a complex journey of social, political, economic and spiritual dimensions which is not easily quantified.
>
> Capewell (2000)

The arguments revealed within the preceding discussion highlight the challenge of providing staff support systems within complex environments, and of establishing appropriate evaluation processes that can assure users and providers of these systems of their effectiveness and value. Methodological aspects of the debate reveal the clash of paradigms and an underestimation of the importance of an ecological approach to the management and evaluation of workplace incidents. The goal of this thesis, in unpacking the components of the impact of trauma and of responses to incidents, is the presentation of knowledge about what works in a manner that is communicable and robust. The challenge to evidence based practice is to construct outcome measurements that lie beyond the purely psychological goal of determining the level of traumatisation (upon which many of the studies described above have their focus) and which take on board the relational nature of the context in which incidents occur. This is a major challenge to the use of Randomised Controlled Trials (Everly, Flannery & Mitchell, 2000).

Capewell (2000) suggested that collaborative research methods may be more appropriate and that there are other outcome measures aside from the individual degree of psychological recovery. She advocates a research paradigm that creates useful knowledge relevant to the real situations in which we work. For me this is recognition of the need for the evidence base of psychological debriefing to be expanded to be able to measure the environmental, social and organisational contexts of critical incident intervention.

A reciprocal awareness can be called for amongst proponents of CISD and critical incident stress management programmes. During my review of the literature, it became apparent that the ethical and managerial commitment to the provision of staff support systems has retained a blindspot in its reluctance to heed the scientific evidence of the potentially damaging effects of some components or processes within debriefing. In particular, the potential of

retraumatisation, hyperarousal and obligation to cathartically express very recent emotional experiences appears to have a solid weight of argument behind it. Those advocating for debriefing services appear to have only slowly moved towards the establishment of, for example, best practice guidelines or frameworks of evaluation that can respond to the complexities of multi-component and transtheoretical models of support.

Synthesis and the development of guidelines

I have acknowledged Herndon previously within this chapter. He presented a paper at the ASTSS conference in 2002 in Auckland, at which he thoroughly reviewed the current research knowledge and debate over CISD (Herndon, 2002). Aside from the theoretical quality of his argument, I was impressed at the distance that he had travelled in order to add his voice to this debate. His comment to me was that to present criticism of CISD in the States would be heresy. This resonated with an observation that I had already made, that the adaptation and critique of the 'Mitchell model' of CISD and CISM occurred at the margins of the American world rather than audibly at its centre. As a development of this notion, I further observe that it is in Europe and Australasia that much of the discussion and publication about the development of best practice guidelines appears to occur. Through initiatives in Lincolnshire, the ESTSS and ACISA, we can chart the progress towards consensus over debriefing and its evaluation, this knowledge assisting in the comprehension of the experiences of participants in this thesis research, and in the construction of appropriate staff support systems.

The Lincolnshire Joint Emergency Services Initiative in Britain represents one of the key developments in the resolution of the debate over appropriate staff support systems. This combined emergency, health and social services, and had adopted the Mitchell model of CISD in 1989, with the assumption that early intervention and psychological debriefing should assist in the prevention of longer-term psychological problems (Avery & Ørner, 1998). Lincolnshire's CISD protocol was discontinued in 1997 due to doubts over the capacity of CISD to deliver these outcomes[46]. There was increasing concern over the threat of litigation for inappropriate treatment. Their concerns echoed the methodological and clinical issues in the discussion above, with findings similar to those of Bisson et al, 1997; Gersons, Carlier & Vrijlandt, 1997). Acknowledging the work of Bisson and Deahl (1994), and of Raphael, Meldrum

[46] Similarly, the Australian Defence Force, responding to the scientific research findings, ceased to use a CISM model of organisational response and developed a model termed Critical Incident Mental Health Support (CMS) which included principles of early intervention, screening and follow-up (Bennett, 2003).

and McFarlane (1995), they argue that factors other than the presence or absence of psychological debriefing in the recovery environment will determine the outcome for those exposed to traumatic events. Mobilisation of all staff into CISD was only warranted after major disasters and highly life threatening situations. As an alternative, they proposed flexible and targeted interventions in post incident response. They therefore moved away from crisis intervention theory for their staff support system toward a focus on evidence base publications about risk factors, risk assessment and a salutogenic perspective on human response to trauma, a move that appears to reflect a blend of positivist and ecologically aware factors. They did suggest that identification of need should come from a management level, which raises concerns about the assessment and triage skills of the managers, in their ability to separate operational and clinical judgements and issues, the acceptability of intervention by managers, and the location of the responsibility for mobilising support.

Lincolnshire's position is not so much a rejection of the Mitchell model but an acknowledgement that a group process such as a debriefing (with or without the cathartic or re-experiencing concerns that are raised in the trauma literature) may only be appropriate under some conditions. Avery et al (1999) stress the importance of the recovery environment, an ecologically sound principle that goes some way to address the concerns that the removal of any intervention will follow the abandonment of CISD processes (de Soir, 2004). They also acknowledge the importance of intermediate and long-term support because of the way that traumatic features emerge over time.

A consensus development process then took place across Europe and Australasia. A Dutch conference on debriefing in 1999 reported immediately afterwards at the ESTSS conference in Istanbul (Working Group, 1999). Out of the fifteen organisations represented that used debriefing, seven used the Mitchell model and eight had developed other models. Similar problems of defining debriefing were noted, calling it a container concept that describes a multitude of possible interventions. They make the point often missed in the research studies critical of debriefing, that it should not be a single intervention but a series of three or four structured in time and monitoring coping and integration of the effects of the incident. The Dutch group also address the key issue of catharsis and ventilation, advising a restriction on the level of emotional expression immediately after an incident. They suggest a beginning emphasis on practical support and empathy, the primary object of intervention being regaining control, with information and education being gradually introduced. They recommend exploration of personal experience after four to six weeks. The Working Group recommended that more research should be

directed at the benefits of group or individual responses. As a result of this debate ESTSS then went on in September 1998 to hold a series of regional conferences, consulting practitioners and researchers on psychological debriefing and early interventions, one of which (through Ørner's facilitation) was the ACISA Glenelg Declaration, a document emerging out of the Australasian conference in September 1999 (ACISA, 2000). I was a part of developing these guidelines, and utilise their content within this thesis as a reference point within my discussion of findings.

The Glenelg Declaration is underpinned by a belief that early intervention is a core element in comprehensive service provision, and like previous commentaries, it acknowledges the call for evidence-based practice. It comments on the discrepancies between outcomes once presumed to be achievable (citing, for instance, Mitchell (1983) and those outcomes that can reliably be delivered (Rose & Bisson, 1998). A strength of the declaration is its integration with other research and best practice perspectives, such as the treatment guidelines for PTSD (Foa, Keane & Friedman 2000). However, the declaration acknowledges that the guidelines should be dynamic and should be developed in line with available information. They make several key statements of principle that reflect some of the latest thinking.

One key principle is that any intervention should not be viewed as an isolated act but part of a systematic and staged process that cannot necessarily be defined chronologically. Underpinning any intervention should be practical action taken to ensure the safety, security and physical needs of all individuals concerned. Only once these have been addressed should psychological crisis support be implemented for victim groups and populations at risk. In the first instance, intervention should be aimed at containing or reducing the arousal state as well as the behavioural, cognitive and emotional reactions associated with it, with a focus on developing an enhanced sense of personal and situational control. It gives examples of good practice such as calming down, non-verbal support, shielding from media, organisation of transport, early reunification with family or close friends, provision of food, drink, and shelter from heat.

The Glenelg guidelines emphasise that communication between managers and providers of support services are essential parts of defining an incident as critical or traumatic. It comments that whilst Criterion A of DSM-IV offers a useful guide, this may not apply to some people because of the nature of their role, suggesting for example that some symptoms may develop later once someone is out of role. On a pragmatic basis, it acknowledges that in a crisis,

emotional or psychological first aid may be provided by front line staff, whose training will of needs require them to accept and tolerate high levels of distress in victims, survivors and bystanders. Second line people also have a role in providing crisis support and may also have to tolerate and accept high levels of distress. This indicates that these providers will need to be part of a system of support and supervision for themselves.

Locating any intervention within a system is stressed, with the suggestion that operational reviews should take place after every major incident, and listing major learning points and making recommendations for effecting improved services in future. Support strategies for victims of trauma or critical incidents as well as those put in place for emergency responder groups should be pre-planned and integrated within major incident response protocols, and should be tested through training and exercises. This sits well with a strengths perspective that looks at systemic support and proactive planning.

The last significant review of psychological debriefing of which I am aware is again one originating from a European perspective, that of the report from the British Psychological Society (Professional Practice Board Working Party, 2002). This contains comprehensive contributions from many of the key British researchers in the field, several of whom I have referred to previously. Like other research summaries and guidelines before it, it endorses the wisdom and efficacy of early intervention, and locates debriefing procedures amongst formal narrative approaches compatible with many cultural approaches to crisis and trauma. Similarly, it acknowledges the difficulty in researching an intervention that has many faces, and stresses that it should be located within a systemic approach to crisis management and post trauma care. It suggests that real world conditions do not allow for the strictly quantitative scientific methodologies of a laboratory setting, and suggests that the inclusion of qualitative research is to be considered.

Conclusion

An ecological perspective argues that recovery for a person experiencing extreme stress or trauma will have a complex contextual relationship with the antecedents of an incident, and with the environment in which it occurs and in which the person continues to function. This review of the debriefing debate has argued that interventions and evaluations that separate the person from their environment, or which focus exclusively on the ontological or body and mind elements of a person's identity may overlook the pathogenic or salutogenic effects of the environment. Similarly, processes that are endorsed

because of political or professional agendas but which do not address the clinical implications of their components may stumble in their search for credibility. Evidence based practice that relies upon evaluation of single event interventions is likely to give false or inaccurate assessments of the effectiveness of the support process, whilst some of the evaluations provide cautionary advice about the content of support systems. Best practice guidelines reflect a synthesis of current knowledge, utilising positivist, systemic and narrative knowledge bases.

The attention of the thesis now focuses upon its own research. It is hypothesised that by accessing the narratives of twenty mental health workers with experience of critical incidents and traumatic events, key principles will emerge that, when combined with the literature already explored, will contribute to the understanding of impact and recovery processes, and to the development of a framework for ecological intervention for critical incidents and traumatic events in the mental health workplace.

Chapter Seven: Methodology

Illumination, understanding and extrapolation

This chapter outlines the methodology that shapes this research. As a qualitative study based upon interviews with twenty mental health workers, this thesis is designed to link the experiences of critical incidents and traumatic events in the workplace with a view to establishing core principles for effective staff support systems. It is written on the premise that qualitative investigations offer interpretative opportunity, the emphasis being on:

> ... illumination, understanding, and extrapolation rather than the causal determination, prediction and generalisation.
>
> Patton (1990:424)

The rationale for the choice of methodology is first explored through investigation of the impact of an ecological approach on research, and subsequently through the learning derived from an understanding of trauma and the debates over psychological debriefing. The imperatives of a qualitative approach are then considered, along with description of the research methods employed.

The 'Scholarship of Integration': imperatives of the ecological perspective

Kuhn (1970) suggests that paradigms are the fundamental points of view in a search for meaning. Denzin and Lincoln (1994) suggest that the paradigm will shape the epistemology, the ontology and the methodology of research. Through defining epistemology, we consider how we know the world, what we can know of it, and the important question of the relationship between the researcher and the researched. Through the shape of the ontological inquiry, we consider questions about the nature and form of reality, thus introducing structural and systemic dimensions. Selection of a research paradigm influences ethical issues for research (Raftery, 1997b).

Buchanon's (1994) distinction between the Aristotelian notion of *theoria* and *praxis* lends understanding to the decision-making associated with the use of knowledge from differing paradigms. He defines *theoria* as a conceptualisation of theory based on natural processes, based on the tenets of logical positivism. He argues that this model, utilising experimental and hypothesis-testing

research, produces theories that are inadequate and inappropriate for understanding human behaviour, and suggests for this, the *praxis* model of theory is best suited. Here knowledge is contingent and contextual, and findings do not necessarily conform to the positivist requirements of testability and generalisability. This suggests that the universal laws of science do not apply to the development of wisdom from human interactions and behaviour: the Freirian development of *praxis* and action research suggesting that the 'doing' of the thesis - the reading, researching and writing - contributes to the learning, that the theory and practice are intertwined (Freire, 1972). Having a praxis orientation, as Ife (2001) suggests, does not separate out education and practice, or practice and research. The dialogical nature of the praxis creates knowledge out of the doing, out of the communication between partners in the research enterprise (MacGibbon, 2003; Mouthner & Doucet, 1998).

This process of praxis is explored by Boyer (1990, in Blampied, 2000), where he makes a distinction between the scholarship of discovery (the new knowledge gained by pure research), and the scholarships of integration, application and teaching. He refers to 'Scholarship of Integration' as the interpretation and interconnection of knowledge, the incorporation of interdisciplinary processes and new methodologies expressed through theory and what he terms 'intellectual patterns'. I see the theoretical and methodological approach of this thesis very much in terms of the exploration of intellectual patterns within complex situations. It is a sense-making process that uses a historical understanding of intellectual thought to assist in making sense of contextually located events, both through research literature from a variety of theoretical traditions, and from the narratives of those in the field. In addition it uses the Scholarship of Application and Engagement to describe the process of relating this knowledge in an intellectually rigorous manner in order to contribute to the understanding of individual and social problems and their resolution. One of the results of the writing of this thesis is an enhanced ability to engage in the Scholarship of Teaching, to construct and deliver informed knowledge to communities of interests and to practitioners-in-training. Many of these latter forms of applied scholarship are therefore about not only the comprehension of knowledge but about its transmission and relevance to different groups. The transtheoretical and multiparadigmatic approach exemplified by an ecological framework is therefore of considerable advantage to a contexualised study such as the experience of incidents within particular environments.

Chapter Two presented the logic for the employment of an ecological approach that negotiates these epistemological and ontological tensions. In acknowledging that within the social sciences there is the possibility for more

than one paradigm to be in existence and in use at any one time, I argued that an interactive dialogue between paradigms is essential in order to create a rounded and grounded understanding of the dimensions of the inquiry. Such a dialogue has been achieved by adopting a historical understanding of the intellectual genealogy of knowledge, and by using ecological frameworks such as *Te Whare Tapa Wha* and the ecological perspective developed initially by Bronfenbrenner (1977 & 1979).

Rather than seeing the tensions between perspectives as evidence of the need for establishing which knowledge is superior (the 'either/or position'), the existence of multiple perspectives is a clear indicator and rationale for a qualitative investigation of the research question, as there is an intrinsic recognition of the validity of differing perspectives of human experience (the 'both/and' position). There is a requirement that the research question should be able to move between knowledge bases and paradigms, rather than working exclusively within one perspective. Denzin and Lincoln (1994) argue that qualitative researchers think historically, interactionally and structurally, echoing the autopoietical notions of structure, relationship, identity and change. There is a path of discovery to be followed, and research can be viewed as an aggregation of knowledge from different perspectives and paradigms, and from different theory and practice environments.

In addition to the perspectives gained from theoretical paradigms, there is another partner in this research that demands consideration. The focal point of the research inquiry is the experience of critical incidents and traumatic events by mental health workers, and the emergent options regarding planning for, and management, of these significant personal and organisational events. The nature of extreme stress and trauma, and the contexts in which these incidents occur, all provide structures, patterns and unique characteristics that influence and determine the shape of the inquiry.

Chapter Four raised issues of complexity in the classification of trauma, and Chapter Five outlined its contextualised impact. This appreciation of complexity in the study suggests that at times there may be a disjuncture between the grand theories that contribute to our knowledge base and the local contexts in which the events occur. This shared social world of meaning, as Buchanon (1994) suggests, places the study of trauma and stress at the complex interface between positivist knowledge and theories and the realms of language and meaning that have such a powerful mediating effect on the human experience. The conflicts within the debriefing debate are further symptomatic of the dynamics of paradigm shifts. Our understanding of the trauma and

stress literature clearly demonstrates the environmentally sensitive nature of recovery yet the review of debriefing suggests that much of its evaluation has problematically conceptualised it as a single phase, one-off intervention. Generated from these concerns, the hypothesised uniqueness and complexity of experience underpins the choice of research methodology and is debated within the realms of social, cultural and political dimensions: it is to issues of the relational, ethical and political drivers of methodological choice that attention now turns.

The value and contribution of qualitative methodology

> Not everything that counts can be counted, not everything that can be counted, counts.
>
> Albert Einstein, in McKee (2004:153)

The management of knowledge from differing traditions becomes a prime imperative when regarding the impact of critical incidents, and it is argued that a qualitative approach addresses this imperative best. One of the parties in this research is the literature itself, and its content spans and utilises knowledge from a range of intellectual traditions. Some of the knowledge contained within the literature review is representative of the deductive practices of bio-medical science: for instance, the neurobiological investigation into brain function, and the privileging of meta-analyses and randomised controlled trials in evidence based practice. The historical analysis embedded within the conceptual reviews of mental health classification and trauma charts the influence of positivist, systems and constructivist traditions, and through this, sets up a methodological position that must span both the deductive and inductive perspectives current within research inquiry (Graue & Walsh, 1998; Rubin & Babbie, 1997). The theory-to-practice concept of a Strengths and resilience perspective, identified and discussed in Chapters Two and Five, suggests that there is value in a methodological approach that permits the quality of a person's complex experience to emerge within an inquiry (Olsson et al, 2003; Ungar, 2003). The overarching methodological goal of the thesis is to hold up both the knowledge from the literature and the unique experiences of a group of mental health workers, and to see how knowledge about the impact of, and recovery from, critical incidents can be enhanced by both. This emphasis on the *quality* of the exchange locates the research within qualitative methodology, whilst utilising the strengths of both deductive and inductive reasoning.

There is at times an artificial divide between inductive and deductive methodologies, a tension that creates the methodological and clinical debates as exemplified in the previous chapter. The political and intellectual dominance of

methodologies that appear to favour the deductive approach of biomedical science may lead to research that uses solely inductive methodology having difficulty in becoming visible, gaining recognition, and receiving credibility (McKinlay, Plumridge & Daley, 1999). The National Institute of Mental Health (1998) in the United States observes that this may result in the tendency to exclude qualitative methods that illustrate behavioural or ecological processes that will rely on interpretation. Nonetheless, others counter that science itself is not value-free and that subjectivity is not only inevitable but necessary (Berger & Luckmann, 1971; McLellan, 1995; Reynolds, 1998; Schwandt, 1994). The imperative becomes more a question of openness, transparency and debate - putting the material 'out there', on show, to be viewed from as many perspectives as possible - rather than arriving at definitive conclusions based on hard facts. The testability, reliability and trustworthiness of the data, the thesis conclusions and recommendations, stand or fall on the theoretical and experiential robustness of the arguments, and the degree of resonance that is struck with the audience.

Because qualitative methods are best suited to addressing research issues involving complex social relationships, the choice of method inevitably has political and ethical consequences. The imperatives arising for this thesis are: the location of the self in relation to the research and its participants; the political dimension of giving voice; and the requirement for integrity and ethical research practice.

Self and others: relational and ethical imperatives of qualitative research

A holistic paradigm and a qualitative approach recognise and legitimate the active roles of people within social science research. These manifest as an active recognition of the self of the researcher, and the contribution of the voice of the individual participant to the collective understanding of the phenomena under scrutiny.

Qualitative methodology critiques the 'invisible authorship', as Krieger (1983 & 1991) describes a hidden research self that may be maintained under a positivist assumption of objectivity. This produces a state of denial about the mediating influence of the researcher's own experience, culture and training (Fook, 1996; Oakley, 1993; Stevens, 1993; Swigonowski, 1994). Instead of seeing the self as a contaminant of data, the self is a powerful tool if made explicit. Denzin and Lincoln (1994) argue that 'qualitative researchers draw upon their own experiences as a resource in their inquiries' (p199). Ultimately, as Stanley and Wise (1990) argue, the work is that of the researcher, who structures it for their

own purpose, interpretation and evaluation. They talk about utilising the intellectual autobiography of the researcher, and relationship between the researcher and the researched. As illustrated by the introductory stories in Chapters One and Two, my own experiences add a powerful motivation, and provide strong metaphors to guide the process and transparency of my research.

Since the self and interpretations of the researcher cannot be avoided, the self becomes the central organising mechanism in an inquiry (Krieger, 1991). Guba and Lincoln (1994) comment that the voice of the researcher within a constructivist perspective is as a passionate participant who facilitates a multi-voice reconstruction in order to make sense out of experience. Through recognition of an interpretation role, the methodology endorses such methods as the semi-structured interview design of this thesis study, which provides creative space for the development of dialogue and the unique experience of the individual, and for the transtheoretical analysis of the data that enables connections between ideas to be made.

Ethical imperatives emerge out of this relational construct. Through the acknowledgement of the voices of the participants comes an imperative to establish codes of practice for relationships between the researcher, the researched and the analysis of any data collected. Relational theory offers a significant contribution, focusing on the use of narrative and interaction to bring about systemic and structural change within an environment. It offers a unifying methodology that is ecological in nature (Fletcher, 1999).

Similarly, this research project has gained significant knowledge through exposure and participation in debates concerning the use and applicability of indigenous methodologies and post-colonial theory. Within the context of this country, this can be viewed as the most influential metaphor that challenges an individualist approach to communication and to research. My own social work practice and teaching involves familiarity with, and interpretation and use of, frameworks such as *Te Whare Tapa* Wha, as evidenced by Chapter Five. Informed by constructions of critical theory as well as by my own interpretation of Maori research writing (for instance, Irwin (1994) and Smith, 1999), there is always the recognition of my location in what is a very political process. Reading indigenous research methodology for my own research practice has provided insight in regard to colonisation, post-colonial and self-determination dialogues (Smith, 1999). The power imbalances inherent in my own identity, the bi- and multi-cultural identity of the participants in the

research, and in the wider (largely monocultural) environment of the organisations is important.

Indigenous perspectives on research itself have taught me much about the approach that I needed to take in initiating and maintaining relationships with participants and their employing agencies (Teariki & Spoonley, 1992). Kiro (2000) comments that the reliance on relationships is crucial to Maori research, especially in the social services. Irwin (1994) uses Salmond's phrase of 'the ritual of first encounter' to highlight the challenging nature of negotiated entry into people's space and knowledge (p25). Afterall, as Hough (1996) comments, the research begins when the door knocking at agencies commences, with interpretation and explanation of evidence also being contested territory.

Throughout the construction of the thesis, I have been intrigued by the debates concerning whether research by Pakeha should include Maori participants. There are clearly issues of concern where one cultural group imposes research methodologies and perspectives in the course of studying the 'other'. Where a range of settings and participants represent a mix of cultures, however, the issues are less clear-cut. This research project could have avoided any mental health workers who identified as Maori, but this pathway was not chosen. My inclusion of Maori workers within the respondent group was made after deliberation about the risks of either 'white washing' tangata whenua concerns, of individualising the particular concerns that they had as Maori workers, and in consideration of the risks of breaking anonymity due to the relatively small numbers of Maori workers within the area in which the study was conducted. My inclusion of reference to tangata whenua scholarship and my comprehension of this is a desire to continue to make sense of all relevant traditions of knowledge and interpretation, within transparency produced by my own declared intellectual and cultural autobiography. The practice principle that I have followed here is governed by a desire for dialogue amongst ideas and experiences, and especially by a degree of humility, within which context any mistakes can be interpreted.

Giving voice: the political imperative of testimony

> Academic debate is... much nastier than it might be if only intellectual disagreements were involved.
>
> Rein (1979), in Finch (1986:210)

Investigating the area of trauma, critical incidents and personal experience is both a personal and political act. As a relational approach, qualitative method becomes inherently political as it struggles with the balancing act between the

importance of personal experience and the development of consensus, which may contribute as much to the suppression of individual difference as to empowering the collective.

Both feminism and traumatology talk about silence and exclusion. Stanley and Wise (1990), for instance, maintain that the researcher cannot be in the position of expert, a stand that strongly resonates with the voices of trauma survivors. Trauma, like the social processes of sexism and gender oppression, has the power to disenfranchise and remove those experiencing its impact from the mainstream of human existence. Its power to exploit and damage should not add to this exploitation by imposing a framework or ideas that are alien to the experience of the respondent and which retraumatise. The way forward seems to be that research methodology should ensure that there is adequate space for the specific views of individuals to be expressed through language prior to any attempts at consensus (Finch, 1984a; Holstein & Gubrium, 1994; Janoff-Bulman, 1992).

Furthermore, the political significance of giving voice to the invisible is a process of change, and a challenge to organisational processes that attempt to determine reality within the workplace (Freire, 1972; Guba & Lincoln, 1994; Punch, 1994). Reflexive research therefore has a transformative agenda that enables us, like Eliot says, in reframing the meaning of experience:

> We shall not cease from exploration
> And the end of all our exploring
> Will be to arrive where we started
> And know the place for the first time.
>
> *Little Gidding*, Eliot (1970:222)

My political agenda should therefore be transparent (Kincheloe & McLaren, 1994). My personal experience provided a political imperative not only to listen to and comprehend the voices of workers but also to use these to make change within organisational systems (Finch, 1986). This is intended as emancipatory research in which participants have a voice and a desired outcome (Oliver 1990; 1992). Here, the researcher is seen not as expert but as a catalyst for change. Smith (1991) talks in terms of critical theory being an appropriate research strategy both in methodology and epistemology because it accepts the basic questions of who has the power to define the research problem, for whom is the research of value, to whom is the researcher accountable, and who gains from it. It follows, for a methodological approach, that research from a critical position must expose the tensions and potential conflicts between interests and power groups, and extend the outcomes of the research into a sense of

movement for those concerned (Pihama, 1993). Structural and systemic change within organisations is therefore implicitly embedded within the thesis process, as participants link their experience of incidents with issues of organisational functioning, resourcing, professional identity and service delivery (Cox, 1987; Hart & Warren, 1997), and as principles for support are developed.

Attention now turns to the ethical responsibilities inherent within this transformational agenda.

Trauma tourism: the ethics of researching trauma

> Now, this honeymoon is complicated enough without your dragging medical ethics into it.
>
> Gregory Peck, as John Ballantine, in *Spellbound*[47] Hitchcock (1945)

There is something potentially voyeuristic about research in the area of trauma. Simply put, the 'push me-pull you', simultaneously attractive and repugnant processes of the extremes of human experience, can engage our attention for a variety of genuine but perhaps not appropriately located reasons. Raftery (1997b) makes a comparison with the interest that the media has in trauma. Research 'on' or 'with' survivors is imbued with sensitivities and vulnerabilities not present to such a degree in all research processes.

Van der Kolk and Fisler (1995) argue that the very nature of trauma rules out many of the standard tools of scientific investigation located within the laboratory setting. Research opportunities, therefore may rely more on retrospective accounts and post-event observation and, in relation to debriefing, several researchers raising ethical concerns about the processes of evidence based research (Capewell, 2000; Creamer, 1997; Ormerod, 2002). Nevertheless, research is important in trauma work, as the discussion in Chapter Six suggests. It is important to public administration, health policy, clinical practice, supervision and staff development (NIMH, 2001).

Arguing that the starting place for trauma research is to identify one's theoretical paradigm, Raftery (1997b) maintains that research needs to be 'personological' rather than logical positivist in its character, a standpoint that tacitly acknowledges that the researcher is entering and interpreting the world of the participant. Fully informed consent and assurances of privacy and confidentiality flow from this (Punch, 1994). Establishing the integrity of the

[47] This film was my first introduction, as a 10 year old, to the notion of posttraumatic effect. Peck plays a witness to a murder, whose memory is alternatively suppressed and evoked by triggers reminiscent of the murder scene.

researcher appears to be of prime importance; voyeurism or unnecessary involvement will damage recovery processes, skew the researcher-participant relationship and open up the risk of becoming too close to the subject matter to appreciate patterns and trends and the bigger picture.

Safeguards against abuse of this opportunity then take the form of clarity in the research methodology and process, under an umbrella of an observed ethical code as signalled in the previous discussion concerning the relational imperatives of research. Raftery's (1997b) article preceded a specific ethical code for work within trauma. Several trauma-related articles, for instance, Eth (1992), Green (1995) and NIMH (2001), acknowledged ethical issues, principles of which developed in the subsequently produced ASTSS Code of Ethics. In particular, the NIMH guidelines (2001) suggest some broad approaches to research concerning recent traumatic incidents that illustrate the relational and systemic nature of trauma support.

The ASTSS Code of Ethics includes within it various points of relevance to the methodology of research. It acknowledges the particular vulnerability of traumatised people, the need to have informed research goals, the need for informed consent and collaboration processes, confidentiality, and an emphasis on the skills and limitations of the therapist/researcher. It also acknowledges the fast-moving nature of the traumatology field, stressing the evolutionary nature of the ethics of research and intervention and the need for collaboration and networking.

Acknowledgement of the role of the researcher's own self and experience, and the dynamic nature of the research process coalesces in trauma research with an acute awareness of the risks of self-disclosure and retraumatisation. These are ethical issues that are shared with the process of therapeutic relationships (Barrett & Berman, 2001). Whilst research is not directly therapeutic in purpose, it certainly sets out not to be counter-therapeutic, and in an area such as extreme stress and trauma, neutrality and zero change in perspective may be less of a goal than the joint construction of a slightly changed perspective on a situation. Constructivism and narrative therapy, after all, teach us the power of testimony in the change process. The common element between research interviewing and therapy is in the power that communication has to elicit information and a dynamic sense of exploration.

One of the questions that Raftery (1997b) raises is about the potential for retraumatisation of participants by the re-evoking of traumatic memory. Conducting the inquiry, therefore, requires sensitivity to the needs of the safety

and health of participants. Interviews for this thesis were preceded by the acquisition of a good grasp and awareness of trauma theory, knowledge of the nature of the support systems within the participants' organisations and the alert within the Information Sheet (Appendix 7) to the possibility of the evocation of emotional and physical responses to the material.

There is a small amount of literature that explores the risks of retraumatisation inherent in trauma research (Martin, Morris & Romans, 1998; Walker et al, 1997). Neither of these studies found substantial revictimisation and indeed noted the integrative benefits of a therapeutically-informed interview. Raised levels of intrusion, in themselves, may not be harmful, of course, but may suggest the growth of better coping strategies. Addressing the intrusive memories in a contained and positive environment may be part of the construction of a meaningful narrative that places the original experience in the past and not frighteningly within the present. The issue for the researcher and the researched, in partnership, then becomes not *whether* intrusive memories re-occur, but *how* they are dealt with. Involvement in a research process may be part of a coping strategy, on both personal and political levels.

I was buoyed by the reports of research with trauma survivors that I encountered. Martin et al (1998) reported that six years after interviews, the majority of their survivors of sexual abuse had found the interview positive, with only a small number suggesting that the interview had re-awakened memories that had a negative consequence. Walker et al (1997), in a survey of women survivors of physical and sexual abuse, and neglect, found a similar positive outcome, with a small number of women suggesting that they became more upset than they had anticipated. The majority said that they would have persisted with the survey even if they had known in advance how they would feel. This gives strength to the resilience of trauma survivors, and places a lot of importance on the ongoing construction of a meaningful narrative as a means to healing. It highlights that the quality of any investigation - its empathy, sensitivity and systemic supports - are crucial. No research related to the complex juxtaposition of traumatic and high stress situations was located, reflective, I believe, of the decontextualising perspective that continues to dominate trauma research

Transference and counter-transference issues have to be faced in interviews of this sort. The ethics of interviewing survivors is similar to the ethics of therapy in this respect: safeguards and support processes need to be in place in case of secondary traumatisation. This highlights the need for the interviewer to have some level of therapeutic skill to detect whether a participant is indicating that

they are responding as a participant in the past critical incident rather than as an interviewee.

Having established the intellectual pattern of the inquiry, attention now turns to the means by which it was carried out. The following sections address the means by which the methodological issues within this chapter became transformed into the method of inquiry utilised for this research. There are two key areas for consideration: the selection and implementation of appropriate method, and the ethical issues arising from the research process.

Selection and implementation of method

Whilst an awareness of context and the dynamic nature of the research process underscore the acceptance that in qualitative methodology there is no strict research template, certain broad traditions of inquiry were observed and explored. As Patton (1990) observes, these mediate with real world conditions to determine the actual flow of the inquiry.

> Purposes, strategies and trade-offs - these themes go together... there are no perfect research designs. There are always trade-offs. These trade-offs are necessitated by limited resources, limited time, and limits on the human ability to grasp the complex nature of social reality.
>
> Patton (1990:162)

Key processes that served to mediate this research design are now addressed, being triangulation; supervision; interviewing and focus groups; and data collection and analysis. The key principle that permeates them all is that of integrity.

Triangulation: the negotiation of reality

Where a methodology is informed by a desire to capture a range of unique experiences, there is value placed on the individual viewpoint and on the dynamics that result from the juxtaposition of ideas and narratives. The relationships within this material are often governed by what is termed a 'triangulation' process that serves to develop the intellectual rigor of the argument. The term *triangulation* is another example of the adaptation of a 'hard sciences' term within health and social sciences. It uses the analogies of surveying and navigation, and the technique of gaining different bearings in order to give an accurate position. Often used as an authentication of qualitative methods up against the scientific rigor of quantification, I employ a slightly different interpretation in its use for this thesis. Instead of having the goal of accuracy, as data may be aggregated within the physical sciences,

triangulation within a qualitative research method has a goal of illumination, using material from different sources to shed light from different perspectives, and thus to consolidate the data.

Connolly's definition of triangulation describes:

> ... the practice of combining or mixing methods with the aim of cross-checking information and interpretation, and thereby improving the accuracy and validity of the conclusions.
>
> Connolly (2002:28)

This definition suggests aspects of quantitative analysis, and thus a dialogue between paradigms, Connolly also suggesting that mixing method can capture a more complete and holistic portrayal of a research topic. For this study, a limited range of methods were employed under a broad qualitative umbrella. The data from participants was obtained from semi-structured interviews, with focus group discussion further illuminating and engaging with the theoretical foundations of the thesis. The literature, however, attempts to integrate knowledge from a broad range of theoretical influences, and it is hoped that the resulting dialogue serves to honour Connolly's definition.

For a methodological exploration of triangulation I have found Denzin's (1989) analysis to be particularly useful. He argues that consensus over research findings will never be reached. Each and every method comes from a different point of reality and a single interpretation cannot be made. Triangulation according to Denzin is an attempt to rise above personal biases and to 'negotiate reality' through dialogue between different perspectives or voices. He makes a distinction between triangulation of data; of theory; of investigator, and of method.

Within the notion of data triangulation, he identifies variables of person, space and of time. Clearly, this study utilises the perspectives of different individual participants, in different settings, with different professional and training backgrounds. Workers were interviewed across different sites, agencies and employers. I chose this stance in order to gain a more representative sample of participants, and a greater breadth and depth to my understanding of experience. Whilst there is no expectation of a quantitatively even spread across all agency settings, my choice of community and institutional environments, District Health Board and non-government agencies and so on, was designed to optimise the variability of their experience. Whilst all interviews were conducted over a six-month period, the subject matter of the interviews related

to incidents and experiences that were historical; weeks, months and years of experience contributed to the stories told.

A cautionary note can be sounded in terms of what Denzin (1989) terms 'aggregate analysis', the interviewing of individuals without links to each other and the resulting aggregation of data according to the researcher's own perspectives. This may have been overcome by an interactive process between the individual participants, such as a focus group. A decision to limit focus groups to the discussion of the theoretical rather than experiential aspects of the research inquiry was determined by the nature of the subject matter in the data; it did not seem appropriate to ask survivors of separate incidents to meet together to pool experiences. Concern over the aggregation of data is hopefully addressed by the presence of the participants' voices and the transparency of the subsequent discussion.

Theoretical triangulation is a fascinating process. Denzin (1989) suggests some rules for its implementation. A comprehensive list of all possible interpretations in a given area is constructed. This will involve bringing a variety of theoretical perspectives to bear upon the phenomena at hand, a process which is particularly relevant to the transtheoretical nature of this research question. Those interpretations that map or make sense of the material are then assembled into an interpretive framework that addresses all of the data gathered. This can then provide the basis for the reformulation of both the data and the initial hypotheses and theoretical frameworks. This process appeals to me because of its dynamic and interactive potential. It seems honest, as the researcher cannot present from just one perspective and ignore the contradictions. It can therefore help to develop theory by thinking in terms of a theoretical synthesis. In a sense, this entire inquiry is an attempt to create an intellectually and experientially sound model of theoretical triangulation, by means of the juxtaposition and interaction of theoretical perspectives within an ecological framework. In a quantum sense, the research can utilise a 'both/and' rather than an 'either/or' approach to the adoption of theory. There is a danger, of course, of blind eclecticism in an uninformed use of any available theory (or no clear theory at all), a risk hopefully overcome by clear enunciation of the relationship between theoretical perspectives.

The structure of the research ruled out Denzin's category of 'investigator triangulation'. This research has a doctorate structure within a social science framework, where collaboration with other researchers within the project is neither required nor expected; however, the literature utilised within this thesis

is the result of investigation by others, albeit synthesised through my own understanding.

Whilst this thesis uses the method of the interview as the prime data collection tool, it does so in relationship to the considerable theoretical investigation and debate that is reflected within Chapters Two to Six. In a very real sense, the research method is a reflection of a partnership between theoretical diversity expressed within an ecological framework, and the data diversity as expressed by the twenty participants. It has provided a rich source of material with which to construct the thesis.

Supervision

During the different stages of the thesis process, I became acutely aware of the nature of supervision and its own characteristics of triangulation. I acquired four supervisors, and parted with two. Perception of the supervising role of the supervisor changed as did my needs. Potential complications were navigated, as both my final supervisors were also sequentially my line managers. This two-hatted approach is not the ideal: without the implicit and well-tested trust that I had in them as people, there were potential minefields of conflicts of interest. The supervision process had to have the moral and personal integrity of trust.

Not only did I have to trust my supervisors, but also they had to have a measure of trust in the autonomy of my ideas and process. Neither had expert knowledge in traumatic stress, although both were experienced social work practitioners with extensive research careers. In a very post-modern sense, they let me run with the ideas and processes that I developed, providing a contact with reality when necessary. This, too, mirrored the approach with the respondents, ownership of content and process having to rest with the person generating the material.

I initially read Irwin's (1994) description of her supervision whanau with a degree of envy. From the integrity and imperatives of her own culture, she sought out kaumatua and academics to guide and support her process. My own experience appears to be more fragmented, though it builds to a supportive whole over time. Academic mentoring and supervision came from the University-appointed supervisors. From the professional community to which I belong came a sense of confirmation and inspiration, as I saw other people struggling with the epistemological and practical tensions involved in the fields of traumatology and workplace stress. In this arena I got the sense of being an equal, of partnership. This emerged, too, out of some of the

interviews, ones where the participant had developed their own distance from, and sense of comprehension of, their experience. This was a different sort of supervision, less formal and certainly unrecognised by the doctoral process, except in the setting of the focus groups. This was the closest experience of a community that I obtained from the research. For me, then, the community of interest spoke my own language.

For the most part, however, this community was not one that spoke the language of social work, and my supervisors did not speak the language of trauma. The supervisory component of this community (clinical knowledge and debate, for the most part) was delivered by psychologists, psychotherapists and an occasional psychiatrist. Given my own professional perspective, even this relationship of equity came with the need to negotiate meaning and to accept differences of perspective, again a key tenet of the interviewing relationship.

The social work community and I had a different relationship from that which I had with my University supervisors, the focus groups and the clinical community. Here I found myself far more clearly in the role as teacher (Blampied, 2000), and because of my promotion of a social work perspective in issues of critical incident stress management and vicarious traumatisation, I often found that I was encouraged and invited into agencies and given the (somewhat undeserved) role of expert. A lot of learning came from this. I learnt again, as I have done every year as a lecturer, that we learn more than we can ever teach, that it is a mutual process of sense-making. In a very keen sense, those with whom I was engaged in teaching and delivering debriefing were also my supervisors and they have contributed to the development of my ideas and the construction of the interview process itself.

Interviews and focus groups

> Interviewing is rather like marriage: everybody knows what it is, an awful lot of people do it, and yet behind each closed front door there is a world of secrets.
>
> Oakley (1981:31)

The next issue within the selection of method is that of the choice of interviews and focus groups as a means of data collection. The ecological imperative to examining the experience of people within their context provided the theoretical rationale for the choice of interviewing as the prime method for data gathering. Accounts of individual experience and perspective provide the richness that honours personal narrative and interpretation, and avoids the sense of objectification that formal surveys or questionnaires may have

provided (Oakley, 1981). Furthermore, a face-to-face interview honours feminist, Strengths and indigenous perspectives that pay respect to the knowledge held by the respondent, and allows for an important exchange to take part between researcher and researched (Finch, 1984b; Rapp, 1993; Teariki & Spoonley, 1992). Higham (2001) observes that this interactive approach allows for the possibility of dialogue and empowerment over what in research may be potentially a previously silenced subject.

The interviewer becomes an active participant; having initiated the research endeavour, they then participate in the interview process. The interpersonal nature of an interview brings into sharp relief the issues of interviewer identity and characteristics, relationship and process. Prior to interview, a pattern of questions was developed, based upon the research questions (Appendix 9) and literature. The pattern followed the ecological rationale of establishing connection, putting people at ease in the situation, and gaining a sense of context and identity prior to addressing the uniqueness of their critical incident experience. This pattern therefore conforms to the descriptions of semi-structured interviews (Patton, 1990), allowing for research integrity to be maintained whilst providing flexibility of process and content that reflects the individuality of the participant's experience.

Establishing a connection with the respondents is crucial in such a research design. Finch (1984b) addresses the development of rapport from a feminist standpoint. Her interviews with women had anticipated difficulties in establishing rapport but in fact she found a readiness to talk. Patton (1990) suggests that the task of the interviewer is pivotal. A successful interview allows the respondent to bring the researcher into their world, the quality of the exchange being contingent upon the skills of the interviewer. An interview becomes a process of validation of subjective experience, the actual interview becoming part of the experience of the incident and therefore potentially adding validity and meaning (Oakley, 1981). The experience of this research confirmed that a less structured interview process enabled a freer exchange and richer data gathering. A set of three core skills supported the interview process in this regard. Social work training emphasises the Rogerian qualities of warmth, congruency and unconditional positive regard (Rogers, 1961). Experience in the mental health environment allowed for the establishment of some commonality and ease of communication, and the theoretical and practical familiarity of the process of debriefing (and in particular, despite its contentiousness, the seven stage process of the 'Mitchell model', as outlined in Chapter Six) allowed for a move from the relational and factual to the cognitive and then emotional facets of experience. Whilst the interviews were keenly

monitored to prevent their development into a debriefing-type process, it is significant that the development of the interview questions easily acquired this characteristic pattern.

With such an emphasis on the unique experience of the individual participants, it was expected that each interview would yield discrete outcomes and perspectives. Despite a pattern of interview questions, each had their own dynamic. Each participant was asked for their own definition of critical incidents, and each selected which incident or experiences to relate. Some participants chose a systemic analysis that fulfilled my need to understand the context of their experience; others explored their subjective experience and focused upon their own personal reactions to threat and conflict. This added to the potential richness of analysis, and further confirmed the contextually embedded nature of the experience of incidents. Each mix of information provided a different balance. For some participants, still processing the events, the interview became a personally emancipating process, adding a new dimension of interpretation through having reframed a very personal experience in a more interpersonal and public arena. Some couched the experience as part of the healing process. The acknowledgement that the incidents described happen within an organisational and social context provided some with the opportunity to construct the interview as a contribution to organisational change.

The series of twenty interviews that form the core of the data collection are thus all unique contributions to the research question. The chosen number was an arbitrary figure mooted beforehand in discussion with supervisors and others, and it seemed to work. Whilst further interviews would have endlessly added to the sum of knowledge, the overall patterns that emerged had, after twenty sessions, developed sufficient sapiential momentum to sustain the discussion within the focus groups, and the analysis of the data. Themes within the interviews began to emerge and consolidate, with commonalities of experience supporting the individual difference in testimony.

The use of focus groups as a tool of methodological triangulation was employed. The specific purpose of the focus groups was designed to provide guidance and confirmation that the theoretical foundations were robust enough to support the data analysis and discussion. Focus groups can either be with subject populations (Vogt, 2000) or with a reference group that acts as consultant or as a debating chamber. Both share some characteristics: that is, multiple participants and a moderator or facilitator who initiates the conversation and then becomes an observer as well as a participant (Gibbs,

1997). The role of focus groups in this thesis was to serve as both consultant and arena for debate.

I chose not to construct a focus group of workers identified primarily through their experience of critical incidents. Concern about potential retraumatisation and ecological awareness of the different professional and agency backgrounds dominated this decision, which was confirmed by the apparent low incidence of research studies that use this methodology. Vogt's (2000) article was the only one that I found from a trauma context, and this concerned the use of groups in the development of assessment tools. A group formed explicitly to discuss their own individual experiences that had occurred within other contexts could not safely provide the levels of support and follow up that I would have ethically sought. This choice does not, of course, exclude the possibilities of incidents having been part of the experience of any focus group member with whom I did work, but in these cases the role and attention of the group members would not have been focused as explicitly on their own experiences.

My prime imperative for the focus groups was not so much to supplement the understanding of critical incidents and traumatic events gained from the interviews as to establishing whether the ecological analysis adopted was inclusive enough to sustain the analysis of the thesis findings and to support the development of robust discussion. The focus groups were to guide the authenticity of the theoretical and practice assumptions suggested by my own understanding of the literature and the information generated from the individual interviews.

In this form, focus groups serve not so much as content analysis as they do signposts confirming that the research is on the right path (Morgan & Spanish, 1984; Powell & Single, 1996; Sussman et al, 1991), and by adding value to other strategies (Morgan & Spanish, op cit; Morgan, 1988). They serve as a means of data triangulation, rather than providing the validation that more positivist processes might (Denzin, 1989). In describing the combination of different voices and the resulting synergies, Carey and Smith suggest that:

> Data collected in this method may be more ecologically valid than a non-social setting.
>
> Carey & Smith (1994:124)

Or, as Kitzinger (1995) puts it, 'focus groups reach the parts that other methods cannot reach' (p299).

Carey and Smith (1994) raise the alert that focus groups can potentially stifle opinion and individual voices. I left the groups with the confidence that this was a minimal risk for either academics or trauma specialists. Perhaps, as Kitzinger (1995) suggests, inhibition may be less of a concern in a group situation where mutual support and the sparking of ideas may produce a synergy not possible in a one-on-one interview.

Two groups were utilised. The notion developed was firstly to test the ecological hypotheses in a forum of social science academics, a collegial group comprising researchers and academics from related but not exclusively social work fields. The second group was held within the network of traumatic stress, a group comprised predominantly but not exclusively of practitioners in the disciplines of psychology, psychotherapy, psychiatry and social work. The unique qualities of the two groups and of the focus group process itself emerged from the experience. True to the nature of the methodology, both groups self-selected after the event was advertised in the workplace for the first group and through the traumatic stress networks for the second. Group members therefore had some similarities (Asbury, 1995) and were naturally occurring (Kitzinger, 1995). I knew most of the members of both groups prior to meeting, although few had been present during discussions related to this research. The literature on focus groups suggests an optimum number of between eight to twelve participants, sufficient to sustain discussion but small enough for individual voices to be heard. The group in the academic environment failed to meet this size, and thus produced less synergy of debate and discussion than either I had hoped for or had expected. Group interaction, of course, is the goal for a process such as this (Asbury, 1995; Kitzinger, 1995), and the requirement that I continue to direct the session after my initial presentation reduced both the exchange of ideas between participants, and the level of observation that I could make. This group at the university produced more 'naive' inquiry and contributions out of personal trauma experience and as such was of less value in confirming the theoretical perspectives embedded within the ecological framework of the inquiry, although it may have served secondary goals of raising consciousness about trauma support within the workplace.

The practitioner group was immensely valuable and affirming both in the worthwhile nature of the research, and the nature and content of the thesis argument. In particular, it contributed most to my comprehension of both the importance of the narrative and meaning making processes inherent in trauma recovery, and in the importance of longitudinal knowledge of trauma and its support. The practitioner group, however, showed less awareness of systemic

and structural issues, which I did not interpret as a repudiation of their importance so much as an emphasis on the somatic and psychological impact of trauma due to the face-to-face work in which the members were often involved. Overall, in this group I was intrigued at the lack of bi-focal application of structure and process, systems and physiology. The learning that I take from this reinforces the need to test out an ecological framework of analysis and strengthened my determination to work towards its development.

Data analysis

All interviews were tape-recorded and fully transcribed, allowing for an open selection of pertinent material. Given that each interview ranged from between an hour to two hours in length, considerable data was then available for selection. The governing principles for the inclusion and analysis of material emerged out of the key themes within the thesis question itself, out of the literature (especially that of the ecological perspective and the debriefing process), and also reflected the structure of the interviews themselves.

Throughout the thesis I have found that there have been naturally occurring patterns and progressions that reflect ecological structure, progress and awareness of context. As previously described, the progressions of the interview questions ranged through concepts of identity and location, through to the specific experiences and reflections of incidents. This pattern was repeated within the data analysis and discussion. For the analysis, and the organisation of the data for the reader, material was first aggregated around the organising theme of an introduction to the person and to their own background. The unique mix of person and environment thus contributed towards the creation of a data set concerning the identity of the participants. Having focused the initial analysis around the key question of *ko au?* (who am I?), and having located the person within their professional and workplace context, the data analysis was then able to progress into a sequential consideration of the particular situations or incidents that the participants chose to relate. Description of the incidents themselves was followed by consideration of the immediate impact. Given the wealth of psychological literature concerning impact, analysis of this data was achieved in part through the tools of a positivist lens, tempered by the introduction of contextual analysis and consideration of the effects over time.

The content of a few narratives were selected almost in entirety due to the power of their flow and description: in these cases, the whole certainly becomes greater than the sum of their parts. For most of the other interviews, key

quotations or commentaries coalesced with others to form part of an emerging picture. Alternative categorisation and coding of themes at times suggested themselves as potential tributaries to the discussion, illustrating a multitude of facets to the same experiences and their meanings. However, the themes all contribute to the development of a cohesive whole within the analysis and discussion chapters, which serve to underpin the future-facing nature of Chapter Ten, which considers the use and importance of the findings of this thesis.

A relational perspective provides the imperative for accountability of this analysis process. Teariki and Spoonley (1992) make it clear that the primary accountability lies with the people being researched. Within this research process, the actual tapes and transcripts belonged to the interviewees; they had the opportunity to stop, erase or correct any of their own material once it was transcribed. Only one person significantly altered a section of their interview, with the intent of clarification rather than correction. Analysis of the data, the act of extraction and synthesis, qualitatively changes the material, but does not remove the relational, political and ethical obligations of accountability to its original meaning and context within the interview.

Acting ethically in the research

This research underwent the processes of both the Massey University Ethics Committee and a Regional Ethics Committee required by (the then) Health Funding Authority. The University Ethics Application forms Appendix Eight[48]. The ethical imperatives for the research are represented within the Massey University Ethics process as issues of access to participants, including conflicts of interest; the protection of vulnerabilities such as informed consent and confidentiality, potential harm to participants and researcher, the participants' right to decline and the use and security of the information; and cultural and legal concerns.

Establishing my credentials: access to organisations

One of the study's initial tasks was to locate and negotiate with those organisations whose workers may have been appropriate for the study. The mental health environment in Aotearoa New Zealand is a relatively small community, and I did not approach this inquiry unknown in the field. Morse

[48] This is in the form of an application for a pilot project that was initially intended to be conducted in another Area Health Board region, and which for logistical reasons did not eventuate: the subsequent research study itself was conducted under the auspices of an extension to this Ethics Approval.

(1994) highlights the dual and incompatible roles that would have resulted from utilising organisational sites in which a researcher had worked. Given my own location within social work education, and relatively recent past experience as a mental health worker, it would have been possible for me to have acquired participants from within my own personal and professional networks, without seeking organisational consent to interview staff. For ethical reasons, this pathway was not chosen. (Furthermore, engaging in gatekeeping processes with various branches of the local DHBs and non-government organisations potentially served a political purpose in raising the attention of management to the issues under consideration.) Given my involvement in supervisory, debriefing and consultancy relationships with a number of agencies, one of the ethical principles that I followed was also not to interview anyone with whom I had had an active professional relationship. If I had, I would have been investigating aspects of the quality of my own work, and the feedback from interviewees would have been subject to influences and biases that I do not wish to introduce into this research.

Whilst Hough (1996) comments that organisations are bounded organisations to which one must seek, negotiate and gain access, many of my approaches were also determined by the multiple identities and relationships that I had previously acquired. The majority of interviewees were introduced to me through the process of the research inquiry but a small proportion were known through past connections, relationships which may have shaped willingness to participate as well as conduct during the interview.

Inevitably, many interviewees were secured through the 'snowballing' processes of networks. Half of the pool of respondents was generated by face-to-face encounters, a point which underscores the arguments of both feminist and indigenous research writers (Bishop, 1996; Irwin, 1994; Oakley, 1993; Smith, 1999). This mixture of direct and indirect access is for me reflective of the nature of mental health service delivery: in the largely de-regulated and decentralised service delivery that characterises current mental health policy, with an emphasis on community-based interventions and interagency dependency, communication within what Mandell (2000) terms a 'network structure' will have both formal and informal characteristics.

Hough (1996) utilises the views of Crompton and Jones (1988), who suggest that all the time spent in an organisation and in gaining access to it should be considered as part of the research. One of the results of this long involvement is that the researcher learns a lot about organisational functioning through these access and approach issues. As an example, a key area in mental health that I

had initially hypothesised would be a rich source of information was one similar to an environment in which I had previously worked. Indeed, had I approached individual workers, many would have been known as ex-colleagues. However, significant changes in management had occurred since my professional involvement in the field, and I found that site management, the third level of gatekeeping after University Ethics and DHB research committees, was a significant systemic barrier to the dissemination of requests for research participants. No volunteers came forward from this site, whilst I am left with an untested conviction that individual staff members would have been more than willing.

Whilst some researchers (Miller, 1998; Rose & Bisson, 1998) note a reluctance of agencies and workers to accept the intrusion of the research into their other more practice-focused tasks, this level of gatekeeping and caution was met only twice, once in the example cited above, and once in the research committee of a large organisation where the interest lay in the amount of staff time to be used rather than in any concerns about retraumatisation.

The size of the organisation was a determining factor in the level of formality required to access the chosen sites. For the smaller, community-support agencies, personal knowledge of key personnel was all that was needed. Several managers indicated assent to their staff participating in the research without having sighted any of the documentation that I subsequently sent. For the larger services a formal approach to the Clinical Director and their discussion within the relevant management structure was sufficient to gain access to service managers, albeit with a detour through a research committee for one.

Protecting vulnerabilities

The ethics of research in the area of trauma carry special imperatives and responsibilities for the protection of both others and myself into the field, and combine with the requirements of academic research to ensure that no harm is done. 'Harm' can take the form of breaches of privacy, confidentiality and anonymity or by means of the unwarranted exposure to unpleasant recollection that leads to retraumatisation.

This research went through the processes of both the Massey University Ethics Committee (Appendix Eight) and a Regional Ethics Committee required by Area Health Boards. Both ethics processes stressed that in this qualitative research, the participants owned the material that they gave, and had options to edit and withdraw. Transcripts of tapes were provided for editing and

further commentary; the actual tape could be returned or wiped. Access to the tapes rested solely with my transcriber, the participant and myself. Security was ensured through the provision of locked filing systems, and the intended use of information within the transcripts was detailed within information sheets provided to participants (Appendix 7).

Whilst confidentiality and anonymity were addressed in the consent forms, the notions remain pragmatically and ideologically problematic. A distinction between confidentiality and anonymity can to be made. I accept Finch's (1986) position on confidentiality, that no material that is likely to embarrass or incriminate individuals should be made public. In the context of the research on traumatic incidents in the workplace, there is an additional level, made clear to me through some of the gatekeeping and access processes with the organisations, that protection of agencies was also required. This is especially crucial where organisational descriptions or operational matters were utilised in the description of participant experience. The events, afterall, did not happen in a vacuum but in the course of work. Anonymity takes this one step further. Identifying features of an incident or an organisation could actually locate and identify individuals. Extrapolation of the data was therefore conducted in a spirit that attempted to preserve anonymity. The material was audited for identifying features, and themes were given precedence over identifying facts. Where the voices of the participants were presented, I identify them only by occupation and location, making a distinction at times between specialist and generic where the context is of relevance. Gender identification is at times possible within the narratives, but avoided in the text if less relevant to the discussion. In some cases this forces the use of the semantically clumsy 'they' and 'their' as a gender-neutral reference utilised instead of gender-specific terminology. Omission of gender-specific material does raise the concern that a gender analysis of impact and recovery may be disabled; nevertheless, the primacy of the need for protection of anonymity overrode this concern, and gender-specific issues related to the impact of incidents may well be best addressed through the use of different methodological tools. Issues of gender, whilst important to the majority of participants, appeared less of concern than the cultural identifiers also acknowledged and managed within this concern for anonymity. In one situation the occupational identity was omitted, due to the potentially legal and operational concerns that the respondent raised. In several cases, omission of otherwise useful information and quotations was determined by the potential identification of participants and consumers, and reference to publicly known events was limited to what existed already within the public eye.

The nature of the crisis and trauma content of the interviews provided a value-added caution to the protection of participants. An observation about the process of obtaining ethical approval for the research process can be made in the light of knowledge about retraumatisation. Obtaining ethical consent was a straightforward procedure and one that raised minor queries and desired changes in the research process, such as clarification in regard to the storage of transcripts. At no time did the University Ethics Panel raise any question about the potential for harm to the participants because of the content of the proposed interviews, an issue that when viewed through a trauma lens remains surprising. A meeting with the Research Committee of one of the major DHBs approached for this study raised serious concerns about the time off from frontline duties that the interviews may have required for staff, but similarly did not address concerns in regard to retraumatisation. A prior meeting with the Clinical Director of a DHB raised important questions about client confidentiality and anonymity, and issues of operational and legal information being safeguarded, issues that were addressed in the final draft of my ethics application. This resonates with the previous discussion in relation to Signal Events within mental health services (Chapter 6): however, the issue of the potential harm of critical incidents and traumatic events for the workforce, and the possibility of retraumatisation through their investigation, remains far from the horizon for many gatekeepers and managers.

During the interviews I became quite hyper-vigilant at times when issues of sensitivity and recall emerged, a result, I feel, of lengthy exposure to the theoretical material in Chapter Five. The two stories reported at length provided the most powerful interview experiences and raised the greatest level of concern that I had for any potential retraumatisation as a result of the interview process. In one case, some limited contact with the respondent occurred subsequently as we mutually endeavoured to ensure their well-being. As with a one-off debriefing, it is the debriefer or interviewer's responsibility to ensure that ongoing support systems are in place. Only in this one case am I left with a nagging feeling that the worker remains unsettled, although not as a result of the interview, which they assured me had gone well: our encounter had merely provided me with a window into understanding the long term impact of their trauma.

The impact on me was also taken into consideration. I have spent several years researching other peoples' trauma. Motivation, fascination and a desire for organisational and political change may sustain a researcher in the area, in a similar manner that the motives for mental health workers entering their professions may keep them going. However, in the light of understanding

about the direct and vicarious impact of trauma, my well-being as researcher was paramount.

A resiliency audit, such as I might construct for workers or students, is a foundation for such research work. I have my experience as a social worker as a guide for some of the triggers that might undermine my resiliency and ability to listen empathetically to people's stories. But as Stamm (1997) points out, people in direct professional roles such as in mental health may be able to handle difficult material and deal to feelings of helplessness and distress by the direct interventions that their role empowers them to make. The role of the researcher, despite discussions about the use of self and of the political uses for research, is predominantly as an observer and as a sponge, and there needs to be mechanisms for squeezing out some of the accumulated tensions inherent in receiving potentially traumatising material.

Going into this research ethically impelled me to ascertain the strength of my support systems, both professional and personal. Supervisors (academic and professional), friends, children and Labradors were all considered foundations of my resilience, and in the event of my considering the need for a formal debriefing, I was aware of the ability to call upon colleagues in the Critical Incident and Traumatic Stress community, congruent with Pickett et al's (1994) recognition that researchers in the area may need formal debriefing.

The pacing of interviews was important. No more than one interview was ever conducted in the same day, and the process of recruiting subjects meant that collection of data occurred over a six month time period. This enabled any stressors resulting from specific interviews to be dissipated before another was commenced. Whilst unique characteristics of particular sessions emerged and to an extent remain with me, none acquired the depth of meaning that would be rated as acutely stressful or traumatic. Accumulation of meaning, of course, is another means of potential impact. I found the actual writing process to be cathartic as it necessitated emotional as well as intellectual processing. I concur with Gilkey and Lieberman (1996) that:

> ... the authors' propensity to share their own emotional reactions reflects neither the loss of critical objective distance nor self-indulgent catharsis and self-revelation. It is rather the responsible use of one's inner reactions as a form of important data about the realities one encounters in dealing with the human situation. It is particularly useful when trying to understand intense emotional situations, where our tendency is to avoid distressing effects and their significance and meaning.
>
> Gilkey & Lieberman, in the foreword to Allcorn (1996:viii)

Above all, a major safety factor for me was the ability to critically analyse and transmute the material into professionally, socially and politically useful content.

Speed wobbles in the processing of the information and most particularly in the balance between emotional and intellectual understanding, occurred largely at times when I myself was under considerable pressure, producing the mixed metaphor of having my nose too close to the grindstone so I could not see the wood for the trees. At times where heavy workloads or personal events piled up, I could identify with participants who described a loss of focus. My response was largely to take a step away from the thesis until it beckoned me back. One poignant incident remains with me. At the start of my ninth interview, I alerted the participant to the fact that I had to leave my mobile phone on, as I had a family issue that may need urgent attention; my mother was dying. Two telephone calls later, I finished the interview aware that I had not achieved the quality of discussion that could have been achieved. The transcript reveals more interviewer words than might have been necessary, less specific detail about the person's experience, and more discussion of generalities. Nonetheless, some good material emerged, more I suspect due to my prior acquaintanceship with the participant and their good will than to the quality of my questioning. My own stress had removed focus. My mother died the next morning, and I withdrew from data collection for two months.

Conclusion

This research is conducted within a qualitative frame of reference, focusing on the unique experiences of twenty mental health workers. Discussion over the methodological approach, and the ethical issues arising out of the method, underscore the importance of accessing the narratives, of honestly synthesising the themes that emerge, and of utilising this knowledge in combination with that gained from the literature, as a launching pad for discussion, debate and recommendation. The following two chapters analyse the data gained from the interviews.

Chapter Eight: The experience of working in mental health

> I said to him: 'what do you reckon, just another day at work?' and he look at me and he went, 'you've got to be pretty good if it's just a normal day at work, bro'.
>
> Maori mental health worker

Conceptual understanding of critical incidents and traumatic events in the mental health workplace has been previously explored by means of ecological tools of analysis. The thesis argues that comprehension of incidents within mental health is best attained through the interrelationship of person and environment, and through an appraisal of the context in which incidents occur. This chapter introduces the twenty participants and then focuses upon their experience of their workplace. The identification of their roles, motivation and experience presents a singular cross-section of work within mental health. It raises issues that highlight workers' perceptions of professional and organisational contexts, and the link that this has with their experience of incidents explored in the subsequent chapter.

Introducing the participants: identity and role

In this introductory section, the professional allegiance, roles and experiences of the participants are described. They talk about their job mobility and changes in occupational identity, and the role of the community support worker emerges as a key player in current configurations of mental health. The work is then defined by modes of working, such as individual or team deliveries of service, and some discussion concerning the distinction between generic and specialist approaches occurs. The role of consumer need in determining the identity of the work role is acknowledged.

The span of professional identities, work roles and responsibilities in this research reflects a range of available occupational groupings currently employed within the mental health field. A quarter of the group were community support workers, community-based and untrained for the specific role they were taking. Others had undergone lengthy professional training, as

in the case of psychiatry. Psychology was the only occupational grouping unrepresented within this sample. Many of the respondents with professional identification in social work, nursing or occupational therapy were employed as generic mental health workers within multi-disciplinary teams.

The location of these workers varied from small, community-based agencies; community mental health teams, residential units, crisis and specialist teams within DHB structures; and independent practice. Perhaps three quarters were currently employed by DHBs. Adding to the potential range of reported experience, some respondents chose to describe historical incidents; for others, the incidents chosen had occurred recently within their current location, both scenarios requiring description of their career path and experiences. A slight majority of incidents selected by the participants occurred within community settings, as several workers now located in the community chose to recount institutional events. As acknowledged in Chapter Seven, the methodology of the research determined that participants themselves chose which incidents to recount, decisions which may have been made prior to interview, or which were selected subsequent to their working definition of incidents being established. In some cases, other examples were suggested by the course of the interview.

In order to establish a contextual understanding of the environment in which incidents and staff support occurred, an initial interview question asked respondents where they worked and the work that they did within their employment. Interview questions can be found in Appendix Nine. Dimensions of professional identity, roles, tasks and geographical location emerged as key identifiers. Most began by naming their appointed position, affirming the importance of role identity:

> I'm a psychiatric nurse working as a staff nurse within an acute unit for children and adolescents. [My role is] ensuring the day-to-day safety of the young people on the ward, [and] delegation of other staff members.
>
> Psychiatric nurse, residential

Supplementary commentary was provided in most cases, linking roles to descriptions of task. For some, there was an acknowledgement that the role was flexible, evolving over time, and may be determined by factors other than their training:

> Officially my role is as a social worker here [...] and I'm also a key worker as a social worker, so that the role is involved in a

> lot of assessment work and follow-up work and counselling and liaising with other agencies if required.
>
> Social worker, community

This initial line of questioning provided opportunity for reflection on the goodness of fit between interests, attributes and the vocational opportunities available within mental health. Mental health appeared to offer choice and flexibility for some to find a niche, to establish a working congruence between their own world view and the type of work they did. Some highlighted the ability to develop one's own particular interests and preferred areas of working, and others reflected that they could work in places where they felt themselves to be emotionally best suited. Several identified that they preferred severe mental illness (the 'sickest of the sick', as one nurse put it) or crisis work, a social worker expressing preference for longer-term therapy because 'thinking that somebody is going to knock my block off, you know, I don't want to be there'.

'Everything is Polytech now': mobility and changes in occupational identity over time and space

Through the initial interview questions, a breadth of work experience and tenure was demonstrated, ranging from new graduates through to thirty-two years' experience. The minimum experience was a year post-qualifying; most would have had at least three years' experience; a quarter had worked within mental health for around ten years. Whilst the youngest participant was in their early to mid-twenties, several older participants had made mid-life career changes, which introduced the possibility of maturity but not practice experience into the discussions. They were part of a highly mobile workforce. Many of the respondents not only had considerable experience before they moved into mental health but had moved between countries, cities, organisations and consumer-defined settings. For some, the move between countries initiated a series of temporary and short term jobs that exemplifies the wide range of opportunities:

> In ten years I've worked in quite a few areas. I've worked with adults, in the UK I've always worked on wards doing shift work with inpatients [...] I came to NZ and to my first private adult acute psychiatric hospital. [...] and [there was] group work, more therapy, so I worked there, and ever since [emigrating] I've worked in lots of places in NZ for very short periods of time. I've got a good idea of all the different organisations. [Most of my jobs] tended to be adults' acute work and then [...] I was a locum for 5 or 6 months so that was my first community-based [post] and then those clients start to

> get younger, about 18 - 20 year olds rather than adults, [...] and then since I've been here at [child and adolescent team] it's got younger still, it's adolescent 13, 12 year olds and I quite like that.
>
> Psychiatric nurse, specialist team

Movement between jobs was more common than lengthy tenure, and often part of a deliberate choice for respondents. The longest any of the respondents had stayed in one post was fifteen years, this person keenly aware of how unusual this was, interpreting their tenure as a mark of stamina but also acknowledging that their decision might need justification in the face of so much mobility around them.

One aspect of occupational identity observed was that of changes in role and qualification requirements. These were identified by several participants with lengthy experience in nursing, reflective again of an understanding of the evolution of mental health service occupations. Some had begun work in training and clinical environments that no longer existed, such as 'handicapped nursing'; that is, hospital-based psychopaedic training. The demarcation between mental health and other fields was determined by both time and geography. The experience of one nurse with twenty years' experience suggests that not everywhere is there a clear distinction. Calling themself a 'first aid kit', they had once worked in a remote rural area, and had practised a dual role of both mental and public health. Currently employed in an urban area, they reflected on the adaptations required by a changing qualifications environment:

> Yeah, I like being out and about... I do the practicals better than the academia. But that doesn't suit me any more; I've got to be a bit brighter. The environment is changing ... ever since they closed [the hospitals and] in-house training ... everything is Polytech now.
>
> Psychiatric nurse, community

This group of respondents demonstrated that mobility, choice and job tenure is a clear dynamic in the mental health workforce. For many of the workers (although not the CSWs) it enabled them to gain varied experiences without moving out of mental health, thus creating advantages of cross-fertilisation of ideas and practices, as well as career prospects and training opportunities. This may, however, produce uncertainties, shortages and a lack of continuity of practice, knowledge and systems, which may in turn produce vulnerabilities in role identity and performance, safety and support. One nurse commented strongly on the problems of managing temporary staff, who may have never worked with some presentations of mental illness and who therefore require

considerable monitoring and direction. In addition, the impact on consumers from this turnover of staff was noted:

> They've always got to be an open book, wherever they go they've got to spill out their whole story, and there's always [someone new here], it's like they can never get away from their past, you know we so traumatise them all the time...
>
> Community support worker

Given the likelihood that the majority of incidents in mental health will occur as a result of person-to-person interaction, staff turnover and skills levels emerge as an important factor in the reduction of risk.

Occupational identity and the role of the community support worker

As noted above, community support workers had shorter tenure and experience within mental health; participants talked about their previous experiences in education, domestic or commercial activities. The role of community support work was presented by participants as having a less developed professional identity, confirming the discussion in Chapter Three, and suggesting that community support work is seen as an entry point for those attracted to work in the mental health field. Despite the absence of prior training (none had completed the Certificate in Community Support Work), support workers often evidenced considerable educational backgrounds and aspirations. Two were currently engaged in Masters degrees in related fields, and one also held teaching qualifications. One support worker had taught an unrelated subject at a tertiary level.

Support work was often defined very pragmatically in terms of location, and hours and days worked. Support workers were also more likely to define their work in relation to that of others:

> We had a psychologist in our team who was his main worker and I was also the other person that was linked in to this person as the community support worker.
>
> Community support worker, specialist team

There seemed to be a blurring of description in how community support workers saw their role. The picture of support work was that of an evolving and fluid occupation defined by role and relationship with others, and one that some CSWs perceived as close in identity to that of the occupation of social work in particular. Two talked in terms of 'doing social work', one commenting that they had been selected for their current position, in part, because of their enrolment in a social work degree. For the one respondent, a professional

identity was structurally hard to obtain. They had been appointed as a CSW, yet were attempting to achieve a social work qualification, for which the management could not perceive a need, preferring to identify the worker as a family therapist.

To my knowledge, none of the social workers interviewed were working in environments in which CSWs were also present, suggesting a bifurcation of roles according to the employment environment. A hypothesis worthy of further exploration would be the degree to which the evolution of care within the community, and the parallel growth of NGO service delivery, has created this two-tier approach to the delivery of social and community-based services, roles previously held by social work. If this analysis is borne out, I would argue that it contributes a policy dimension to the current challenges facing the social work identity within mental health, and perhaps further perpetuates the differential status of socially-based interventions and community-based mental health programmes. The demand for the professionalisation of CSWs, explored in Chapter Three, can be interpreted in this light.

Team or individual, generic or specialised? Modes of working in mental health

The unique characteristics of work within mental health were reflected in the variety of modes described. For some, tasks and roles were conducted alone; others co-worked key tasks, or functioned in a team-focused residential setting. Specialised or generic work roles reflected both individual worker characteristics and the policy direction of current mental health practice, and therefore have great operational significance for the shape of critical incident response.

For a few of the respondents, their work role was played out in a relatively independent and isolated manner, one nurse commenting that 'I don't need an office, I just wander around, cellphone in my pocket'. For some, this was determined by structural factors, such as a psychiatrist in private practice. Working on one's own was more acceptable to some than others, a family therapist suggesting that whilst their preference was to co-work cases, sometimes it was easier to get on with things by themselves. A Maori mental health worker had to strike a balance between having to work alone because of their unique cultural expertise, and the cultural and clinical imperative to work alongside others with complementary skills.

Working alone did not exclude the possibility of having a sense of team and connectedness:

> ... basically my week is on the road on my own out visiting people. But ... because all our people are part of another mental health service or something, there is teamwork. [...] We have meetings with the nurses and especially in crisis time we can be part of a big team. Yeah, we're part of a bigger team really.
>
> Community support worker

Such a variety of work practices has implications for the design and implementation of support systems. In particular, individualised work practices may not be best addressed through group interventions such as CISD, and even where teamwork and cooperation are more evident, the specific roles and tasks of individual workers may provide a differentiation of need in the event of a critical incident.

Dominating most of the interviews was the desire for a form of collectivity in the work. Of particular interest was the set of discussions around the issue of specialist or generic working, a tension which has appeared as a result of the changes in the way in which mental health services are structured within community settings (Chapter 3). One social worker described their team as level rather than hierarchical, sharing key worker and case management roles whilst retaining respect for specific professional expertise and perspective. The following respondent carefully teased out the definition of team and multi-disciplinary team when I asked if the team they were in was multi-disciplinary. This began to define the evolution of the concept of the generic mental health worker, as opposed to models of inter-disciplinary working.

> It is kind of is multi-disciplinary here at [the workplace] but on the [...] team we actually work in a generic way. I mean, there's different disciplines but we are generic, so I will pick a client up because I want to, not because I'm a nurse. There's two of us nurses here ... and I guess we both pick the same kind of clients up. I don't think, no, it's not multi-disciplinary.
>
> Psychiatric nurse, community

The concept of the key worker emerged, not without comment on some of the structural difficulties inherent in establishing it. One social worker observed that the original intention, for every consumer to have an identified key worker, was restricted by lack of staff, and that allocation of responsibility pragmatically followed a match of staff skills to consumer need. This respondent also commented that they still identified themselves to the consumer according to their professional identity and role, as the concept of key worker was somewhat ill-defined. A doctor in the study felt that their role and identity were stable and recognisable features for both themselves and

others, suggesting that dealing 'with the issue in the doctor mode' served as a protective factor when dealing with critical incidents.

The picture painted by many of the participants was that of an evolving field that at times mixed professional identity and role. In my own practice experience, I recall resistance to the development of key workers and case managers, as these roles appeared to potentially diminish the specific skills and analysis that the social work profession brought to mental health. Similar tensions surfaced within some interviews, a governing factor appearing to be in part the perceived status of the individual and their profession. Where a team environment, for instance, valued the skills level of an individual and accorded their profession some respect, an easy congruency between work role, identity and expectations of performance was achieved. Where work roles appeared to be less distinct from those of other occupations, concerns and anxieties surfaced, factors that the later data concerning incidents suggests could intrude into a person's resilience in the face of critical incidents.

The complexity of involvement: defining the work by consumer need

A strong theme running through many of the interviews was the sense that the mental health workers strived to work in a way that was responsive to consumer-driven need, inextricably lacing service delivery with the presentations, diagnoses, strengths and demands of the individuals and families identified as consumers. There was a dynamic interaction between worker and consumer that contributed to the context of critical incidents and staff support. An occupational therapist talked of working with individuals and families in terms of motivation, esteem and confidence in the building of daily living skills. A social worker clearly illustrated the realities of an ecologically complex and socially embedded involvement, by describing their work as incorporating early intervention, family work, and psycho-education, utilising psycho-social skills, an understanding of crisis, coping and attachment theories, as well as the structural and systemic effects of disability and stigma.

These dynamic interactions at times created potential for different imperatives to drive the matching of consumer need with worker skill. At times this had occurred on a purely pragmatic basis, such as the matching of a support worker to several clients because of gender or culture. In some parts of the mental health services, participants suggested that diagnosis rather than consumer need determined the allocation of cases, specialist teams emerging as particularly constricted by statutory and service requirements to service the needs of identified consumers. Whilst the interview questions did not explicitly

elicit analysis of the theoretical stance of the mental health agency in which participants worked, several passed comments suggestive of a clash between the medical model and the perceived needs of the consumer:

> This client was an ongoing client, who really was a square peg that didn't fit into a round hole, and then he had a lot of Axis II diagnoses, personality traits, and he didn't present with the traditional Axis I of mental health, schizophrenia.
>
> Community support worker, specialist team

A common theme that emerged within the interviews was the perception by frontline staff that mental health agencies could at times be improved by an enhanced focus upon the needs of consumers rather than on the fulfilment of requirements of legislation or resource availability. This may enable a better ecological fit between the needs of consumers and the abilities of those working with them to respond accordingly, an easing of tension that may influence the occurrence of incidents.

Motivation, sustenance and resilience

> Do you reckon we should accept there are some things you can't do, you can't actually solve them?
>
> Social worker, specialist team

Another central focus of the interview questions considered the motivation for people's entry into mental health, along with the factors that they felt were important in maintaining their commitment and resilience. Key imperatives that emerged for the individual workers were those of personal experience, the relational aspect of mental health work, and the importance of getting the right mix between their personal interests and aptitudes and their working environment, and the relationships within it. Environmental determinants of worker well-being are also explored.

Head or heart: life experience and motivation

Respondents in this study reflected a wide range of education and training backgrounds. For psychiatrists, for instance, a lengthy period of education and training had also involved 'on the job' learning and exposure to incidents. All of the social workers and psychiatric nurses interviewed had professional qualifications, and several had Masters degrees or Postgraduate Diplomas obtained either as part of gaining the professional qualification, or as a post-qualifying specialism (for instance, Cognitive Behavioural Therapy (CBT), child and adolescent mental health, play therapy or psychotherapy).

Support workers, both community and residential, represented in particular a group of workers for whom employment could be obtained through life experience and aptitude rather than specific training. They demonstrated a far greater mix of educational backgrounds and aspirations than the other workers. Some of the support workers validated their life experience as credentials for their current positions, citing addiction or co-dependency, vicarious experience of mental health issues within family and friends, or a sense of social justice and compassion. Life experience emerges as a potential dynamic within the experience of critical incidents, shaping response and influencing vulnerabilities and resiliencies.

For some, involvement in mental health reflected a personal journey:

> So I went off to [a drug and alcohol centre], and did a programme as a co-dependant [...] So at the age of, I don't know how old I was (really old!) found I had to accept who I was, for me, and part of that, I started being involved in the alcohol and drug field, [...] and a position came up as a Community Mental Health Worker, and I decided to apply for that, just part of discovering myself. [...] And it was trying to get myself into balance, and just really loved mental health.
>
> Support worker, residential

In one case, a support worker had been hired specifically because of their personal history of addiction. Such previous experiences provided both motivation and a focus for activity. A sense of reciprocity, or giving back, emerged:

> I feel really strongly that people were there for me in my lifetime and supported me and put up with some really crazy behaviour. [...] And I feel the same about the clients, I think that's one of things I do like about the job, is that you can be an advocate for them, [...] I don't say 'well go off down to WINZ[49] and ask them', I will say 'let's make an appointment with WINZ and I'll take you'.
>
> Support worker, residential

Vicarious, as well as personal, experience of mental health problems also provided motivation, a support worker sourcing their experience of a mother with depression (an 'amazing woman but a sad lady') as an underlying theme reflecting commitment to the work.

---

[49] WINZ (Work and Income New Zealand) is the government department administering the social security system.

Employment in mental health for some appeared to be a vocational match between a core component of their identity and what they felt they could give to their role, a support worker describing a mid-life career change as an opportunity to express the compassion and caring that they felt were core personality attributes. For others, they located themselves within particular sectors in mental health because of a commitment to working with the client group, as with one psychiatric nurse who relished the hope attached to working with children.

For one support worker with a retail background, the 'heart' determined the move into the field, and the 'head', the desire for knowledge and skills, began to grow once in the position so that they now felt empowered by training:

> I've been doing [the job] for seven years. And coming in with no training and thinking I could rescue the world [*laughs*], to learning an awful lot and seeing the importance of doing training. I've done part of my certificate in community social work but this last year I had an opportunity through the [...] Institute of Cognitive Behaviour Therapy and I got one of their free funded places, so this year I'm doing that and 100% trying to get my head around that. But for that I'm really grateful, because to me it's that tool that I've been looking for, and I've done Integrated Mental Health Care[50] training and that's a wonderful tool too, so I feel now I've got a toolbox to be able to work with.
>
> Community support worker

The comments above illustrate that the support workers were the most forthcoming and eloquent about their motivations for entering the job. In part, this may be explained by their comparatively recent entry into this new occupation, whereas many of the nurses (in particular) had maintained job tenure over a number of years. It is also worthy of consideration, however, that the professionalisation process in some way subsumes individual motivation beneath a collective professional identity which is felt to be sufficient an explanation in itself.

Acknowledgement of the power of past experience to determine and shape response to critical incidents has been made within Chapter Five. The workers within this research carry with them into their roles, the experiences such as those related above. Within the discussion in Chapter Nine, there is further acknowledgement of the issues inherent in prior experience and the processing

[50] The Integrated Mental Health Care training is the package of assessment and intervention skills based on work by Falloon and others (for instance, see Falloon and Faddon, 1993) and adopted for use within parts of the community mental health environment.

of critical incidents and traumatic events. Retraumatisation, vulnerability and environmental triggers become key factors in the management of, and recovery from, incidents that occur in the workplace.

The relational imperative

> I think the most rewarding thing is the therapeutic relationship you're able to build with your client.
>
> Community support worker

People moving into mental health do so, as we have seen, for multiple reasons, a considerable part of which emerges as a positive and deliberate desire to make a difference in people's lives. In these interviews, it emerges that this key focus of involvement with, and commitment to, people is a major dynamic in the experience of incidents. Mental health employees are actively engaged with both consumers and colleagues in often volatile and complex situations. With one exception, all the incidents described by participants in this study had a direct relationship with the behaviour, actions and mental state of those for whom the services worked. Even the one exception, where a new graduate was rocked by an accusation of unprofessionalism from a colleague, had at its root a debate about the appropriateness of service delivery for a consumer.

The relational aspect meant that face-to-face work with the prospect of change and reciprocity was often a more favoured work environment than having a role in systems management:

> On the days that I go home at the end of the day feeling that it has been a good productive day? I suppose working with clients where something really positive has happened. You know you've either helped them gain some really important insight ... or you've helped them problem solve something or you've been able to do something and you can see on the face of the person that you're talking with that something important has happened and changing - yeah, that makes a really good day... [It's] the connection with people on that level that's interesting.
>
> Social worker, community

Compassion, liking and respect of consumers for their resilience in the face of adversity were strongly emergent themes for several respondents, a social worker stating that 'the clients are first and foremost what keeps me here and interested'. One CSW expressed admiration for the resilience of consumers who had experienced so much distress and trauma in their own lives, seeing their untapped potential as an opportunity for change. They reflected that the lives of some of the consumers would have broken them had they been placed in the

same situation, and that this created challenges that provided both hope and frustration on a daily basis. For one CSW, the way of describing their relationship with consumers provided evidence of an attitudinal position imbued with expectation and meaning:

> So if you're having a rotten week and all yours are misbehaving and things are going [...], you think, well, we all have our ups and downs, it's like bringing up kids isn't it?
>
> Community support worker

For workers so embedded in relational processes, many issues emerged that were potential dynamics in both the experience of, and recovery from, critical incidents. Identification with their histories and situations, the extension of compassion, empathy (and at times, sympathy), all highlight the interdependent relationships between consumer and worker.

For several, including the following, a common cultural identity provided a core relational imperative:

> That's what you get when you get with Maori... You take the responsibility if he's one of mine. Maori gets into the All Blacks or the Silver Ferns[51], she's mine, we take that responsibility. This is not a way of disrespecting any other cultures other than Polynesian and Maori, but I haven't yet heard of one Pakeha that has said, 'oh, that person is mine'. You make that claim, it's a natural thing, for bad or for good, that's us.
>
> Maori mental health worker

For them, this redefined the relational possibilities when a consumer killed themselves. The connection that they had made through a common culture was perceived to be of a greater quality and meaning than that established by other clinicians, and the death therefore reverberated in a profound manner that caused them to reflect that 'he was more than just a client, he was a friend as well'.

The importance of seeing change and opportunity for consumers emerged as almost a universal theme, indicating a strong commitment and involvement with the life of the consumer that may not have required daily reward but which sustained their commitment to the field through hope and expectation. This further reinforced the hypothesis within the thesis, that connection with others is likely to have a significant influence on the outcome of critical incidents:

---

[51] The national Rugby and Netball teams, respectively.

> Seeing change, that's definitely it. Quite often it's like a suicide attempt or some significant event where they feel they've reached rock bottom and they're reaching out for help. And to see the changes in people when you support them and when you get medication on board, [...] and actually see ... their life get back on track, and see them enter the service and exit the service, that's a really good thing. I think that's probably inspirational.
>
> Social worker, community

Coping with the slow pace of consumer recovery was interwoven in several commentaries about motivation, with varying degrees of optimism, one nurse reflecting that it was about not having great expectations. Others looked for small steps: as one support worker put it, 'even if we might only work with a speck but at least they're giving a speck a chance'.

Nevertheless, uncertain clinical outcome had an impact:

> I sat in a meeting this morning and a boy's name popped up on the list and I had often wondered what happened to him - I saw him when he was eight and I sat there and I listened to the story and I said that's the identical dynamics they're operating now and that kind of grieves me too, that there hasn't been a resolution.
>
> Social worker, specialist team

The interface between personal expectations and consumer outcome created potential dissonance when faced with scale of the challenges that some consumers had faced. One support worker, awed by the daily struggle that many people faced, considered that the most important thing that they could offer was 'that they at long last feel that someone's heard them'. With acceptance of the slow rate of recovery for some consumers came reflection on the accommodation to behaviours:

> ... things like people stroking you and they're manic. You just step back and say 'don't do that please', it's not such a big deal, something like that; you get used to it.
>
> Psychiatrist

A residential support worker suggested that accommodation to unusual behaviour, whilst part of their working life, still caused friction within their own family, who had less exposure to mental illhealth, and less understanding.

This balancing act between acceptance of behaviour that may be illness-related, and awareness of risk to self and others is a defining and stressful characteristic of mental health and one that most respondents acknowledged. A social

worker said that they assumed that they were safe when visiting people's homes, and a support worker felt that 'some weeks, it can just be just a breeze', whilst also commenting that they also needed to be alert to how people responded to them during home visits. One family therapist voiced the opinion that clinical presentations were getting more severe over time, and a psychiatrist observed that to use 'madness' as an excuse for inappropriate behaviour was not acceptable. Participants described alertness, degrees of acceptance and accommodation, and perhaps desensitisation. A social worker described this balance:

> I think you still have to operate with a degree of protection around. Like, you have a caseload of thirty people, any of them who may kill themselves at any given moment, and because I work mainly with clients who are borderline personality disorder or mood and anxiety disorders, probably are one of the higher risk groups, and add in a bit of alcohol use and it's sort of a really high risk group. So in order to keep going in the job, I can't always have [suicide] in the back of my mind.
>
> Social worker, community

The implications of accommodation and desensitisation to risk had practice implications for these support workers, and major implications for the retention of skilled staff:

> I think if he was newer to the service, our intervention would have been a lot different, but he'd been with us for a period of time, so we had become quite nonchalant towards him. [...] So after a while you become a bit indifferent to it, which is a little bit sad, but especially in our team, I mean, so much suicide and self-harm and self-mutilation...
>
> Community support worker, specialist team

Another support worker commented that to remain committed to the job, you had to like and have compassion for the consumers, and that for them, they moved into a managerial role because they got 'really pissed off at people and felt really threatened'.

The relational aspects of mental health suggest that workers can become containers for a raft of emotional and cognitive processes and may carry levels of concern and sensitivity to risk with them in their daily work routines. Interaction with the environment and with the social world will play out meanings, questions of volition and intent, culpability and values, all of which provide challenge for workers, for supervision and for management systems.

Person in environment: occupational niches and motivation

> What a privilege [it is] to be able to work for an organisation who sees mental health as more than just pill popping.
>
> Community support worker

From an ecological and Strengths perspective, the location of a person in either enabling or entrapping niches will be crucial for developing and sustaining motivation. Citing issues of interests, skills, the right location, working routine and issues of autonomy, many participants commented on their need to get the right environment in which they could practice.

> I like the community, I prefer Monday to Friday, [it's] tough, 'cos it's like the daylight hours, you know, that's when everybody else is out and they want things done ... but I'd find it hard to go back to shift work now, I wouldn't like it. And if I did I'd want a change, I'd want a total change.
>
> Psychiatric nurse, community

One element of work within the community was the less-structured routine, which provided autonomy and flexibility, or as an occupational therapist put it, 'it gives you the feeling that it's okay to drop off and pick up a few vegies for dinner'. Variety and scope for practice was stressed by two social workers, one describing the breadth of tasks that their work contained, and one commenting that changes in the consumer focus and development of the service over time had provided the variety that maintained momentum in their professional development.

Congruency between interests, abilities and opportunities in the work environment figured prominently in the narratives as major contributory factors to job satisfaction. For some this determined where in mental health that they chose to practice. A psychotherapist commented that they relished the balance between longer term and crisis work. Whilst one social worker commented that they were emotionally suited to long-term work (which others found contained unacceptable levels of frustration at the slow rate of consumer progress), this psychiatric nurse was drawn to the moments of intense clarity that came with crisis work:

> In a very, very awful sort of way it's really easy, stand on the side of bridges and talk to them ... I know whether to call a doctor or where to send them.
>
> Psychiatric nurse, community

Congruency between a worker's perceptions of their abilities and the opportunities to use their skills in practice clearly contributed to job

satisfaction. A relatively recent social work graduate compared their employment and what kept them going, with a colleague in another area of the city who had a different and perhaps more behaviourally challenging caseload. They acknowledged that working with different client needs would necessitate different coping strategies, and require a different measure of satisfaction.

Embedded within discussion of balancing the caseload were references to clarity of role, task completion and continuity of care, key parameters of the ability to measure one's own performance:

> I think you can case manage your own [client] from pre-admission right through to discharge and see that how you've made progress and feel [...] responsible for that. Providing them the sort of input and the right sort of [care]. You've done everything that you should have done in terms of filing, of the admission and the discharge...
>
> Psychiatric nurse, residential

Role clarity is, of course, in part dependent on validation and affirmation by the actions of others. These factors are addressed later in this chapter.

Reflecting the interaction of person and environment, several respondents suggested that their ability to make effective change at a systems and structural level was crucial to their own sense of job satisfaction and motivation. One nurse had experience in both inpatient and community settings. Whilst currently in the community, they said that they would happily go back in to a ward setting, especially if they were in a position to effect change in the ward environment themselves, rather than being passively recipient of 'decision making from very high up'.

Resilience and the maintenance of motivation were demonstrated as not being static or stable processes. Several respondents acknowledged the variable and dynamic nature of what kept them going:

> The other day when I had a lousy day, I said to [the manager] 'look, I always said I'd never go back to that boring shop and dust those shelves and do all that; today I feel like happily dusting those shelves and serving all those ladies over the counter'.
>
> Community support worker

A nurse, who soon after the interview moved out of contact with me, described frustration with some structural elements of their workplace and commented that:

> Well that's a good question and probably not the ideal one to ask me right at the moment!
>
> Psychiatric nurse, specialist team

The narratives within this chapter have attested to the key role that the environment plays in providing role validation and support, and in defining the relational characteristics of mental health work. The participants depict a dynamic contextual experience that has the potential to influence the creation of, and response to, critical incidents. It provides a platform for the argument surrounding the need for support systems to be similarly environmentally embedded, that is presented in Chapter Ten.

Attention now turns to the role of cultural identity and expectation amongst the workers in this study.

Cultural factors in identity, role and commitment

Within the individual interviews, culture emerged as a key factor in the person-environment dynamic. From an ecological perspective, culture is a major determinant in the way we view the world (Chapter 2). Current Western ecological frameworks approximate understanding of indigenous models of health, and some utilisation of indigenous frameworks (*Te Whare Tapa Wha* in the case of Chapter Five) has crossed over into bicultural practice within this country. The bicultural construction of many of the issues facing mental health and service delivery within Aotearoa New Zealand raises the profile of ethnicity, cultural identification, migration and of the level of acknowledgement of culturally-specific processes within mental health practice. These issues present in a unique configuration within this country, but resonate internationally both in terms of tensions between different cultural practices, and in the manner in which critical incidents may be constructed, interpreted and responded to.

Whilst selection of organisations in this research was limited to those identified as being in the 'mainstream'[52], there were several ethnicities and cultures represented within the respondent group. For two of the workers, their selection or location were determined specifically by their culture, one gaining employment as a cultural consultant within a 'mainstream' team, the other working in a Kaupapa Maori site within a District Health Board. Several raised

[52] Organisations accessed in the research tended to fall within the second or third stage of the bicultural continuum (Durie, 1994), in that some acknowledgement of, and some attempts to respond to, a Tangata Whenua perspective were made, whilst mental health models of service delivery and treatment belonged largely to Western perspectives. The definition of mainstream, of course, depends on which river you happen to swim in.

culture as an issue due to their status as migrants from Europe or North America. In some cases, the mental health environment itself raised issues of culture, cultural identity and cross-cultural communication which the participants considered were important factors in their descriptions of their work environment.

This discussion first addresses observations made in regard to the notion of being Maori, and specifically considers the role of the Maori cultural consultant. Issues of cross-cultural communication that underpinned some of the incidents related in the subsequent chapter are then addressed.

Maori staff or staff who are Maori?

> It's about aligning cultures, not about dominating cultures.
>
> Maori mental health worker

Cultural identity and communication processes often shaped the way in which mental health, treatment and incidents were perceived. For the group of twenty participants in this research, four identified as Maori. Tauiwi ethnicity was represented by a fairly even split between New Zealand born Pakeha, and migrants from Britain and North America, with two of the former group acknowledging a shared cultural identity with the Pacific and with Asia. All the Maori respondents, and some of the Pakeha workers, appeared acutely aware of the potential for cultural identity and dynamics to affect processes within service delivery.

Mental health intervention itself came into focus. The cultural consultant highlighted a clash of perspectives between Tangata Whenua and medical models:

> This boy, he's hearing voices, seeing things, just medicate him. Whereas in our culture we see that as a gift, but it's understanding how far this gift goes back. If it's a recent event that's happening to this boy, then we'd look into it deeper but if there's a line of generations where this gift has been prominent, so to us that's more of a gift than it is a curse. Medication perhaps disturbs the gift and created more of a problem for him. Sure, we need medication sometimes, but [it's important] to know why you're taking your medication and how it's going to affect the cultural treatment as well.
>
> Maori mental health worker

For the Maori mental health worker, their own sense of cultural location assisted them in defining their role. For them, 'it's just about shifting the mindset of the marae to the teamwork', implying that cultural communication

practices could benefit a team as a whole. Determination of role for other Maori workers within organisational structures was at times problematic. For one Maori support worker within a 'mainstream' team, their cultural identity was used by the organisation as a functional identifier for allocation, perhaps at the expense of other assessment processes:

> ... if they are dark or brown and dangerous, then [I'm seen as] the man to deal with it, and we have a lot of dark and brown and dangerous people coming through, so my client rate is always higher.
>
> Community support worker, specialist team

Even for the cultural consultant, employed specifically as a Maori health worker and utilised because of the depth of their cultural expertise, there were tensions and confusions, some of which manifested within the interview itself as we attempted to gain a mutual understanding of the interface between perceptions of 'cultural' and 'clinical' work. They talked about needing to develop a working relationship with clinically trained staff:

> I have been doing some work on my own but professionally it isn't safe for a person that has the same background as me, where I have no clinical training. So what myself and my supervisor have been doing is we've been putting in procedures that basically cover myself over this role. So therefore clinical responsibilities belong to the clinician, and the cultural responsibility is how I involve myself.
>
> Maori mental health worker

The interview then queried whether a distinction between the cultural and clinical could be made:

> Yes, for sure, if it came down to working clinically with the family. Say if there was a need to involve a family therapist, culturally I can provide that, but if the whole team makes a decision and say we will put this in a family therapist's basket, I wouldn't override that. I get your question but it's hard to like separate myself from not helping the family, so I would assist the process in saying, 'okay we need to refer this to the family therapist, that's clinical'. I could also provide another form of family therapy by the cultural side of my role, but it really comes down to a team decision not just my own individual decision.
>
> Maori mental health worker

The importance of incorporating a cultural perspective in whatever clinical process is occurring clearly emerges here, in contrast to what this worker saw

as a tendency for Western knowledge to compartmentalise a cultural perspective as just one of the available options.

> Well that's always been a bit of a debate, going back to your question, how you say, define the clinical and cultural. [From] a cultural perspective, you can be as clinical as you want to, because we're coming from a cultural perspective. But if you're coming from a non-Maori perspective, then it has to be this in this box. So you know being clinical, we have our own way of being clinical.
>
> Maori mental health worker

Whilst this Maori mental health worker clearly argued for the importance of working 'from the inside out' rather than as external to any service delivery, the application of Kaupapa Maori processes within the team became problematic in a time of crisis, and affected the manner in which a debriefing offered after a suicide was perceived. The cultural consultant described the mourning process as having been effected in a Tangata Whenua manner. A Pakeha nurse, describing the same incident, talked about tensions that emerged between different parts of the same service, in terms of who was able to attend the debriefing:

> And in this particular incident, you know, our Maori clinicians were involved, so there were big cultural issues. He's a part-Maori boy and there was considerable support for the individual clinicians from [Maori Services] but also it initially felt that other people were being left out because they weren't Maori, so all sorts of issues around, you know, who's included, who's excluded.
>
> Psychiatric nurse

My interpretation, having been vicariously exposed to this issue through being party to both interviews, was that the management system of this particular team had not been able to reconcile differing understandings of process. Tensions (described by the nurse above as 'cultural issues') were in fact reflective of systems-based organisational issues far wider than the role of the cultural consultant. Nevertheless, the Maori worker declared some vulnerability because of their situation. They asked whether it was possible to have a support person (a Pakeha colleague who had acted as mediator in arranging the interview) attend the interview. Whilst the support person and myself were at pains not to let their presence interrupt the flow of the interview, it was clear by their nods of affirmation at times, that the cultural consultant had become marginalised within their team, and less able to work

within their own cultural frameworks of understanding. These tensions are explored further in Chapter Nine.

Several respondents, especially this Maori mental health worker, had highlighted the expectation that a service informed, in part at least, by Maori kaupapa and sensitivities, would have a greater emphasis on the support of staff and perhaps a more open and empathetic communication style, as characterised by the collective emphasis that they saw within Maori culture. The following suggests that this cannot always be assumed, and that units operating on a kaupapa Maori basis may be as vulnerable to inadequate preparation and ongoing support as any of the tauiwi services.

> Because I'm working in the Maori Unit, and this [serious incident where my life was threatened] happened within the Unit, I think that adds to my disappointment. I expected more understanding, just more to be there, you know. If I worked out in one of the services in the 'mainstream', this [is what I would] expect, and in actual fact it seems to be the opposite. I know at [community team] they have over two weeks' stress leave, we don't have any stress leave here. [...] I think that really added [to the problem].
>
> Support worker, residential

The learning from these exchanges is two-fold for this thesis. Primarily, it appears crucial that any intervention, be it mental health or crisis focused, has embedded in it recognition of the fundamental manner in which culture is an integral component rather than an appendix. Secondly, it removes the naive assumption that may be made that Maori-focused environments will have, because of their 'cultural' appearance, adequate support systems in place. Attention now turns to the issues of cross-cultural communication addressed within the interviews.

'Sausage rolls with tomato sauce': issues in cross-cultural communication

Whilst bicultural tensions in Aotearoa New Zealand are often depicted as being sited between Maori and Pakeha traditions, this sample of mental health workers revealed a less well acknowledged cross-cultural issue concerning the disparities between New Zealand-born workers and those who had migrated as adults from other English-speaking countries. About a quarter of the mental health workers with whom I talked had received training overseas, with most of these having trained in Britain. This reflects the active nation-wide recruitment policy of overseas trained staff. Several of the New Zealand-born

respondents has also travelled and worked overseas, and introduced cross-cultural experience into their discussions.

One British respondent commented about the social and cultural transitions made when they arrived in Aotearoa New Zealand:

> The work and the culture [here] are hugely different and it's been challenging and a huge adjustment. Going from basic things like the structure of the health service and how health is provided here, to other things like [...] food. I do a women's group. When I came here a year ago, I had to learn basic things like people here, often [...] eat sausage rolls with tomato sauce and this was something I did not appreciate as important.

Having a personal history of immigration was not always perceived as a disadvantage. The following Maori community support worker observed:

> I've noticed a real difference between New Zealand doctors and overseas doctors. I find overseas doctors are more sympathetic to families, they seem to have a better view of the way the family fits into things, and they seem to be more open to family views. Whereas in New Zealand, medical model trained, or whatever you want to call them, apart from playing God at the meeting and those sorts of things, they've got a working model that I think is a bit archaic, and they are not open, they give you their opinion, they take on that whole God role, like, 'I am the be all and end all ...'
>
> Community support worker, specialist team

Part of the migration experience, it seems, provides an acceptance that the new environment necessitates fresh learning about family and society. Those raised within the mainstream of Pakeha society may not have had hegemonic assumptions challenged.

Several respondents focused upon the inability of the services to respond fully and appropriately to the needs of Tangata Whenua:

> I don't think that our team is addressing that well, I think they are falling into the gaps, I think Maori and Polynesian families in general tend to look after their own, so therefore they are not likely to call the services, they don't let their cousins present and [...] they don't present to the service and therefore they are not seen.
>
> Community support worker, specialist team

A strong feeling that mental health services were struggling with cross-cultural issues and the preparation of staff emerged in the following. After the suicide of a client, this social worker commented:

> Then the police saw the family and that was [difficult] too. And I didn't get that part right, it was a Pacific Island family and I was not there all the time as I later learned that I should have been, and so then that kind of brought on this whole other sense of guilt that I'd done it wrong, six months later.
>
> *Q: You should have spent more time with them?*
>
> Yeah, in terms of the cultural appropriateness of grieving and that was completely foreign to me. And it's that [implication] of coming from a [non-Polynesian] background, that sort of thinking about liability and not wanting to be too involved in the grieving process versus a cultural expectation that you're a part of it and there is no blame. ... I was very new to here at that time.
>
> Social worker, community

I asked the social worker if they had had any preparation from their employer to deal with these issues of culture. Their reply indicates just how much a lack of cultural awareness compounded the effects of the incident:

> No, no, none at all... I think that would have been tremendous to have any kind of cultural preparation for any other culture... But, you know, I do have responsibility around finding that out for myself, but [that's all] following the fact. So that was a large part of it too, that I had the 'what did I do wrong?' about the actual incident itself, but then I had the other thing about I did something wrong after the fact as well, so that was not so great.
>
> Social worker, community

Cross-cultural communication, therefore, may potentially be a dynamic in many critical incidents in the workplace.

Attention now turns to the environmentally located characteristics of the mental health workplace in relation to the experience of stress and support.

Personal stress and support in mental health

Another major focus of the interview process was the respondents' awareness and recognition of stress symptoms, and their personal approach to stress management. Participants then contextualise their experience in relation to support systems and accountabilities within their organisations.

Of particular interest was the interface between the ambient stress experience and the acute stress that arose in response to critical incidents and traumatic events. The hypothesis here is that the impact of any critical incident or traumatic event in the workplace will interplay with pre-existing coping strategies and resilience factors, as well as with any prior experience of stress and trauma. Studies of debriefing outcomes explored in Chapter Six have not considered the interface with pre-existing stress levels, preferring instead to perceive outcome as a direct relationship between event and subsequent psychological health, whilst the argument of this thesis is that incidents and their resolution will in part be determined by pre-incident contexts that serve either to strengthen or erode resilience.

Managing stress

Important in the management of stress and stressors in the workplace is the ability of workers to recognise their own stress levels. Several participants gave clear descriptions of their own ability to pick up on the physical, cognitive and social impact:

> I can remember my back and shoulders, that's one of the things when I'm stressed. I was so tense and stuff so I wasn't sleeping. I was really stressed. I wasn't communicating with other people.
>
> Social worker, community

The recognition of high stress levels enables attention to be paid to the pace of life, a CSW describing fits of weeping and irrational thinking as clear signs that they needed to slow down. At times, the demands of the work role meant that a worker had a sense of merely 'getting through', suggesting that the impact of ambient stress can temporarily be held at bay whilst job demands are attended to:

> At the time [when I'm stressed] I think I'm just trying to focus on the job at hand and often painfully aware of the need to at least look in control and to be able to follow protocol in order to contain the situation and involve the people that I need to involve to help contain it more.
>
> Psychiatric nurse, community

The difficulties of addressing stress management were acknowledged, with one worker pointing out the vicious circle between stress, fatigue, and reluctance to seek physical exercise. Perhaps not surprisingly for mental health workers, there was a high level of awareness of stress symptomatology within those

interviewed. Respondents identified that the impact of the work and the organisational environment not only had immediate but cumulative effects:

> You'd see people gradually ground down to the point of burn out and people coming in with high ideals of why they wanted to work there and what they wanted to achieve and to do, that become increasingly frustrated.
>
> Psychiatric nurse, community

Several interviews led to discussions about personal coping strategies. Many workers were interviewed within their own offices, and I was often struck at the personal touches and decorations that had been employed in what could be read as a deliberate attempt to create a calming, relaxed and symbolically peaceful environment for themselves, colleagues and consumers who may have access to the offices. Many had art works, children's paintings or photographs, and some had brought in fabric, furniture or plants. Others named deliberate strategies, including writing songs, reading, cycling, walking the dog or going to the gym.

Others commented that the stress release processes that they occasionally used could be counterproductive, a social worker acknowledging the dysfunctional use of coffee, which produced as much anxiety as it did stress relief, and a nurse stating:

> If you had a difficult day or someone died or things went deadly wrong, then you did what everyone else did and drank, and you got drunk.
>
> Psychiatric nurse, community

The social and sense-making benefit of communicating feeling and ideas to others was almost universally mentioned. For one, this was described both in connection with others at work and home, but also with a personal God. For this support worker, their relationship with God was a strength-giving partnership that had brought them into the job, and sustained them in it:

> You know, for me personally my faith is a huge strength. I'm a Christian and [...] so even in the time of being there [at the incident], feeling like I wasn't alone. I've never prayed so hard in my life but being aware that there was more than just me there [...] I really feel I can't go and do this job each day unless I've got that support to go and do it. It's more than I'm naturally by myself able to give.
>
> Community support worker

Spiritual belief for several participants was a key factor in the interpretation of and recovery from highly stressful experience, and clearly emerges as a factor for consideration in any support programme.

The interface between work and home

Significant to nearly all the participants was the interface between the activities and stress levels of the workplace, and the effect on their home life. The emotional membrane between the work environment and the home emerged as porous, with high stress in either arena having a flow-on effect in the other. This support worker recognised the interrelationship between their roles in work and within their own family. They took on caring and nurturing roles in both, and need to be responsive to the demands placed upon them:

> It's not only work, because I like to do all these other things. I'm a nana now and I've got an elderly mum, and [...] so it's time to think of cutting down and nurturing me for just a couple of weeks, and for work it might be just doing the very minimum until I'm on that even keel again.
>
> Community support worker

Others were aware of the need to maintain a balance, one social worker pointing out that with the constraints of commuting in a city environment, their working and travelling day extended to twelve hours or more, especially if a case demanded overtime. Whilst this placed strains on their home life, they also commented, indicative of the porous boundaries of microsystems, that when there was 'a whole lot of stuff' occurring in their home life, the energy flow reversed and they threw themselves into their work.

The need to keep a balance emerged in several narratives. One nurse talked in terms of 'practising what you preach'. Given the porous nature of the connections between work and home, there was a need for a constant adjustment of the balance, and a means of turning off work concerns on return home, in order to reduce the accumulation of tension:

> Sometimes you can leave work and some days it just goes with you, you're thinking constantly. And you get home and all you want to do is sit down and the questions go: 'how was your day? What did you do at work today?' Thinking I'd just forgot about it as soon as I got in the driveway!
>
> Maori mental health worker

Boundaries between work and home were also imposed because of the need for confidentiality and protection for consumers, thus acknowledging some of the constraints of communication between microsystems:

> Like being whanau, it's really cool but the information that you disclose, you have to be very, very careful. So you can't disclose the stuff, you just share what you want, what you can at the time...
>
> Maori mental health worker

Concerns over the appropriateness of relaying information and emotion into the home environment strongly suggests that levels of support within the workplace must be adequately able to address both cumulative and focused periods of stress.

I asked several participants about the degree of general support, understanding and awareness that they received from within their home environments. One support worker praised the support she got from her partner. For another respondent after an incident, their partner expressed concern about their work conditions:

> He's horrified that I do visits on my own; he thinks that's really bad practice. He thinks it's appalling that there's no check-in at the end of the day. So he was angry that the whole safety thing was dead dodgy.
>
> Occupational therapist, community

Many chose not to let off steam at home, or felt that there was a limitation to how the home environment could support their stress release. Perhaps a quarter of the respondents acknowledged that their partner or other family members also worked within the health system, and they did not feel it was fair or appropriate to offload to someone who knew only too well what their stress levels were about:

> We really try to maintain boundaries around home and work, for our own sanity. But it's inevitable that the person that you trust the most gets it, but I don't always think that that's the best way.
>
> Social worker, community

For one, the similar occupations of their immediate family assisted in smooth transitions:

> I go home and my partner [and] my mother [are also health professionals]. We have similar things, the way we handle things, so [...] instead of 'how's your day?' ... they tease me or 'do you want a feed?' ... and that takes your whole mindset away from work into thinking what's good for you.
>
> Maori mental health worker

Other more formal processes of stress management, including supervision were acknowledged, and are addressed in the section below.

Workplace stressors: the strengthening and undermining of resilience

The nature of the stress experience of the workers is thrust to prominence by an ecological awareness of the embeddedness of incidents within workplace environments. In this section, both the sources of stress and key dimensions of support are explored. Processes of orientation and familiarity, peer and management support, and the provision of supervision were identified as protective factors, whilst key undermining processes of poor peer relationships and hostility, and workload pressures, were addressed. The systemically-embedded erosion of resilience is exemplified by commentary from one of the participants, whose assessment of issues of accountability graphically describes an anxious organisation.

Strengthening processes in the workplace

> I suppose one very useful thing about working in mental health is that I would like to think that most of my colleagues would all have a good understanding of [stress] so that anybody that I would go and choose to sit and talk about it with would actually have [...] a wonderful intellectual understanding of something without really knowing the true impact personally.
>
> Psychiatric nurse, community

Respondents made clear and explicit acknowledgement of the importance of supportive and safe environments, the nurse above reflecting an often-voiced opinion in regard to the importance of sound collegial relationships as an integral factor in building resilience and coping mechanisms. Most commented on the importance of orientation and familiarity with the work environment for their identity and well-being.

Those that could recall their orientation were few, some suggesting that they had effectively just slotted into existing processes without much induction and certainly without being alert to processes for the management of risk. A social worker who moved from being a student straight into their first job in the same agency commented:

> So I didn't really have an orientation 'cos I've been a student [there] and I was just plonked into the middle a bit and had to organise my own filing cabinet. The manager was away sick, nobody really needed to show me around because they knew I already knew my way around and because of that I didn't get

> told the systems, [...] things like statistics - I wasn't told how to do them and it was at my six month performance review that I was told I was doing them wrong.
>
> Social worker, community

This support worker's response to whether they had an orientation was typical:

> No, I didn't and I just walked in there on the first day and I was right in it. So I just observed what everybody else was doing and from [...] there were incidents that were really uncomfortable, that I could see other people dealing with it, other incidents [with] aggressive people.
>
> Support worker, residential

Lack of knowledge of the wider system contributed to the conditions that had caused the critical incident for one social worker. They suggested that new employees needed to learn a balance between collective and individual clinical responsibility, and to develop effective working alliances with colleagues who were trustworthy. Learning these ropes had enabled them to feel more validated and supported in their role.

Such embedded pathways of communication and support endorse the argument for awareness of a systems role in stress inoculation. This can manifest in both informal peer support or in the formal structures provided by management or supervision. In exploring the role of formal and informal supports, a Maori health worker suggested to me that for their work practice, there really was no distinction, focusing instead on the notion of teamwork.

> [The Maori team], for one, has also got really good team colleagues and good team mates that just tap me on the shoulder now and then, to let me know 'how you're getting on? You haven't run away anywhere, you're still here'. Just to see if I'm okay.
>
> Maori mental health worker

One psychiatric nurse cited teamwork and congenial colleagues as the foremost factors to their well-being. This was endorsed by a support worker who emphasised its importance because of the high proportion of time they spent in individual work with consumers.

There is logic in the hypothesis that small teams can provide immediate and more person-centred support for a worker, as both need and response are more visible and available. This is borne out by the experience of one of the CSWs, based in a small suburban agency:

> I just went and said to [the manager], 'I actually don't know if this job's for me anymore, I just think the stress is getting too big, I don't know that I can cope', and he said 'What can we do for you?' and I said, 'I actually need a week off to actually evaluate where I am, to have time to process what's going on and at the end of that week I'll come and let you know.' And he said, 'Off you go now, special leave'.
>
> Community support worker

The independent practitioner setting in which a psychiatrist currently worked enabled them to experience a degree of control over the environment, stating, 'I am my own system'. In both these situations, the support provided was dependent upon the skills and awareness of the manager, and perhaps less on the existence of complex systems and protocols.

The Maori health worker provided a definition of a good manager who, in their view, was one who was accessible, approachable and congruent in their communication:

> We've got an awesome manager, who is very, very pro-Maori and very, very fair in fact he's really great and he really helps a great deal. He's left, right, centre, up, down sometimes, not even here, sometimes busy elsewhere, but he's one link that I know that I have my support from, and I'm quite sure that a lot of the team too, they can also find that sense of support in him. Yeah, he's genuine...
>
> Maori mental health worker

The role of supervision

Several participants stressed the importance of supervision as a process of support. Supervision as an ongoing support structure is a professional structure advocated by social work and utilised to a degree by other disciplines, although several nurses suggested that for them, it took the form of mentoring only. Goals of supervision can be to provide the orientation and connection with the system as a whole, the psycho-education about the nature of the work and its impact on the self, and can also monitor pre- and post-incident stress levels (for instance, ANZASW, 1998; Brown & Bourne, 1996; Hawkins & Shohet, 1989; Kadushin, 1992; Morrison, 1993).

Significantly, however, the social work understanding of supervision, which contains both affective and personal components as well as clinical and management accountabilities, did not appear to be universally applied in all work environments.

Many of the respondents had had experience of supervision, although it was by no means a recognised and mandatory component of support and accountability for all. It appeared that psychiatry, therapeutically-focused specialist services and some smaller CSW teams had structured these processes more effectively than, perhaps, nursing within generic mental health teams.

> Occupational therapists are really strong [on supervision] like social work, that it's an important part of good practice and it's an essential requirement, but the nurses don't have that. And I think again, there is that flip side of some people wanting to offer it and get support and I feel that management are suggesting it's a good idea and we've got a new clinical co-ordinator who is supportive of it, but I gather, I feel a bit of a reluctance in the nurses, because that means you've got to talk about what you doing. And if professions don't grow up with that sort of model, then it means they have to change.
>
> Occupational therapist, community

For an independent psychiatrist, there was a supervision arrangement constructed out of previous training structures and perpetuated by strong but informal bonds. Supervision, at times structured into a work environment but sporadic in its availability, did not provide the level of support that one psychiatric nurse sought, as it was provided externally, only monthly, and on a group basis. However, good supervision was acknowledged by one social worker, whose crisis within the workplace had been brought about by interpersonal conflict and criticism of their professionalism. They were able to work through the issues and develop a perspective through use of supervision.

An emergent difficulty was that staff support structures for well-being were often not separated out in function from the clinical accountabilities and systems geared at support for the client, a concern also raised in experiences of debriefings. A support worker described their experience of supervision as 'ticking boxes and finding out clinically where a person's been' and suggested that they found it a waste of time.

This research found that support systems do not necessarily evolve formally through team structures, but through the allegiances created by professional or cultural grouping:

> ... the [manager] from [a Maori unit] came along and asked me if I [knew] there's actually a free service out there in [the organisation] for Maori mental health workers so I'm going to pursue that. Having said that it doesn't mean they are any good.
>
> Community support worker

Where supervision existed, its availability and frequency may not have dovetailed with the needs determined by a critical incident. In the case of one support worker, committed on a professional basis to use supervision, the lack of its organisational provision for support workers forced them to acquire a supervisor from another discipline on an informal and therefore unsanctioned basis, which whilst meeting their needs, did not provide the organisational accountabilities that might be expected with formal supervision. Similarly, their sourcing of external supervision did not appear to be dovetailed with operational and clinical processes.

These comments highlight the need for the raising of institutional awareness of the necessity of accessible and appropriate support systems. Without this, staff may either not seek support, or coping processes will be individualised and potentially dysfunctional. There is the possibility that without the accountability and feedback loops of formal processes, the support processes adopted may be at variance with the goals of the organisation or team.

Undermining processes in the workplace

The major challenges to well-being cited by the participants in this research were those of workload strain, collegial and inter-agency relationships, and poor accountability structures. These three issues emerge as intertwined threats to stress levels and job satisfaction, and very much reflective of the arguments in Chapter Six. This section examines the tasks of balancing the workload and maintaining communication systems across sites, and contains a discussion about accountability in anxious environments.

Some of the sources of tension for the workers were located within the prioritisation demands of busy mental health agencies and the various roles and tasks required for both consumer need and service outcomes. Working in mental health services entailed for most respondents a balance between hands-on clinical work and involvement with consumers, and meso- and exo-level servicing of needs and requirements through administration and management, liaison, advocacy and networking.

One support worker suggested that for every hour that they spent in face-to-face work with a consumer, there were five spent on administration and liaison work. Another suggested that allocation of cases was purely based on numbers and not on assessment of need, creating the mismatch of consumer and worker as a potential flashpoint. Others highlighted the need to prioritise in situations of intensity and competing demands:

> The job is a balancing act. [...] I can't decline the admission whatever I might think about its merits, I make it easier, I balance the needs of the client, the admitting team, [...] and balance everyone's perceived needs...
>
> Psychiatric nurse, residential

A social worker also talked about achieving a balance in a caseload, in terms of challenge and severity, and signalled the stress that could result from such systemic and structural issues. Consumers in crisis entailed staying late in the evenings, with the knock-on effect on their home life.

In the view of one CSW, this balancing act resulted in the constriction of best practice systems, suggesting that their team ended up immersed in day-to-day problem solving which resulted in re-encountering the same sorts of issues more frequently than necessary. They considered that this affected the perceived quality of the work, with documents defensively justifying decisions so that (in a delightful mixed metaphor) ' we get so busy chasing our tails, we forget to stop at the bowl and eat'.

The learning derived from these reflections centres around the complexity of the demands within the mental health workplace. Similar to the experiences of other intensive human service fields, the triage processes of flexibility, speedy assessment and re-organisation of priorities emerge as crucial requirements of the work, and ones that will feed into the management of stress levels and crisis response.

Roles, tasks and the perception of safety are not only dependent upon the individual worker's practice or the local team's protocols. Many participants commented on the quality of the relationships between their own worksite and its wider organisational reference points, demonstrating the influence of meso and exo-level factors on their work performance and well-being. This is of particular relevance within the community environment in which most mental health service delivery occurs, and in the interface between agencies serving the needs of the identified consumers, or between components of single organisations (for instance, between community mental health teams, specialist teams or the inpatient units).

The expansion of care within the community was observed to have had a detrimental effect on the standing of acute and residential work:

> Over the years, working with inpatients has been increasing devalued. It's been seen as not a challenging, exciting interesting area, [...] so it attracts new graduate nursing staff

> and a lot of staff from overseas who see it as a stepping stone and find out where else to get a decent job. Which perpetuates it, 'cos the staff working in the inpatient unit aren't skilled or experienced, so the decisions ... aren't always the best.
>
> Psychiatric nurse, residential

With a reduction in the reliance on residential and institutional care, one of the vexed questions has become the transition points for clients becoming unwell and requiring a move from community-based support and monitoring to a more intensive regime of active care. Some respondents were located within agencies that worked at this interface, one nurse commenting on the differing perceptions of hospital and community based staff:

> ... and the complete lack of understanding of what each other's job entails. Inpatient staff have absolutely no idea of what it's like to be sitting in someone's lounge in their house and they're acutely unwell and they should be in hospital and you know they're going to explode and you're sitting there with them saying 'oh excuse me, this might take three or four hours before I can find out if I can put you in hospital'. Just as the community staff have no concept of what a slow moving, institutionalised, hierarchical doctor-heavy place the inpatient unit is, and how no actions are taken in speed.
>
> Psychiatric nurse, residential

Organisational initiatives such as the creation of teams designed to respond to these tensions appeared at times to add to, rather than relieve, the pressures, a CSW in a community early intervention team suggesting that whilst they kept people out of hospital, it increased the vulnerabilities for consumers managing distress in the community. Gatekeeping tensions between teams at this crisis interface were at times determined by personal issues and distrust in communication between staff members, and systemically based communication breakdowns:

> One thing [the incident] did highlight was the communication between the teams, how much you can trust someone who you are not a colleague of directly, the fact that Hazard Sheets don't get passed on....
>
> Occupational therapist, community

Emerging from these dialogues was a sense that for these workers, the communication systems that were set up to support consumers often failed both consumer and worker. One CSW cited the lack of consistency in documentation, providing the example of one consumer who kept knives under their bed and was reluctant to admit workers into their house,

information which was not documented across all teams that needed to know. They alluded to a recent public inquiry that had criticised an employer for having five case files about a single client, all containing varying levels of crucial information.

Several narratives located tensions for mental health workers as being organisationally based, with systemic strain resulting from poor accountability practices. In what one CSW termed 'the crab model' of accountability, several participants entered into discussions about the reluctance of employers and colleagues to take authoritative responsibility for safety issues concerning consumers and staff, thus creating a side-stepping and defensive definition of management:

> There's always that underlying current of the 'crab syndrome', where you have team members who are like a crab. When you start to get out of the bucket they pull you back down because they don't want someone coming out and doing something a little bit too radical, or a little bit too different, because then it might undermine their position, or their career goals, or whatever.
>
> Community support worker, specialist team

Accountability structures in mental health concern the issue of who takes responsibility for the management of systems of communication and the maintenance of sound clinical practice. The impact of managerial approaches to mental health administration has been to separate clinical and management roles to the extent that managers in mental health, although perhaps initially trained as mental health professionals, no longer practice or have clinical responsibility (Chapter 3). Professional identities in the mental health system have increasingly experienced flattened career structures and pathways. This has at times challenged the influence of clinical knowledge in decision-making, and created tensions between workers and those they see as management. Whilst one participant saw the definition of management as a non-clinical person, others felt strongly that they had to have a clinical background so that they could have, as one social worker put it, 'some understanding of what you're really facing and have done it themselves'. The ability to communicate need and priority to management seems to underpin this position.

A social worker commented that the two key roles within their ideal team (the clinical coordinator and the consultant) would both be clinically rather than managerially focused. However, even within clinical roles, hierarchies in terms of knowledge, consumer contact and accountability emerged, highlighting the vital necessity for clear communication processes:

> Within a multi-disciplinary team there is a responsible clinician who is generally a doctor and I was the key worker and also a clinician responsible for that person's care, but ultimately, the big decisions are made by the doctors but the key worker has the most contact and I guess knows probably more information at times than what the doctor would, 'cos sometimes the doctor may actually see people once a week, once a fortnight, three weeks, once a month, once every six weeks, depending on the need and the situation that you're in at the time.
>
> Social worker, community

Accountability appeared to be constructed of an uneasy blend of sapiential and profession-based authority, which was an object of some frustration for this social worker:

> The thing that happens here is while they say that the doctors actually have the liability, it's the key workers that do all the work and the reports and the crap and have to be the ones to stand up and assert.
>
> Social worker, community

From the other end of the hierarchy, this psychiatrist spoke:

> I guess the other thing is that you're the doctor; you're the one who's in charge. The nurses can go and whimp out but you don't. Well that's partly, I think, self-imposed, just as who I am, but I think it's also really partly a structural thing in hospitals.
>
> Psychiatrist

Confusion of hierarchical accountability and consensus team politics thus created uncertainties for professional practice and ethical behaviour.

Several respondents discussed the impact of high profile cases that were current within the region, a support worker above highlighting the impact on their own team by suggesting that 'it isn't so much that have you done everything you can, it's now, have you covered your arse?' This respondent talked about how, in their perception, fear of blaming and media attention had caused people to develop a reluctance to stick their neck out in cases, to retrench accountability to a very restricted definition of work role and responsibility, and to be quite ungenerous in how prepared they were to see consumers as whole people. Describing an attitude of 'why bother?', they eloquently talked of processes of shifting responsibility on to others, of back-stabbing and innuendo, and suggested that 'you're not going to have a nice sort of open de-brief when those sort of things are the environment you are working in'. Furthermore, such attitudes affected morale and job commitment:

> In terms of burn-out, you start thinking, is it worth coming to work to do this much when, you know, your next door neighbour seems to be doing the bare minimum and getting paid just as much as you are?
>
> Community support worker, specialist team

This support worker's analysis heavily underscores the arguments acknowledged in Chapter Six, that the integrity of support for both staff and consumers can be clinically and ethically compromised by defensive practice in anxious environments. Given the Health and Safety appreciation of mental health environments as contexts that are inherently high risk, and the frequent incidence of inquiries within the mental health system (Chapter 3), it is important that the conditions in the work environment are monitored and incorporated into any system of staff support after incidents. Both the meaning and interpretation of experience and the degree of uptake of any support offered are likely to be influenced by anxieties present within the workplace.

Conclusion

The narratives of the participants in the individual interviews have thus provided rich descriptions of their own perspectives on work within the mental health system. In describing their occupational identity, roles and tasks, they have begun to paint a picture of the complexity of the service delivery environment in which critical incidents and traumatic events may occur. Crucial in this cross-sectional depiction is the extent to which their happiness, stability and professional best practice is determined by the contextual issues of communication, power and organisational functioning, an issue that lies at the heart of the thesis question and its attention to the ecological embeddedness of response to incidents.

Attention now turns to descriptions of the incidents and to their experience of what helped or hindered their recovery.

Chapter Nine: The Experience of Critical Incidents and Traumatic Events

This chapter focuses upon the experience of the twenty respondents in relation to critical incidents and traumatic events in the workplace. This experience provides the unique descriptions and reflections that act as a counterbalance to the exploration of the contexts, conceptualisations and theories in Chapters Three to Six. The narratives suggest strongly that an ecological understanding of context and time are important factors in the impact of, and recovery from, incidents within the workplace.

Dimensions of the definition of incidents are first explored, followed by participants' views on the level to which they were individually and organisationally prepared for such risks. Consideration of the nature of the environmental supports for incidents with which the workers were familiar forms the last description prior to description of the impact of the incidents themselves, which is constructed in part as a trauma audit, informed by knowledge from Chapters Four and Five. The chapter then considers the processes (both personal and organisational) that assisted or hindered their recovery, using as an ecological framework the model of recovery constructed by Herman (1992a; Chapter 5). Participants comment on their own learning from the experiences, and finally, address the relationship between their own narrative and the interview process that they underwent for this research. Like all exposure to critical events and experiences, the reading of these experiences comes with a health warning; it is at times not pleasant, occasionally engrossing, and sometimes quite humbling to read of the incidents that had motivated people to talk.

Defining critical incidents

> I guess a critical incident, whatever the text books must say, must be something that happens that really gets to you in a way that even nasty or difficult or dangerous things don't... I don't know what the official thing is, but it must be something that gets past all the others.
>
> Psychiatric nurse, community

The participants in this research gave particularly thoughtful and rich replies to the issue of defining critical incidents. Whilst some focused on the nature of the stressor, as early PTSD diagnoses had done (APA, 1980), most utilised an appreciation of impact that ranged from the physiological to the social and existential, and through reference to the workplace, acknowledged the particular mix of cumulative sensitivities and one-off impacts that is hypothesised to occur in contextually-defined incidents. Many called upon constructivist interpretations to acknowledge that training and role, the level of support, and personal degrees of vulnerability and resilience could mediate the impact.

Whilst participants were asked to talk to their own definition of critical incidents, the act of definition was not totally determined by their own experience: many, if not most, had been introduced to the concept of critical incident support by virtue of their job tenure within mental health, and the introduction of a form of debriefing within agency structures. Perhaps a third had been professionally involved with the establishment of critical incident responses within their workplace, a commitment that may have lent some impetus to their agreement to be interviewed.

Thoughtful consideration went into the framing of their definitions:

> I'm on our critical incident debriefing team so I've got some other models, but I'll define it for myself ... I see the vicarious traumatisation in two kinds of ways. In many ways for me the more insidious difficulty is the on-going barrage of people's stories, the things that they've come through; but a critical incident to me would be a defined event that really affected me in lots of different kinds of ways, physiologically and emotionally and mentally in terms of a real challenge to my concept of the world, and the after effects of that, and a real kind of shock.
>
> Community support worker, specialist team

Naming both cumulative secondary traumatisation and the impact of incidents, they considered a range of impact from the physiological to the construction of meaning. Their comments speak for several interviews that linked cumulative stress, resilience and incidents.

Critical incidents were viewed as something that penetrated the membrane of predictability, normality and acceptability. The following definition blends the physiological with the role definition of what can be tolerated within

professional training, and touches on the notion of an event being outside of one's normal experience and control (APA, 1994):

> [It] is something that makes you step back suddenly. Shock, there is shock involved, and when you are suddenly acting on your gut response, and it's outside your professional training.
>
> Occupational therapist, community

Not unsurprisingly, some respondents defined critical incidents by means of a particular stressor, such as the disappearance and suicide of a consumer, or an assault. A nurse described critical incidents as encompassing the deaths of clients, but also potentially, complaints made against them within the context of the workplace. Another example cited a murder in which they had no direct involvement, but which reverberated within the entire team, thus illustrating the powerful effect of secondary stressors. They also raise the issue of organisational support, a factor that is of considerable importance in the analysis of actual incidents that follow.

An important feature of the narratives of several workers was that not all incidents with major stressors become critical incidents or had traumatic impact:

> There had been so many things that could have been very traumatic, like people setting themselves on fire [...], people like this gentleman [...] who used to cut his throat or his testicles saying 'nice female', we'd have to sew him up again. So the other sort of things that would [potentially traumatise] like armed offenders callouts, those sorts of things. I generally haven't felt traumatised by it, the tear gas one was just jolly painful.
>
> Psychiatrist

These comments are representative of many, suggesting that what makes an incident critical is not strictly a question of scale but reflects mediating factors such as the degree of helplessness, control and as one put it, 'fairness' within a situation. These factors were seen as dependent upon micro and meso level issues such as role strength and identity, and support from others.

Accidents waiting to happen: individual and organisational preparation for critical incidents

With a working knowledge of each participant's definition of critical incidents, discussion moved to the nature of the support provided by their work environment, an inquiry underpinned by the ecological hypothesis that the workplace shared responsibility for both the occurrence and response to

incidents. Discussion included exploration of any specific awareness or training about the potential for incidents within their own professional development or organisational experience. Participants were invited to reflect on the preparedness of their work environment and on any particular structures of support that were in place.

Participants' preparation for the experience of incidents

The issue of being prepared for the occurrence of incidents was explored. This included preparation in training, in selection for their current post, and in the routine of their work. For some respondents, not only was preparation absent, but there was no recognition of the potential for impact when concern was raised:

> I can think back to my beginnings in my work and being in a house with two unwell people, no training, getting on the phone and saying. 'I've got these two people doing this,' and the boss lady was saying 'You'll cope' and I'm thinking, 'Wah, I'm not coping.'
>
> Community support worker

This CSW was able to reflect on changes within their organisation that had been instrumental in increasing their sense of support, naming supervision and procedures for critical incident support as key factors. The importance of both systemic and individual awareness and preparedness on behalf of the worker and the management was underscored. CSWs are perhaps especially vulnerable because there as no requirement for preparatory training to provide an element of stress inoculation. A support worker with drug and alcohol experience suggested that casual staff, who whilst not highly represented in this sample of workers but who may constitute significant numbers within residential services, may be omitted from scheduled induction and orientation processes.

Interview narratives suggest that even for those respondents professionally trained, there had often been little or no acknowledgement of risk during their training, especially in periods prior to the mid-1990s. One worker, trained in two separate mental health professions, had not had preparation in either. Several observed that whilst they could not recall any formal training that they went through in regard to incidents, their training in practice settings had connected them to experienced mentors. A social worker commented that whilst some training about self-care was given whilst a student, it may not have been meaningful for someone later working within mental health and confronting incidents. Participants often had very strong views about their lack

of training and resultant poor coping skills, with one respondent expressing sadness and anger in regard to their lack of preparedness to handle the attempted suicide that they had dealt with. Several reflected that they thought that increased awareness of risks would have had a knock-on effect in current training programmes. In selection processes, too, the existence of risk and nature of support systems did not gain a high profile. An occupational therapist commented that whilst they had not been informed at interview about inherent risks within the workplace, neither did they consider it appropriate to raise, preferring instead to trust that the organisation had planned for incidents.

Overall, it appeared that the participants felt that prior training and awareness of procedures in relation to critical incidents and traumatic events was greatly lacking in their particular backgrounds, with newer graduates having a heightened awareness - although not with specific training - from their formal education.

Organisational responsibilities and preparation for incidents

In recognition of the thesis argument that much of the responsibility for planning for, predicting and mitigating the impact of events lies within the organisational setting, participants were asked to comment on their awareness of how the environment supported safe systems of practice.

Critiques of the physical layout and its effect on personal safety figured prominently, especially in narratives from those with residential experience where wards and accommodation houses become the focal points for most interactions with consumers. A psychiatric nurse described the frustrations of attempting to interact safely with unpredictable and violent teenage males, in an environment designed for physically ill young children. Structural constraints interfaced with management decisions and lack of consultation around the use of space, with external control over decision-making frustrating nursing attempts to improve security.

Mental health agencies in the community also contained structural and systemic vulnerabilities. For offices, this was often at the public interface, the front desk:

> In the house, there was no protection of any kind; anybody could just walk in off the street at any stage. And we all took it in turns to cover the half a day crisis slot. There was a particular stage where a couple of guys were quite abusive and threatening in their manner and they would just front up at the front desk and turn on a performance and we really had no

> good systems and all we could do was anybody who was aware of it would gather and hover. I realised that I went through a period of being quite sick, getting up and going to work in the morning, and then I realised it was actually just a generalised anxiety, who the hell was gonna walk in the door that day?
>
> Social worker, community

Whilst this social worker agreed with others that organisational awareness of risk had improved over recent year with the introduction of things like panic buttons for receptionists, they commented that any system was only as good as the willingness of workers to maintain them. Denial and minimisation of risk appeared to be located both at individual and organisational levels:

> We have people going off in their cars, nobody would necessarily know because we don't have a good checking-in system. Now that we have cell phones in each of the cars, we sign ourselves out [...] and say what time we're coming back, and we've discussed having a system whereby if people haven't checked in by the end of the day then somebody would notice. But I'm not sure that we've actually put that in practice - it's hard to find foolproof systems that staff don't feel is an imposition.
>
> Psychiatric nurse, community

Community-based services necessitate more of a reliance on 'soft' systems as opposed to structures. A lack of awareness may be based on assumptions of invulnerability, but may also be systemically lodged in the values and attitudes of staff groups. One worker who began professional practice in the mid-80s commented on the 'old school' attitude of not accepting that one could be affected by an incident. The stressor here was not the consumer but the attitudes of the staff:

> I had to go and assess [patient] and it was my first registrar year and I went down and the [hospital] boys thought it would be a great joke to shut me in the room with him, who I knew was a murderer who was quite psychotic. I got pissed off. I mean, he was clearly mad. So it was nothing to do with him but [I knew] what he had done and then [to be] shut in the room with him and he'd be glaring, [with the] guys outside.
>
> Psychiatrist

Both in the interview and in writing this, this narrative resonated with my own experience within the psychiatric hospital, which I described in Chapter One. In both situations, power was played out through dynamics of gender and rank,

and in an organisational context of denial that the workplace was an environment where harm to staff was recognised.

For both residential and community environments, the availability and suitability of staffing was a theme raised by several participants. In terms of organisational responsibility, the use of casual or locum staff was named as a repeating problem as they are often unfamiliar with the physical environment and systems, had little skill in de-escalating incidents, and replaced more experienced staff who had moved elsewhere.

The stories of all the participants revealed strong support for the influence of the environment on the instigation and course of the incidents. Residential facilities have particular structural and systemic issues. The more closed an environment, and the more focused the interactions amongst staff, and between staff and consumers, the more there was potential for incidents to occur. In my own experience, the closure of the old psychiatric hospitals was determined in part by management difficulties over workplace relations and entrenched attitudes within longstanding staff groups whose job descriptions and livelihoods were threatened, factors not often cited in the literature but ever-present in the unionised environment of large institutions. In the community, on the other hand, the flexibility of work practices and the fact that many consumer interactions occur within private homes, suggest that worker vulnerability may at times be exacerbated by an absence of structure and attention to process. The implications for the establishment and use of support systems are immense: not only do such systems need to be acceptable within the environments they are to operate but they will be required to flexibly implemented to acknowledge the differential needs of each workplace.

Critical Incidents: awareness of prior training and systems

Awareness of the potential for incidents and about the impact of workplace stress was prominent amongst participants, and several reported optimism about a change in organisational culture that encouraged help-seeking and informal peer support. At times, as an occupational therapist commented, this remained a matter of personal responsibility and self-advocacy, as did obtaining training, a point raised in particular by nursing staff.

The provision of training often focused upon the opportunity to learn how to de-escalate or manage conflict and physical situations of risk ('breakaway techniques' were cited by the occupational therapist), clearly an important element but one that does not address the issues of psychological harm, or secondary or cumulative stressors. The cost and accessibility of training was

also a factor identified, one nurse complaining that not only was it difficult to get rostered time off for training, but that they were interrupted during training with clinical inquiries.

Most respondents were familiar with the definition of debriefing, although significantly, none specifically described a package of staff support similar to the definition of Critical Incident Stress Management (Chapter 6). It is noteworthy that in several responses, it is the 'Mitchell model' that was described as almost synonymous with debriefing, a result, I suggest, of the debriefing training being provided by Australian consultants affiliated with the ISICF. One participant (themselves a trained debriefer) identified that their organisation had incorporated debriefing procedures, but suggested that the availability and take-up of this service was patchy, local variation implying that incidents in one team would necessitate the 'borrowing' of support from elsewhere. The variation was often due to the level of interest and trained personnel. One social worker expressed scepticism that they would ever find the motivation to establish a team, without the impetus of a major incident and the subsequently heightened sense of awareness.

Once a response system was introduced, it needed to fit with the particular demands of the environment. A nurse commented that some sort of awareness of debriefing procedures had been latterly introduced into a ward setting, but that its implementation was haphazard, not always in place before the end of a shift (implying that it was not provided for up to five days), and that no one in particular had responsibility for putting it in place.

The existence and potential use of Employee Assistance Programmes and the support of Occupational Health in larger organisations was also acknowledged in some interviews, with few participants indicating that these services had ever been used in relation to critical incidents. Lack of familiarity with the counsellors and advisors, and counsellor unfamiliarity with the services were cited as drawbacks, along with difficulties in accessing their support. Such assistance was not part of the daily fabric of life in the system:

> Occupational Health is a [organisation-wide initiative] but [they are] over at [another site], [...] I know it's a role that they've been presented as taking on, but whether we've actually used them, I'm not sure. They're out there so there isn't a connection with what we're doing here. They're not really known and we're just so used to doing it ourselves and fortunately we haven't had a major incident to deal with.
>
> Social worker, community

A degree of scepticism in the ability of large organisations to effectively set up and maintain support systems for critical incidents emerged across all professional groups represented. Scepticism, too, was expressed in terms of the motivation for some people training in debriefing, it being cited as a vehicle for people to get out of face-to-face mental health.

Overall, most participants, although knowledgeable about debriefing and CISD processes (and in some cases, actively involved in establishing or providing such supports) doubted the integration of support systems within their workplace. Largely, where debriefing processes were offered, they were either under development, with the attendant issues of staff commitment, or in operation in other geographical sites or occupational groupings, raising issues of the acceptability of the process within particular contexts. The experiences of debriefings themselves are acknowledged in consideration of the impact of incidents, later in this chapter. Participants did not reflect on how debriefing can be conceptualised as a component of a wider support programme.

Into this discussion is now introduced consideration of the incidents experienced by the participants in the research.

The Incidents

The interviews invited participants to present their experience of critical incidents in mental health. There was no stipulation as to whether they should select one, or more, from recent experience or past practice. The majority chose to talk about one incident outstanding in their memory, but even in so doing, mentioned others in which they had involvement or knowledge. Given this choice, the determining factor about which to talk was often the vividness of the experience. The potential for retraumatisation is discussed at the end of the chapter. The following table identifies the form that incidents took, each category potentially overlapping within the narratives as respondents selected key features or described sequential events.

Table 9: Types of incidents experienced by participants	
Self-harm	Learning of suicide
Intervention in attempted or completed suicide	Suicide postvention
Physically and verbally aggressive consumers	Staff conflict (verbal)
Legal and coronal inquiries	Media attention
Assault on self	Assault on others
Resuscitation	Threat to life
Threat to family members	Challenge to professionalism
Indecent exposure	

A trauma audit of the incidents

Descriptions of the incidents are analysed by means of a trauma audit, utilising the knowledge described in Chapters Four and Five in order to highlight the key characteristics of experience that may assist in the future construction of appropriate staff support systems. The accounts took either a sequential or a more compartmentalised form. Some participants chose to present their story in sequential narrative, substantially steered by chronological memory of the event and its impact. In these cases, whilst some extraction of particular information was important and appropriate for data analysis, the sum of the whole was also crucial in order to convey the overall impact and evolved meaning. Several vivid narratives in particular are presented in this form, some almost in their entirety, and are contained for reference as Appendix Ten. Emergent themes from these accounts, along with illustrations from other incidents, are presented below.

Other experiences were presented with emphasis less on chronology than on the desire to reflect specific processes of experience and resolution. Perhaps significantly, the people who presented their experience to me in the most chronological format were those who had experienced more objectively severe stressors, such as the need to take life-saving action, to avoid threat to life, or who had experienced extreme helplessness. My judgement is that these incidents were still very much alive and playing out in the experiences of these very strong people. In other words, the narrative form provided an integrative and containing function over vivid recall, and reduced the requirement to summarise meaning. It also reflected that for these people in particular, processing of the experience remained constrained by the overwhelming sensory and emotional reactions with which they were left.

Previous discussion in this thesis has suggested the difficulty in determining whether an incident will have a traumatic effect on an individual (Chapter 5), and has attempted to tease out some of the complex issues involved in determining organisational responses to events that may influence recovery for those involved (Chapter 6). Discussion has also centred around the conceptualisation of traumatic impact, and the limitations of the DSM-IV constructions of PTSD and ASD (Chapter 4). As qualitative investigation, the interviews did not attempt to screen for or diagnosis such post-traumatic effects. Nevertheless, emerging from many of the interviews is a keen sense of traumatic effect. Following sections use the device of mental health disorder and the criteria listed in the diagnoses of PTSD and ASD as a means of

presenting the experiences of the participants, whilst recognising that many factors in impact and recovery extended beyond these criteria.

Firstly, however, one narrative (Narrative 1 in Appendix 10) is presented and discussed in order to signal the potential breadth and depth of impact. It is essentially a verbatim account of an incident by a psychiatric nurse, who was working in a community team when they discovered the attempted suicide of a young woman.

A trauma audit of this account reveals much about the impact of the incident. Whilst the worker concerned worked in an area where crisis by definition was routine, and their professional training sensed a dissonance between the consumer's presentation and their prior knowledge of her needs, the actual event was nevertheless unanticipated, shocking, and required them to take immediate action. Although the incident had occurred a significant time before the interview, the visual impact enabled them to recount very small details, and my impression of the interview circumstances was that for this nurse, the traumatic impact was very much with them, and had persisted well beyond the point of impact.

The quality of recall of this incident is stark, to the point that I can envisage not only the nurse, but their colleague, the consumer, and her bedroom. Imagination completes the picture. It is noticeable that the account was given factually, with little interpretation or synthesis of theory, clinical assessment or operational perspective except at the beginning, where they describe the routine of the medication drop-off, and the ethical indecision of whether to intrude into someone's private world where they are not identified as a consumer of mental health services. Once the crisis took hold, the narrative had no space for reflection on their decision to investigate further, and no acknowledgement of the value of their doing so in order to keep the consumer alive. The sensory information captured the narrative, depicting sight and smell, the distortion of time, and feelings of horror and fear. Momentary indecisions and loss of cognitive ability to recall simple processes such as dialling the emergency number were described, as well as the dissociative actions of the flatmates in order to deal with the unfolding scene. The tunnel vision provided by training and role is illustrated in the practical ability to dispose of blood-soaked clothing and bedding, and contrasts with the flatmates' later disorganised responses. The responsibilities of the nursing role continued to govern their description of their behaviour, until such point as they were required to build a narrative for the benefit of others, whereupon the sensory and emotional impact intrudes into their usual sense of professional

detachment. They were unable to present the information in a language-based mode, at handover the next day, without the visual images intruding. The impact of the event endured for many months afterwards. Their commentary in this regard is addressed elsewhere in this chapter.

Aspects of the incidents reported in the interviews are now presented, utilising the understanding gained about trauma within the literature review, in order to thematically audit the data.

'... so I felt very much a prisoner': fear, helplessness and horror

> I think it was like an extreme case of anxiety going on underneath, in fear. Actually it's like your world has been turned upside down.
>
> Support worker, residential

Criterion A of both PTSD and ASD (APA, 1994; Appendices 1 & 2) refers to exposure to a stressor affecting themselves or others that provoked feelings of fear, helplessness or horror. Participants recalled a broad range of incidents that were potentially harming, such as actual or threatened violence to self, others or property, concerning disappearances, and arson.

Some workers themselves were the focus of incidents, the description cited as Narrative Two (Appendix 10) reflecting the fear felt when a psychiatrist was assaulted and trapped during an assessment in the community. This account illustrates the potential for levels of fear to remain at high level in cases where incidents in the workplace are episodic rather than one-off events, reflective of Terr's Type II events (Terr, 1991). Similarly, a support worker in a residential unit had their safety compromised over a length of time, through two direct assaults and an ongoing threat to their life through potential blood contamination. They described the frustrations of having security personnel available but who were reluctant to physically restrain a violent consumer, who then absconded after assaulting the participant. For this person, the puncture of the membrane of safety continued over the next few days with the offender still at large. Trying to 'behave normally', they were then called to go back into the workplace, fearful because they thought the offender would be watching the unit as she had escaped from where she had been held.

Prior knowledge of previous incidents involving consumers (in two cases, a threat to kill, accompanied in one scenario by the presentation of a firearm) fed into the levels of fear. For one worker, the threat to their life had been made via someone else, but it had major impact on her well-being: her story is located in

Narrative Three, and is considered in the later discussion of the power of events to connect with prior experience.

Working in teams opened up the possibility that the impact of events could involve them in a less targeted but nonetheless immediate manner. In the following, the visual images of a suicide were described:

> What I recall now, eight or nine years ago, was the face of one of the nurses running towards me saying [my name] and when we went into the room, she'd cut the patient down, the patient had been dead for a time, 'cos she's cold and the thing that comes to me is seeing [the nurse's] face coming towards me.
>
> Psychiatrist

Others were impacted upon through learning what had happened to consumers with whom they had a connection, without the visual or auditory cues of direct experience:

> He went wandering off in the [suburban] area, came walking back down on the railway and got run over by a train; they found bits and pieces of him down the track.
>
> Community support worker

Not only was the manner of death so extreme, but these workers also faced the role of liaison with and supporting families afterwards.

Common to several narratives was the experience of loss of control and helplessness. Narrative Four reflects both a loss of control embedded within the professional duty of responsibility for a group of vulnerable consumers, and a physical and emotional disgust at the behaviour. This respondent clearly identifies the immediate physical and emotional impact of the incident, the lack of perceived control, and also illustrates the perception of changes in the passage of time characteristic of dissociation. Whilst the incident did not involve a threat to life or physical integrity, the worker's account to me suggested that they would have at least partially fulfilled acute stress criteria, with the experience drawn out by reminders of the offender's ongoing presence in their own community.

Another respondent articulated clearly the sense of things being out of control. As a support worker, their role involved working with vulnerable consumers in supported accommodation. One resident was new and still being assessed. They described the scene as they entered the house:

> She just went straight down the stairs, past me into the kitchen where this girl was doing dinner, big karate kick in her stomach

> and then one of the other girls came over and then she started hurling cups at her. So my first thing was I've got to get these women out of the house. So she pulls the phone out of the [wall] but that was fine 'cos I had my on-call phone on me and I rang 111[53]... I just walked out of the house and tried to get these girls hurrying along the street and hid behind a bush hoping that she wouldn't find me, but she came out and paced along the road, and then she went and got a stone and cut her wrist, and then she came [and smeared it] right down my face. And at the time I didn't think anything of that, I thought, 'that was easy, she could have punched me' [...] and it did seem like an eternity before the police came...
>
> Community support worker

Fear was evident in their description of their physical vulnerability, as they hid themselves from the assailant and tried to avoid potential weapons. Again, this worker related their altered sense of time, and the loss of control experienced, alongside awareness of the responsibilities of their role. The meaning of being smeared with blood (the threat of blood-borne disease) did not occur to them in the focus on physical safety. These experiences signal that incidents occurring in the context of work roles and responsibilities can have a profound effect on a person's recovery.

Whilst helplessness and loss of control appear as central characteristics that influence the course of impact, remaining in control, conversely, is not always interpreted positively. Here, a social worker interpreted their strong reaction as a weakness because they lost their professional 'cool' during an incident in a psychiatric unit:

> She got between me and the doors, I couldn't get out and she started getting really abusive. And when I think back now, my reaction to that was being stunned and getting angry with her. I remember being furious with her, it was like instead of recognising it as to what might have been going with her, I took it as a personal affront and I was furious [...] and I think she was so stunned at the time that she actually backed off. But I mean it was very unthought out, [...] I look back now, it probably [...] wasn't necessarily the most appropriate way of dealing with the circumstance!
>
> Social worker, community

There are clearly potential tensions between acting professionally in role, and legitimising the human cost of being confronted. It is situations like this that

[53] 111 is the emergency services number in Aotearoa New Zealand.

lead to confusion within debriefing and similar procedures between operational and staff support functions, an issue addressed in Chapter Ten.

The indirect impact of incidents figured prominently in the narratives. The language used in DSM-IV is that a person needs to have experienced, witnessed or been confronted with, the stressor that affects themselves or others (APA, 1994). This is often interpreted as direct exposure, although it does permit vicarious learning of an event, thus potentially opening the definition of a stressor beyond what he considers workable. What is crucial in the analysis of the indirect effect of incidents is that the stressor in these experiences was not necessarily the event (such as the assaults and suicide attempts described above) but also the other forms of involvement with the primary victim. These contextual sources also bring in to play expectations of role, accountability and job performance as protagonists in the impact. The depth of involvement between a mental health worker and a consumer, for instance, may well set up situations where the impact of the stressor is felt strongly despite the event occurring beyond direct experience, as it resonates through relational ties and professional obligations. Narrative Five illustrates this point, and also suggests that duration of involvement also contributes to the impact.

Systemically-embedded involvement with the lives of consumers emerges as a key feature of mental health work and a significant factor influencing the shape of critical incident support.

Parasites of the mind: re-experiencing of the event

Criterion B of the diagnosis of PTSD is focused upon the intrusive re-experiencing of the sensory qualities of the original stressor (APA, 1994). This is distinct from the cognitive and constructionist processing of the event into declarative memory. Narrative Two was a psychiatrist's description of their attempted strangling. They continued:

> The other thing, which I don't know if it's a posttraumatic flashback or it really happened, but when I walk up to the doors [... it] is her eyes, her coming rushing towards me. So it's maybe that when I was there she saw me and rushed towards me with the door closed or maybe I hallucinate, I don't know. Anyway I can still get that sometimes.
>
> Psychiatrist

One of the interesting points in the quotation above is that the worker makes a distinction between a flashback and a real event. My interpretation of this is that after some ten years, there is still a lack of integration in their memory, and

they use the term 'hallucinate' as if they do not recognise the posttraumatic nature of the recall.

Intrusion involves ongoing reminders of events. The following illustrates that in many contexts, this does not necessitate direct exposure but symbolic representations of the experience:

> And I still, whenever I see a rope hanging from a tree, just have a sort of immediate reaction, 'take that down, that's really dangerous'. Even kiddies' swings and things like that. [...] I guess you'd visualise how it would have been. I don't actually have a conscious awareness of having visualised it, but it is there and it comes up all the time whenever I see any means possible of someone hanging themselves.
>
> Social worker, community (Narrative 5)

Holes in the resilience membrane can therefore be punctured over considerable distance and time. Here another social worker talked about a consumer suicide:

> I saw [the suicide] as a tragedy at the time and I still see it as a tragedy and it comes up every now and then, because the daughter [of the woman who killed herself] is a [public figure] and every time I see the name, I'm very aware, [...] so it obviously hasn't completed.
>
> Social worker, community

These comments suggest that even where a posttraumatic diagnosis would not have been forthcoming, there will still be active reminders and triggers within the personal and occupational experiences of mental health workers. These, potentially, could become dynamics in practice, and are issues that are located in the interface between support processes such as debriefing, and those of supervision and personal stress management programmes.

'Push me-pull you': the tensions of avoidance and arousal

Criteria C and D in the DSM-IV diagnosis of PTSD describe the twin set of symptoms that reflect persistent avoidance of stimuli associated with the trauma, and persistent symptoms of increasing arousal. These twin tensions orbit around each other and a person who has been exposed to a traumatic event will, in the diagnosis, experience symptoms of each. Typical of several narratives, this support worker reported an intrusive and aroused state after an assault:

> I must have got home about 1 o'clock in the morning and it was my birthday, I remember that, but I didn't sleep all night because I was too wound up and I just kept thinking that this

> person was gonna turn up. That all that was on this person's mind was to get me...
>
> Support worker, residential

The nurse in Narrative One commented:

> I didn't know whether I needed to talk about it or if I didn't know whether to, for everyone [else] just to never mention her name and never mention what had happened ever again, and I've vacillated between the two, so I wasn't sure which one would be the most useful. It's hard because I wanted to talk about it but I didn't want to.
>
> Psychiatric nurse, community

Avoidance, of course, is part of a natural process of coping with overwhelming sensory experience. Sometimes it can be quite overt, as in the case of the support worker in Narrative Three whose life had been threatened, who immediately got off the phone from their informant, notified their manager, and in response to being asked what they needed, said 'I want you to send me to Hawaii'.

Where situations intrude on a person's sense of control, a divorce or separation from a perception of 'normal' reality may occur. This dissociation, as previously described, is the fragmentation of sensory and cognitive experience through which the body and mind's reactions strive to adjust to the overwhelming experience. This is part of the Criterion C of the DSM diagnoses, and it is often indicated by the loss of cognitive capacity or control over language, such as the inability to recall how to dial '111' in the account of the attempted suicide provided in Narrative One. Feelings and actions become separated, a residential support worker talking about 'walking around in a daze for a couple of days'. Similarly, clarity of memory may fall victim to the effects of numbness, described by a social worker as a 'foggy process' and 'a bit unreal after the fact'.

Dissociation often manifested as a distortion in the sense of time. As one CSW said, 'it did seem like an eternity before the police came'. Depersonalisation was reflected in the occupational therapist's experience of the consumer who masturbated in the relaxation group (Narrative 4). I asked them whether they had altered the programme in order to keep the consumers' eyes closed until the sexual exposure had finished.

> No, I wasn't saying anything like 'keep your eyes closed' or 'keep the breathing up', I wasn't able to do that, I couldn't act

> creatively. I was aware that somehow the script was getting read, but I wasn't hearing the words.
>
> Occupational therapist

These experiences illustrate the 'push-me-pull-you' tensions characteristic of traumatic incidents. These will become active dynamics in the psychological and social recovery from incidents and will be players within any support systems that require the development and use of narrative.

The past lives on in the present: triggers from prior experience

The past experience of workers is an area of significant importance in the processing of any new experience. Within the literature I have explored the particular tendency of traumatic experience to repeat, and the vulnerability of workers to be triggered into sensory and emotional states reminiscent of prior experience. For ethical reasons, the interview questions did not set out to explicitly ask participants about their prior personal histories, nor were any links that respondents made between their own stories and that of their reported incidents explored in a therapeutic manner. Nevertheless, several of the workers reported with great integrity on some of their own personal motivations and experiences, the interview relationship generating a degree of trust for them to establish their own means of linking events.

Some discussed their past experience as having shaped their means of coping with acute stress:

> My childhood wasn't a piece of cake, my mother was always a very depressed and tearful sort of person and she went in and out of hospital for treatment. It wasn't always a happy, loving environment and I just learned to block things out because that kept me safe. [The] doctor [at work] said 'at times it's the most valuable thing to be able to do' and I think that is a help.
>
> Community support worker

One nurse linked the meaning of a consumer suicide into their own experience of depression, explaining that it had left them 'acutely sensitive to other people when they are depressed'.

One testimony emerged within the interviews to clearly illustrate the potential devastation of prior experience on the interpretation of and response to incidents in the workplace. This residential support worker's account of their experience of a threat to life is reported here as Narrative Three. It provides a rich and very human insight into a situation that by all measures evoked a traumatic response. Their narrative underscores the importance of the past

within our present life, and raises important questions in relation to early intervention, ecological awareness and staff support.

This worker was rung by a colleague in another team, and informed that a consumer who had been asked to leave her unit had made a verbal threat to her life. She reported she immediately took this seriously as she had been alarmed by the seriousness of the consumer's prior offending as detailed in a victim impact report. In her interview, she described the impact on her. The sense of helplessness and loss of control is palpable, saying that 'I was frightened to be somewhere and I was frightened not to be there, and I just didn't know what was right and what wasn't right'. She reflected on how, despite significant levels of personal therapy and support, these past experiences were resurrected during the threat to her life.

Her description of the immediate impact of the threat bears many post-traumatic characteristics. It clearly illustrates how her family life became threatened and altered by the anticipation of violence (Narrative 3a). At no point had she been directly threatened but the consumer remained at large in the community and unlocated by mental health services or the police, and she relied on family support her for several weeks afterwards.

For me, this was perhaps the most emotionally draining of the interviews to be involved in. The connection with the respondent's prior experience of violence essentially dominated the affective components of her description, and the extent to which home and family life was permeated by this sense of threat was clearly ongoing despite the incident having occurred several months previously. Whilst returning to work and immersing themselves in the clinical and political environment of the unit, I was left with the impression that for them, strengths and vulnerabilities were continuing to struggle to remain in healthy balance.

Prior experience, from a strengths perspective, can also contribute to resilience by strengthening the trauma membrane through processes of meaning and acceptance. From a tangata whenua perspective, this worker eloquently describes processes for grieving that assisted their recovery, linking the concepts of tangi to that of debriefing:

> Culturally, I'm equipped for situations like this, through my whole upbringing, going to tangi. You go to the marae, from the karanga you hear the wailing from inside the whare as you approach [...], and then you go right up there and you hear the people on the side of the whare, they're crying too and you get up to where the body is and the sound is so intense that you

> know you can't not but cry. And then you go and you greet the grieving family and then you move around to the whole whare, everybody else is greeting and then it's over to the orators and then there is an opportunity then for us to express ourselves like a debriefing situation. And we also sing our songs of grief, it's how we express ourselves. I don't say it in arrogance but that's how we are, we are just equipped for situations like this.
>
> Maori mental health worker

The disparity that emerged for this worker was the translation of comfortable cultural processes into the alien environment of a mental health team, where not all members shared the expectation that grief would be addressed in this manner. As cited in the previous chapter, when the death of a Maori client was responded to through Maori kaupapa, it appeared to have unwittingly excluded some Pakeha staff members from attending. This issue is also addressed in commentary later in this chapter.

I was reminded of the quotation above, at a training session with health social workers a year after I conducted these interviews. During a discussion about critical incidents and debriefing, a worker in a Pacific Island team reported that they would only perceive a need for a debriefing-type process if the incident had offended their culture; at other times, the usual collective expressions of feeling would address any need. This is an important ecological contribution to the discussion contained in Chapter Six. Clearly, support systems within mental health environments in Aotearoa New Zealand become part of the tensions between cultural exclusion, inclusion and the dynamics of cross-cultural communication.

Beyond the diagnoses: the ecological effect of the incidents

Whilst the hallmark characteristics of the DSM diagnoses of ASD and PTSD contain the physiological and cognitive descriptors of impact, many of the participants chose to describe the traumatic impact in terms of their social and existential experience. The ecological embeddedness of the incidents within work and home life emerges as significant features of ongoing attempts at recovery and healing. Those respondents whom I have identified as potentially meeting DSM criteria also in part were able to address some aspects of the wider impact, though remained more focused upon the immediate and individual aspects of their experience, suggesting the ability of traumatic experience to sever connection. In several narratives, participants were able to straight away describe issues of meaning and the impact on the wider environment, and in most of these cases it is apparent that the incidents, whilst disturbing, had either not happened to them personally, or whilst critical, had

not impacted traumatically. They were able to maintain a distance from the event during the interview.

The complexity of impact often plays out in the development of meaning over time, as was evidenced by the support worker who, smeared with blood 'was just relieved that that is all she did to me, that it wasn't a great big brick hurled at me or something.' Logic that infection could only occur through cuts to the skin, which had not occurred, was able to prevail in the post-crisis setting.

A significant concern about the accuracy and use of the PTSD diagnosis (Chapter 4) is that of its incorporation of social and environmental influences and interpretations. From an ecological perspective, such a move reflects a logical and necessary acknowledgement of context. However from a diagnostic perspective, it is detrimental. The dilution of the specific criteria required for a diagnosis is perceived to threaten the integrity of the scientific, political and legal definition of traumatic impact.

There is no clear resolution to this debate. Rather, it depicts the ongoing tensions in which issues of the provision of staff support systems are played out. Without a clear distinction between critical incidents and traumatic events (which this thesis argues is not a possibility) and with a moral imperative for organisations to provide some sort of staff support system, the impact of contextual factors is a necessary consideration. With appreciation of this, the following discussion focuses upon issues in the recovery from critical incidents and traumatic events in the workplace.

Key stages in the recovery from critical incidents

Herman's (1992a) three phase model of recovery from trauma is utilised here as a framework to describe the processes of coping, recovery and re-integration after critical incidents and traumatic events. It is a framework that acknowledges the ecological complexity of a journey of recovery, through its engaging with issues in a person's life that have embedded themselves within behavioural, social, cultural and spiritual dimensions. Issues related to obtaining safety and meeting immediate needs are first addressed, followed by discussion about the processes of assistance and healing adopted or offered both formally and informally. This includes acknowledgement of debriefing processes when used. Finally, the integration of the experiences into a wider whole is addressed.

All respondents had different journeys through these stages. For some, elements of safety and freedom from further harm had only brief importance as

the legacies of their experience were quickly internalised and absorbed into practice experience and reflection. For others, an ongoing commitment to their own stability remained paramount, as the sensory impact of the incidents continued to intrude. Nevertheless, those within this latter category had remained in the workforce and maintained often demanding and responsible roles. (It can only be speculated that some incidents had had such a catastrophic effect on some individuals so as to impel them out of the mental health workforce.) The unique matrix of outcome demonstrated here has major implications for the provision of sound staff support systems.

Stage One: Safety

As participants attested, recovery from a critical incident or traumatic event will be impeded or prevented if the incident is ongoing. Priority falls first on the processes of demobilisation (Chapter 6), the act of removing oneself, or of being removed, from the immediate situation, or of otherwise beginning to gain an appreciation of safety. From a trauma perspective, therefore, safety acquires aspects of reducing the impact of fear, helplessness and loss of control. For several interviewed, the embeddedness of the incident within an organisational process such as casework responsibilities determined that delineation of the end to an incident did not proceed in a lineal fashion that might be expected from one-off events in other environments. Nonetheless, reflective of crisis theory, most could delineate the acute stage of recovery from lengthier and more complex organisational and personal responses that played out in subsequent days and months.

In incidents where there was actual or threatened violence, establishing safety was a key task, and participants recalled the emotions that accompanied this. For one worker, the sense of safety was initiated whilst the incident was ongoing. They felt 'held' by the police officer on the phone:

> It did seem like an eternity before the police came but the officer on the phone was fantastic. I mean she walked me through the whole thing but it was blinking scary. [...] She'd say what she doing now and she was [...] really fantastic.
>
> Community support worker

Immediate response and follow-up from emergency services, management, colleagues and family perpetuated this feeling of safety. Recognising that they needed space rather than a talking opportunity, both their manager and their partner gave them assistance in taking time out for themselves.

After the threat to her life detailed in Narrative Three, the support worker with a personal background of family violence was encouraged by Occupational Health to take time off work. They commented that this was what enabled them not to quit on the spot, and to buy some time to make a reasoned decision about the viability of their return to the workplace. This is a significant piece of learning for the delivery of support systems, suggesting that for some workers, a formal process of debriefing may not be immediately sought or perceived as needed for recovery.

The use of both formal and informal supports during and immediately after the incidents highlighted several issues for respondents. One commented that however good it was to receive the support of colleagues, and to be able to talk things through with familiar people, they were worried about exhausting goodwill. Another suggested that reverberating impact over several weeks reinforced a sense of being new to the agency and the region, and a lack of induction to organisational systems. The incident in Narrative Three reflected the efficacy of the systemically-based supports:

> And he was asking me what I wanted to do. Granted our Service Manager was fairly new, [so] he rang the legal office and asked them what to do, and they were looking into what needs to happen, my Team Leader at the time asked me, did I want the rest of the staff to know and I said, yes I did. So she called all the staff urgently into a meeting, and asked them to be aware and just to make sure ... and be aware of me when I'm on, and if I'm here and concerned, get someone to walk to the car park with me.
>
> Support worker, residential

Reliance on the awareness and support of others produced immediate relief but also longer-term vulnerabilities, three participants making comment that by taking the issue out of the immediate workplace and into the hands of others (in several cases, the police), they may have not received the credibility, feedback or practical assistance that they continued to require. Sensitisation to ongoing levels of fear was an outstanding characteristic for those whose life had been threatened and for whom the threat remained imminent because, in several cases, the perpetrator remained at large. There was an unmet expectation that the authorities (the mental health services or the police) would assist.

> So he took me down to [the] Police Station and I was interviewed, and they said while he didn't make a threat to me, he made it to a third person, they will investigate it, but it's not

> high priority, and, I mean I understand it logically but it didn't feel good at the time.
>
> Support worker, residential (Narrative 3)

Sensitisation to fear may endure beyond the involvement or awareness of others. In one case, a worker felt extremely vulnerable some seven or eight months later, and said that only hearing back from the police would make any difference. Similarly, a support worker was told that their case was not top priority, and commented that the impact 'was similar to when it actually happened, I wanted somebody else to do it for me.'

On a physiological and behavioural level, a person's stress response can only begin to return to normal levels of functioning once the threat has subsided. The literature in Chapter Five suggested that there are medium and long term risks should stress levels remain high. For several participants in this study, there was no definitive closure to an incident, requiring physical and mental alertness to the potential re-occurrence of threat. The two support workers towards whom threats were made both commented on the enduring nature of their experience, fearing that they were being stalked by the consumer who had demonstrated violent and threatening behaviour.

Such ongoing risk and reminders of the incidents thus become potential challenges to stability and well-being which at times necessitated attention, illustrating the spiral as opposed to lineal nature of recovery processes. Despite returning to the workplace and routines, an individual's recovery may require ongoing attention to safety as well as integrative processes of recovery. Illustrating this, the nurse in Narrative One had described in detail their very vivid visual recall, and had difficulty switching to talking about the impact of the event in the subsequent days, even losing the train of thought when I asked a question, several months after the event.

Events that had punctured the safety membrane for a worker, and which did not have clear endings due to professional commitment to a case, or the community-based location of a perpetrator, appear to require longer-term support, and underscore the importance of systemic relationships between agencies. They also suggest that issues of safety, the first task of Herman's model of trauma recovery, will in some cases endure beyond the immediate impact of an incident, potentially impeding both recovery and a return to full professional capability. Such issues underscore the importance of having some provision of ongoing support processes that can monitor and support recovery and stress levels.

Stage Two: Issues in recovery

> It's hard to remember [how long things took to feel normal], because I still feel it now, every morning, so it would have been a really gradual kind of desensitisation. But I also was phoning the family, so I imagine part of [recovery] was as I didn't phone the family any more, so that would probably be five months, six months, and probably, I mean the worst was before. Afterwards it's not like there's any sense of relief, but there was a 'known'. So, if you were graphing it, it would be really high and then that would have happened, and then probably stay high for a bit and then come back [...] gradually down, and I think that process would have probably have been, the worst would have been a month, and then sort of a slow decline to probably six months and then...
>
> Social worker, community (Narrative 5)

For many participants, responding to immediate needs after an incident emerges as the most successfully accomplished part of the recovery process. The freshness of the event and the obvious disequilibria of those directly affected promote a level of awareness and willingness to respond. Once the immediate situation has been dealt with, and demobilisation achieved, however, the narratives of the participants in this study suggest that for many, the effect of an incident compromised their well-being for a considerable time afterwards. As the experience became embedded in the personal, familial, social and organisational contexts in which a worker is located, so the outcomes of recovery were mediated by complex determinants of self, others and the organisational environment. This section first addresses aspects affecting the individual's processing of the event, and subsequently considers relational issues and factors originating from the organisational context.

Why me? Searching for a sense of meaning

Only one of the interview participants suffered long-lasting physical harm from an incident, a factor that could potentially dominate recovery processes. Recovery for the majority focused exclusively on the psychological, social and existential processes of coming to terms with the events. The struggle to establish meaning permeated several narratives, the perceived randomness or unfairness of the incident creating confusion and distress. After their life was threatened (Narrative 3), this support worker commented:

> I can understand if I was the one here who said 'okay, that's it, we've had enough of you, you're going', but I wasn't even at work that day. I understand that... he had trusted me probably and he felt let down [for having been sent from the unit], and

> so I'm the target, and I've had my children attacking [me] when it's their father that they're upset with, and so I understand some of that. But I want to feel it's unfair too.
>
> Support worker, residential

Expression of the need for explanation and answers to people's behaviour reinforced that all of the incidents cited were those involving social interaction within the context of mental health service delivery, and professional commitment toward positive outcomes for consumers.

> ... one of my clients suicided and I really was quite stunned, because it [was] unexpected, even though you learn to live with suicide in people. I had real empathy with her. And I really felt we'd done everything we could and I thought we were over the worst and it was such a tragic situation, because ... her daughter was coming back from overseas and it was something she was supposedly looking forward to. We felt that once the daughter got here then things would quieten and she killed herself on the morning her daughter arrived. We were so near and yet so far. The daughter arrived at the airport about three hours later. I still don't understand why.
>
> Social worker, community

In the attempt to understand actions for which a satisfactory explanation could not be found, values and beliefs came into play, a Maori mental health worker stating that 'in our way of thinking if you're gonna die, then die fighting or die doing something productive - not that way'.

Meaning and language are inextricably linked, as I have explored in Chapter Five. The use of narrative, as exemplified by the interviews themselves, provides both a vehicle and a measure of recovery. Communication provides a means of distancing oneself from some of the issues, and of being acknowledged and their feelings validated. One social worker, badly affected by inter-staff conflict, initially constructed a letter as a potential means of formal complaint, but finally utilised it as a therapeutic tool that reflected personal stress management processes of journalling. They never sent the letter, but found that externalising their concerns assisted in maintaining their feeling of self-worth.

Overall, the testimony of the participants suggested that attempts to make sense of an event are universal. Some explanations for some events will be readily provided within training and role awareness. Where an incident punctures a personal membrane of safety, however, a new sense-making quest

is instigated, and it is here that the ability to develop a narrative and receive external affirmation are key.

Learning to cope: processes of sensitisation and desensitisation

A key experience of several participants was the degree to which incidents affected their perception of invulnerability, the 'shattered assumptions' described in Chapter Five.

> I thought if anything like that ever happened to me, it wouldn't bother me, because it was just part of the job. I was surprised at how much it did bother me and yeah, the aggression of it.
>
> Support worker, residential

Several participants in the interviews noted that as a result of incidents, they felt less resilient in the face of subsequent events, suggesting the erosion of resilience under stress. The nurse in Narrative One talked about their skin becoming thinner, of wanting to talk but also not to talk, and of having to make a conscious attempt not to revert to old and unhealthy coping mechanisms such as drinking. One support worker challenged their own (and the agency's) assumption that the impact would fade over time, commenting that at times it receded, and at other times, they still struggled with its immediacy. A social worker described the death of a consumer as a loss of innocence, a bursting of a protective bubble that had held them believing that bad things would not happen. In their words, 'suicide wasn't a concept any more'. This becomes a challenge to the development of awareness in pre-employment training, and suggests that there may be a natural limit to the preparation for events prior to job selection. The corollary to this, of course, is that support systems within the workplace must be geared towards the extreme impact of events.

Several described processes of distancing themselves from situations. This community support worker observed various reactions in team members following the very public suicide of a client:

> I was just watching all the people meet, like the psychologist and the nurse dealing with it. One was very medical model, clinical: 'well you know he was responsible for the choice, he shouldn't have been there... blah blah' and very matter of fact about it. The other one, you could see it impacting on her practice, it was like 'I've gone out on a limb here with this client, I won't set myself up to have that happen again'.
>
> Community support worker, specialist team

They described their personal process:

> In terms of taking it home, what I did was, quite consciously, I went through my process in terms of 'did I do enough for this person? Did I do all I could have done?' And I guess I slept well at night, and I switched off from it after a while, because being in a system like this you come across it all the time, so after a while you become a bit indifferent to it, which is a little bit sad, but you do.
>
> Community support worker, specialist team

In terms of crisis theory, a critical incident can contain both an element of danger and of opportunity. After an incident, all participants demonstrated the necessity to utilise and develop coping strategies, which could potentially contain both positive and negative implications for themselves, their organisation and the consumer. One respondent, still acutely vulnerable, described how their anger towards the management of their organisation was blocking their decision-making processes and trust in management decisions. On a personal level, such behaviour can be interpreted as self-preservative; however, its impact on work relationships and clinical performance may weaken a system.

Such descriptions highlight the tensions that result from exposure to critical incidents. By definition, elements of crisis or trauma are present which alert the individual to the need to respond. Coping may create vulnerabilities, and may also instigate protective processes involving distancing and adaptation to distress. The potential for this to impact negatively on practice thus becomes an organisational issue, and I would argue, an organisational responsibility to ensure that individual coping strategies work in harmony with any support processes within the environment.

'I feel like I'm here now to get paid': questioning of role and career

> I don't know that I want to stay in this job, I've had this, and now this, and there's another one, I don't know if I can cope. Is this what I really want? Do I need to face this everyday?
>
> Community support worker

The sense-making process embedded in the majority of experiences rapidly acquired context when incidents occurred in a workplace setting. The cumulative effect of exposure to distress and incidents created questions of role and commitment for the mental health workers.

> Sometimes [the impact] is huge, sometimes very distressing and sometimes less. So there were occasions, thankfully not many, where I left the ward feeling absolutely worn out, exhausted and feeling like I didn't do a good job in that

> situation, questioning what you did and when and whether you could have done it differently or better.
>
> Psychiatric nurse, residential

This querying of actions was echoed by several in the interviews, both in the sense of knowing that they had done all they could, or having been left with a residual sense of responsibility or blame. These questions were contextualised within issues of clinical practice such as whether warning signs of self-harm had been identified. Questions of competency and the judgements of colleagues created guilt about professional performance:

> I questioned my own competency hugely after that and thought felt that I had handled that wrong. And that was another traumatic thing, because I'd done what I'd just had been able to do.
>
> Occupational therapist, community (Narrative 4)

In reflecting on their own performance, comparison was sometimes made to the apparent coping of others. Such comparative attempts, similar to the discussion about 'pissing contests' in Chapter Four, suggest an acute dependence on validation by others:

> I remember something being said about another worker going through something and how brilliant it was that they just bounced back and acted normal, and I can remember thinking how this person was praised for just brushing it off and carrying on with the job. And I didn't feel like that, so I thought maybe I'm not suited to the work, because they thought this person was so cool, or it probably wasn't as traumatic as what happened to me.
>
> Support worker, residential

Commitment and tenure were both threatened by incidents, a support worker suggesting that they began to take more sick days and felt like doing the bare minimum of work afterwards. Significantly, this was as a result of collegial attitudes rather then the impact of the event itself. For the CSW in Narrative Three, it was as if the experience had permanently changed their perception of their work from being a vocation to questioning their commitment:

> It's made me know that I'm more important and looking after myself is more important than a job. [...] I really felt like I had some ownership in this place, I couldn't envisage me leaving here, and I don't really feel like that anymore.
>
> Support worker, residential

Not all incidents, however potentially disturbing, had a traumatic effect, and what emerged from several narratives was the inoculating effect of meaning derived from training and a sense of professional purpose. Many incidents were described in terms of part of the workload, the reason why the respondent was doing the job. Key to their coping was the participants' feelings of being supported and their feelings validated both at the time and afterwards. Clearly emerging from the narratives was the importance of the relational aspect of a Strengths approach to a person's role, performance and coping.

Peer support: the acknowledgement of others

> It's a real privilege to work with a team when you can do [talk about what has happened] and people don't want to put their tuppenny worth in and I felt really heard and really supported and that was fantastic.
>
> Community support worker

Incidents at times involved other staff members, as in the case of the two nurses discovering an attempted suicide (Narrative 1). For many workers, however, the nature of their work precipitated them into situations where they alone bore the brunt of an attack or a threat. To convey the impact post-event required a degree of narrative development that some clearly found initially impossible. For most, framing the experience in words was an immediate, and sometimes long-term, challenge, governed not only by any posttraumatic aphasia and the emotional arousal that might ensue, but also by socially determined anxiety about its reception, such as it being judged as 'malpractice':

> And I was frightened, talking to my professional advisor and thinking that she would say 'what a fool, why on earth did you carry on the group for?' I felt that somehow I'd been foolish...
>
> Occupational therapist, community (Narrative 4)

Concerns about the approbation of others limited the range of people to whom a worker would turn. Several were clear that their immediate support would come from those that knew their work environment and who knew them, because of the unspoken understandings and shared knowledge between colleagues. A nurse, commenting on experiences in a ward setting, was clear about choosing peers who had actually been present, or who were experienced in similar roles. Bridging the gap to talking to family, management or total strangers was not a desired option.

> Often it's not so helpful talking at home, they don't understand, you know. I mean they do their best to understand the working

> situation but of course, when you're working, you're talking to people who actually know the people.
>
> Community support worker

Validation and affirmation from others appears to provide a feeling of being understood, which removes the isolation imposed by a critical incident and provides a sense of externalisation and potential reframing of the problem. However, this social worker reflected on the limits to the support that two similarly affected people could provide for each other:

> So I think the two of us were both so busy trying to make sure we did miss anything that neither of us were of particular help to each other.
>
> Social worker, community

Several respondents experienced shortcomings in the expected ability of peer support to meet people's needs. The seemingly dispassionate nature of working in a large organisation disappointed several support workers, who reflected on the impact of events and the alienation experienced as a small cog in a large machine:

> Interestingly enough, [after the consumer died] nobody in our team has ever come to and said 'oh, I really felt for you' - nobody ever did. Considering we're in a caring profession, nobody cared.
>
> Community support worker, specialist team

Some of the validation experienced was not from immediate colleagues who worked in the same team or had experienced the same incident, but was gained through professional reference groups, which although not formally created as staff support or incident-focused, were already organised, spoke the same discipline-specific language and which had potential to support the fallout from an incident:

> The consultants have put in place, partly as a requirement of our ongoing medical education, we have these peer review groups and one I'm in, luckily, is a really good one and it's the sort of thing which you feel you can talk about and you can even say some things that feel quite embarrassing because it's a really good group of people I've known for a long time.
>
> Psychiatrist

This person went on to comment that 'psychiatrists are, I am afraid, the ones that carry the can', and that because of their special roles and responsibilities, whilst multi-disciplinary support was valuable, there was a special place for peer groups for doctors. I would expand this argument to say that professional

groups, often by necessity organised across sites, appeared in this study as vital lifelines not only for critical incident support but also for continuing professional development and role confirmation. Organisational preference for the appointment of generic mental health workers as opposed to those with professional or occupational identity potentially undermines this source of support. Similarly, the power issues that may emerge in the support of those in leadership and management roles can easily be overlooked, suggesting that collective recovery processes may not always provide them with equitable support.

Peer support on an informal basis provided a substantial part of workers' early recovery from the impact of an incident. Its characteristics of being embedded in natural social relationships, its ease of access and the sense of not having to 'reinvent the wheel' when a person was already straining to communicate highly emotional narrative, proved a popular form of support. Participants were vocal about the importance of strong and positive relationships in the work environment, in which the impact of an incident could be immediately cushioned, but many were also realistic about the limits of its help, in terms of the degree of shared exposure to the distressing incident, the potential for minimisation or accusation, and the degree to which they could ethically burden a colleague. In some cases, the needs determined by the event simply outweighed the capacity of those immediately available:

> Superficially [my peers] were supportive, in terms of 'gee, this is really lousy'. I don't remember anyone taking me aside and saying 'listen, do you want to talk about this? '
>
> Social worker, community

These issues signal the complexity of the environment and potential incidents, the importance of organisational awareness, and the requirement to provide formal and identified support.

The complexity of recovery in the mental health environment

The embedded nature of mental health work within systems and casework relationships provides multiple entry points for traumatisation. The complexity of roles and responsibilities within the workplace and the potential for incidents to become attenuated and enduring was clearly illustrated within several interviews. The psychiatrist in Narrative Two, after having been attacked in a closed room, had no time to address the impact of the attack before escorting the same consumer to another site. In another incident, they describe being called into a room shortly after a person was found hanged:

> [It was] expected that [the psychiatrist] did formal things, debrief, notifying, I phoned the consultant on-call. He said, phone the relatives. So I was a general registrar, [...] not the consultant, which I think was a bit unfair and I think if I was a consultant I'd probably say 'would you like me to call relatives and do it' but anyway I had to phone. So of course, phoning up to say, 'sorry, she's dead' is diabolical and I can really recall the room and where I was in making that phone call. I was the support system, while being the registrar on-call, while being involved. It was actually me doing the looking after, sort of bizarre, but that's how it was. I think I said, 'should we have a debrief meeting?' I remember I ran it and said if anyone has any trouble with it, just call me. Then one of the nurses that actually found the patient, I remember she actually came out and said, could she come and see me at home and talk a bit about it. She was having nightmares about seeing the body hanging and so I attempted to do the debriefing for that.
>
> Psychiatrist

Note how they mentioned still having a visual memory of the room in which the telephone call to the relative was made, and the expectation of acting within role despite being personally involved in the incident. I find the blurring of boundaries between home life and a work role of support is also of concern, as is the potentially damaging tensions in the psychiatric hierarchy manifested in the relationship between the registrar and the consultant.

A crisis or traumatic situation may thus have several stages or elements, which span both time and changes in role. The social worker whose client went missing and was later found hanging began to experience extreme stress on first knowing that they were missing, which continued in different manifestations as the consumer was found and then mourned (Narrative 5a). Even with single incidents such as this, there are antecedents and consequences that do not allow disengagement and resolution. The complexity of involvement in situations may play out over several months. Narrative Five (a) suggests that the destabilising component of the incident was not just the client death, but the need to provide liaison and support with family, requiring them to be the recipient of blame for perceived organisational errors.

The occupational therapist in Narrative Four, whose relaxation group had been violated by sexual exposure, feared for their life for several weeks afterwards. This was exacerbated by a fresh encounter with the perpetrator of the sexual offence (Narrative 4a). Heightened fears for personal safety made the environment a hostile place. A support worker echoed this fear, revealing a paralysing fright that the person who had assaulted and threatened them was a

member of the same close-knit community in which they associated. Community in the words of participants did not refer to strictly geographical locations, but also to the affiliations and networks of culture, religion and sexual orientation.

Narrative One had a short duration in terms of the immediate intensity and actions that they had to take. For both nurses involved, their recovery was affected by later events. In one case, this was due to the nature of mental health service involvement with consumers:

> Obviously [after the attempted suicide] she ended up being admitted to a psychiatric unit for a period of time, [and] I didn't participate in [discussions] for a period of time. Strangely, I did end up going to a few meetings several weeks later [...] and it was brought up and everyone said 'it's her, she saved her life, it's her, it's her' and she's not actually a very popular client and people see what I've started talking about. I'd just starting to get a lid on it and that kind of re-opened it all then. And she was discharged and we met each other again and she was in a bad mood and she yelled at me for it.
>
> Psychiatric nurse, community

For their work partner, the processing of the work related incident was hampered by an event in their personal life:

> He had something else awful happen shortly afterwards or certainly around that time. He was out with his wife and somebody jumped off and landed in front of them and kind of splattered everywhere and that took his focus off our client and me.
>
> Psychiatric nurse

The cumulative power of sequential incidents cannot therefore be overlooked. For one respondent, the initial incident that they described did not feel as if it merited taking any time off. However, another incident occurring shortly afterwards challenged their resilience and questioned their suitability to withstand the job's pressures. Their description illustrates both the cumulative effect of stress within the workplace, and a positive level of support from the worker's manager:

> And for me I had this critical incident and then I went to visit another [...] and when I got there she'd overdosed and I had to call an ambulance and this was all in a matter of two weeks and I just went and said to [the manager], 'I actually don't know if this job's for me anymore, I just think the stress is getting too big, I don't know that I can cope,' and he said 'What can we do

> for you?' and I said, 'I actually need a week off to actually evaluate where I am, [and] to process what's going on and at the end of that week I'll come and let you know.' And he said, 'Off you go now, special leave.'
>
> Community support worker

This quote illustrates that with an integrated understanding of the needs of a worker, cumulative stressors can be addressed. These incidents were also followed up by thorough supervision and management of case allocation on their return from leave.

The following discussions consider issues that arise when workers do not feel that they have received the level of acknowledgement and assistance that they perceive that they needed, and then addresses the provision of formal supports.

Organisational denial, minimisation and amnesia

The impact of an event can thus have a potent and enduring effect on the primary victim: others in their environment may not recognise or recall its longer-term legacy. Recovery from events is also intimately linked to the degree to which the environment continues to sustain or ignore the impact.

For the worker in the following excerpt, some of the lingering effect of the threat to their life was linked to the fact that other people in their workplace appeared to have forgotten about the incident, or did not recognise its enduring impact for the worker. This was compounded by the dissonance that they experienced working within a Maori team, where their values had suggested to them that they would receive more support (Narrative 3b). For them, the personal meaning and impact outlived the institutional awareness, and introduced a feeling of personal failure for not having recovered quickly enough. Minimisation of what had happened followed.

Organisational needs and demands were often cited as having superseded any awareness of the personal cost. The words of the psychiatrist in the previous section suggest that at times, the role and clinical engagement requires continual involvement in potentially volatile situations. At other times, the sense of responsibility was more generalised, implying expectation that an incident was what was expected within the job.

The perception that those in authority cannot or should not experience trauma because it infers weakness resonates with the notions of hysteria and malingering explored in Chapter Two. It appears to suggest the military notion that leadership and professionalism entail strength and that displays of human

weakness undermine discipline and the achievement of end-goals. A similar assumptive process was discovered by a support worker, whose experience was that as a male, they were assumed to be able to cope with the extreme stress through existing non-crisis systems of support.

A lack of organisational awareness and culpability places the onus of recovery on to the individual, a process that duplicates the isolation imposed by becoming a victim of an incident. For the social worker in Narrative Five (b), the onus was on them to take time out using their own sick leave, and to re-organise their workloads. A residential support worker echoed the emphasis on self-help, reflecting that although their employer arranged payment for a series of counselling appointments, they had to locate a counsellor themselves.

The comments above suggest that there may be a dissonance between the experience as perceived by those immediately affected, and the perception of what is needed, the work performance expected, and what can be offered by the organisation. The following discussion addresses issues that arise when formal critical incident supports are provided.

Formal processes within organisations

> I don't think anybody should work in an area where other people are vulnerable without having those supports there.
>
> Community support worker

It is within the narratives about the provision of formal processes of staff support that the major hypothesis of this research is borne out. A clear distinction is revealed between the experience of the discrete elements of intervention, such as the immediate demobilisation processes or a successful counselling session, and the experience of the systemically based process of managing the multiple components of the incident. This mirrors the distinction made in Chapter Six between processes of CISD and CISM. In an ecological sense, most staff support systems explored in the narratives of the participants were patchy and piecemeal, and not presented as an integrated whole that addressed both personal and organisational needs. In many cases a confusion between operational and staff support purposes occurred.

Formal responses to a serious incident took a range of forms, including supervision, debriefings and operational reviews, formal legal inquiries, and the delegated use of Employee Assistance Programme (EAP) counselling. All situations where there had been a serious assault or consumer death initiated formal organisational responses within the workplace, although not all the participants were party to these, as some incidents had not involved them as

primary or secondary victims and they had not been recognised as crucial to the process, despite, as the following suggested, having had at least a functional relationship and responsibility. Commenting about the provision of organisational support, the social worker in Narrative Five said:

> And it's interesting now, when I look back on it, just where the systems lay. I actually wasn't invited to the SIP, the 'serious incident process', which is the formal organisation that looks at serious incidents.
>
> Social worker, community

Emerging from the narratives is a sense of confusion as to the purposes of many of the processes, with a blurring of operational and clinical need with that of staff support itself. Where the response attended to the needs of the individual worker, feedback from several participants suggested that this was well utilised and helpful, detailing that they felt confirmed, had done the right things, and that people hadn't forgotten about the incidents:

> But I think the best thing, the first session when I rang up this therapist, she said I could go pretty quickly and it was a really good session. It felt like she normalised the fear that I was living with through. Whatever she did [was] good...
>
> Support worker, residential

The support worker in Narrative Three also had good immediate support from the organisation after having their life threatened, and on return to work was able to use EAP services. They expressed some reservations about the confidentiality of the process, and commented that the separation between support services and the life of the unit on which they worked undermined some of the effect of the support.

The use of EAP, both organisationally-based, or as counselling mandated and initially paid for by the employer, was uneven in its application or effectiveness. In particular, the physical distance between the person and the EAP provider was never reported as a positive element in the days, weeks and months following an incident. The strength of EAP provision can be identified in part as having an overview of how to access resources and to activate support systems. One support worker reported extremely positively about the external counselling obtained through provision of EAP, although felt undermined by their employer's recanting on an agreement to maintain a level of funding for this process. The counselling, however, remained focused on their personal issues and was largely disconnected to the organisational and professional levels of functioning that would have maintained their long-term

job tenure. Instead, the counselling process became a means of endorsing their decision to leave direct practice.

For one worker, the existence of external systems of support would have been invaluable. Their professional identity and account of systemic abuse and violence has been largely been excluded from this text to ensure anonymity; their narrative painted a clear picture of institution-wide abuses and threats of recrimination for whistle-blowing that limited any assistance for threats made against them. They had witnessed a staff assault upon a consumer, and when they formalised a complaint, were told that they had been in the wrong place at the wrong time:

> I'd done what I thought I could but I very much felt silenced and the sort of trauma that it caused me was 'cos they said that I'd blabbed on them.

The argument here concerns the level to which a system should or could support its own staff. The ideal for all of the participants was for their immediate work environment to be the source of most of their support, and for any other support that they were utilising to be integrated in with the workplace. Only where the workplace itself was dysfunctional did workers choose to source outside help exclusively. Sometimes this was done in an unsanctioned manner:

> [We] went and saw a Maori gentlemen that I'm quite close to, and I also spoke to my supervisor that was my original supervisor in [another city], and [my employer] doesn't realise it but using their cell phones, I had quite a good sort of discussion with him about it. And what was really good was that because he was detached he went through what we'd done, but he also talked about the emotional side of it, and he did things like validating that it was okay to feel bummed out about it, and it was okay about wanting to do something to try and rectify it and be part of it as well.
>
> Community support worker

In some cases, as a worker has previously described, it was assumed that existing arrangements for supervision would carry responsibility for formal response. As explored in Chapter Eight, supervision is not universally provided or funded within all mental health disciplines and teams, but where it is, it may provide, or be perceived as providing, some of the necessary psychological and systemic supports. However, it is not a crisis-oriented system; a supervisor may not necessarily have the availability or the skills to respond when needed; and the appropriateness of such an individualised

response to a collectively experienced incident can be questioned. Where a worker was able to wait until the scheduled supervision time, and was able to use narrative process within the session, it was deemed helpful by respondents.

Discussion now turns to the experience of what worked, and what did not work, in the formal psychological debriefings that were offered.

How not to do a debriefing

> So in terms of that being a critical incident, I guess one of the main things I learned was that if there are things that are troubling you in a team, or if you have trouble with something, if something flashes back, and you think 'oh, that reminds me of blah blah', really what I have learnt is that you don't deal with it at work, you take it away with you, and that the most unsafe place to deal with it is actually at work. That troubles me because I think it should be the opposite, I don't think I should be going home with my baggage, I think my baggage should be staying here before I leave.
>
> Community support worker, specialist team

As described in Chapter Six, Critical Incident Stress Debriefing (CISD) or generic psychological debriefing has been an available option in some mental health organisations in Aotearoa New Zealand since the mid-1990s. Without exception, all of the participants in the research were familiar with the term, and most used it without prompting in their narratives. Several times the meaning of 'debriefing' reflected a generic understanding of some form of organisationally based review of what had occurred. Some of the incidents that respondents related had occurred prior to the inception of debriefing within their organisations, and they were able to make comparison with current practice. One nurse commented that she knew she would have utilised such a process had it been in existence, and a social worker reflected that not only had there not been a formal debriefing aside from an operational review, but that those individuals affected had dealt with a consumer suicide on their own without a peer support process. Others had been through formal processes of debriefing, and it is the discussion around these experiences that forms the basis of this section.

What emerges is a confused image of support provision with a substantial majority of participants remaining concerned that the incorporation of operational issues had weakened debriefing's support functions and had possibly exacerbated the harm to the worker. The context of the interviews did not unpack the debriefing processes in any depth, leaving an analysis of timing, length, structure and content, debriefer identity and skills and other pertinent

issues to be investigated through evaluation processes outside of the remit of this thesis.

Despite heavy criticism of the actual performance of debriefing sessions, the workers interviewed were universal in their endorsement of organisational responsibility, a social worker describing its introduction as 'heartening'. The views of one worker encapsulate the expectations that debriefing would respond to:

> ... how we felt, if there was any issues that you felt you wanted to talk about, getting over emotionally what had happened and what may have affected the individuals that were involved with the case.
>
> Maori mental health worker

Despite the existence of a debriefing process within their organisation, several participants suggested that responsibility for its activation was left up to those affected, listing the need for managers to cover several sites and components of services, and a general lack of co-ordination and leadership that encouraged a reliance on self-help. The sentiment of many was that management structures were slow to take the initiative. One nurse commented that as senior staff were absent, their debriefing was not arranged for a week after a suicide, with the result that:

> I actually found the debriefing too distressing and whether it was because it almost felt that it was too late, that we got to a point where we started to progress and they were digging it all over again. So I think it needs to happen fairly quickly and I [...] also think that there was just one meeting set up. To my mind there needs to be a process, rather than something that happens all over again.
>
> Psychiatric nurse

Comments such as these suggest that staff perceive the window of opportunity for assistance to be more immediate than a week, confirming literature that suggests that cognitive and emotional schema begin to settle within the first few hours and days of an event. Adaptive or accommodating processes will have developed before this, and other bigger picture issues will have started to intrude. In addition, the debriefing referred to above was conducted by an outside facilitator unknown to participants, and in another case, by the Clinical Director legally responsible for consumers under the Mental Health Act (1992). The skills, relationship and power position of those conducting such sensitive group processes emerge as prominent considerations in the safe and sound design of support systems. The vulnerability of having one debriefing rather

than a series of support mechanisms that could monitor the changing tides of external forces is a point addressed in the following chapter.

The two comments above originated from an interview in a unit in which I interviewed several staff, two of whom made considerable comment about the same debriefing. Whilst both were scathing about the outcome, their critiques were launched from different perspectives and their concerns were very different, highlighting the sensitivities inherent in the aftermath of critical incidents. Although the debriefing process after a consumer suicide was delayed for a week or so after the death, I was told that its actual organisation was done quickly without very much apparent thinking through of appropriate content and process. Because one of the workers had a split allegiance to two separate parts of the service, one part (in my understanding) took responsibility for the process, and as a result, several other staff members that felt they should have been present were excluded, and several were present whom one respondent felt should not have been. Superficially this may be read as a tension between the cultural and clinical components of a team, but a further reading also suggests that the issue centres on the lack of assumed responsibility by a management structure that oversaw both parts of the service. Furthermore, it reveals the frequent scenario that one consumer may have had involvement, at varying depth, with many workers within one agency, causing a nurse to query 'do you direct it to those people who've only been directly, absolutely directly, involved?' A social worker elsewhere, hurt by the disparaging remark of one participant in a debriefing, felt that it had been made by a person only distantly affected by the incident, suggesting that the needs of those attending, inevitably reflecting numerous perspectives, would be best served if everyone had shared a similar degree of emotional proximity to the event. Beyond this, they implied, there would be a tendency to want to discuss wider, more operational issues.

From yet another agency, a similar comment that reflected the lack of clarity about membership of a debriefing, and the value attached to the process:

> A memo was put in my pigeonhole and I was invited along. I think the way the memo was structured was, 'if you had any involvement, you are more than welcome to come'. Now, that was supposed to be the way of saying 'if you've got anything useful to say, come; if you've got nothing useful to say let's speed the process up, don't bother turning up', and the meeting was scheduled in between two meetings that were happening. So [...] you had one meeting, leaving, they came into the critical incident thing and then another meeting...
>
> Community support worker, specialist team

These sensitivities are captured within the issue raised by many who had gone through debriefings, that of the overall perception of the purpose of holding the process. The mixing of the operational and affective within systems was commented upon in all of the accounts of formal responses, and emerges as a key issue in this discussion. Comments addressed the dissonance between a person's affective needs for validation and the clinical or management desire to establish causality and responsibility:

> And I think debriefs that I've been involved in, the ones most on my mind [were] trying to do both and that didn't really work well. Left me feeling quite criticised really, not reassuring [me] about anything that I've actually done in that situation.
>
> Psychiatric nurse

The participant in the following excerpt was part of an organisational debriefing following a client death. The debriefing did not, however, address the considerable potential impact on the affective processes, but was recalled as concentrating on operational issues of staff performance. The respondent had been expecting the opportunity to express some of their feeling about the death:

> It actually was the complete opposite, you know, it's 'business as usual, let's get on with it'. And I know for me, my own dealing with it was, here's a young man who is about my age, with a young family. I took the afternoon off and I left, and the interesting thing was because of my personality, everybody just assumed I was off skiving, big smile, you know, he's probably off doing nothing. But I went home and just hung out with the kids [...] and that was my way of dealing with it.
>
> Community support worker

It appears that in many experiences of what was termed a debriefing, the meeting was turned into an accountability exercise as opposed to an opportunity to look at personal involvement and impact. One CSW talked about ticking off items in order to place a stamp of approval on the actions of the organisation. Several thought that their employer appeared to care more for the existence of a debriefing process than the quality of what was offered, a nurse reflecting that:

> I suppose what worries me with the debriefing process, it's a bit like [how] we used to teach grief counselling, do you remember those days? You know - stage one, two, three. And I think that's what worries me that the organisation can see this in a kind of mechanistic way, that somehow fails to take account of the fact that it's actually a process rather than just

> something like 'a critical incident debrief, let's do that and then it will be all right', you know.
>
> Psychiatric nurse

Several participants raised the organisational relationship between a debriefing, formal reviews, and mental health and coronal inquiries. Some suggested that awareness of these pending external events created an atmosphere of defensiveness ('pointing fingers' and 'covering backsides', as one worker put it). A psychiatric nurse illustrated this by saying that in a recent inquiry, the names and work locations of individuals had been released in the media, making the issues very personal and close to home.

Whilst all the interviews containing reference to the experience of debriefing made a point of defining the difference between operational issues (the accountabilities and responsibilities invested in the agency and its workers, often by statute and by organisational policy) and affective issues, several participants also raised the issue of clinical performance both as an accountability process and as a professional development issue. The line between these two areas appears less clear than that between the operational and affective. In the operational context, many of the participants had suggested that a debriefing appeared to want to establish responsibility, and several emerged from the experience talking about blame and recrimination. The focus was on the professional performance of the staff concerned. In the perception of debriefings as clinical review procedures, the emphasis was on the consumer and what had been done for or with them, and what could have been done better. The expectation of one nurse was that their debriefing, alongside 'the opportunity to have a really good sulk' would enable them:

> Just to sit with all the people that had been involved with [that] one person [...], in terms of knowing, just for reassurance that maybe we worked to the best of our ability in that kind of situation and just acknowledgement of how difficult we all felt it had been at the time this happened.
>
> Psychiatric nurse

Several participants felt that the central issue for the debriefing was that of the establishment of blame for what had gone 'wrong', rather than best practice issues of clinical performance: a social worker talked of seeing people 'shattered' as they left. This worker, caught in the uneasy tensions between being a 'cultural' and 'clinical' worker (Chapter 8), was still hurt by the apparent questioning of their expertise and performance. They experienced an undermining and an effective attack on their own capabilities:

> What they said in the debriefing, they never once brought it up when we were handling the case. If they did, then it was brought up a different way, I didn't recognise it, so you know it blew me away and I was quite disappointed in that. If you're gonna say something after, that's too late, or you say it before it happens and work with each other, that's why I was quite positive that I made a good balance with the clinical side. *And it was a ground-opening event [which] I would never want to wish it upon anybody else.*
>
> Maori mental health worker [my italics]

The narrative about this debriefing very clearly revealed that it has added to the initial distress of the consumer death, and in many ways, could be construed as a critical incident in its own right. My respondent had been outward-focused in their concerns for the consumer and his family, and organisational defensive practice experienced forced them to question their own role and tenure within the team:

> When I heard these comments, I actually started to feel a bit uneasy with who I'm working beside. I felt I was speaking on behalf of the family and on behalf of this [person] in a crisis and yet it was quite obvious to me that my colleagues were just basically covering their backsides, without too much emotion toward what had happened. Like, 'you could have done it this way and that way', but to me the debriefing wasn't about that, it's about making me feel more secure about your role and how you involved yourself in the case - and sure, we can talk about what could have happened but I mean to put someone on the spot like that, I don't feel it's about that.
>
> Maori mental health worker

Others experienced a distinct lack of systems ownership of the event that also suggests a defensive and individualised focus as distinct from a collective sense of responsibility for workers and consumers. A community support worker suggested that people were trying to distance themselves from involvement, ownership and responsibility as a way to manage their emotions. This divisive attribution of responsibility (with its attendant effect of blame) flew in the face of the assumptions of collective work on behalf of the consumer held by many in this research, and expressed most forcefully by those with either social work training or a Maori cultural location.

Environments of defensive practice appear to create debriefing and other support processes that focus on culpability and performance issues, and provide less of an opportunity for either the professional development or personal well-being needs of the workers. Dissonance emerges between the

motivations and commitment of mental health staff to engage with consumers on meaningful levels, and their perception of their organisations' willingness to do the same for them.

Stage Three: Reconnection and Integration

For those workers remaining in mental health after experiencing critical incidents and traumatic events, the hallmark of recovery was their ability to reconnect with other people and facets of their life, and to integrate an understanding of the incident into meaning and into daily life. This process forms the third stage of Herman's (1992a) model of trauma recovery. The narratives of participants suggest that for many, accomplishment of this stage was not achieved, or was only partially successful. Responses to the immediacy of crisis had become subsumed beneath organisational and 'other-focused' processes; organisational and collegial memories lapsed, and in some cases, the original feelings of isolation and vulnerability created by the incidents were left to consolidate and embed themselves into the patterns of daily living. In this section, continuing vulnerabilities and the importance of closure are addressed, the role of the job context and environment is considered, the bigger picture professional and political processes of systems change are examined through the eyes of the participants and the absence of an overarching programme of staff care is addressed.

Learning about closure

This third stage of recovery from trauma and extreme stress refers to the ability to move past the experience, to cease responding to events and the environment as a victim, and to integrate an understanding of what has happened into a manageable whole with which to face the future. 'Being stuck' in the repetition of sensory and narrative forms of the memory can, as explored previously, have major implications for behavioural, social and professional functioning. Past events continued to have a hold on the present for several of the participants:

> My concern about this incident... is that I suppose I've got some feelings towards management and stuff that I don't feel happy with, and I need some sort of resolution around that.
>
> Support worker, residential

Without validation and support from the environment, traumatic experience has the power to isolate and pathologise the individual. This psychiatric nurse continued to live for many years with the legacy of an attempted suicide and

felt vulnerable to the interpretation that the impact on them was a sign of weakness:

> [I felt] it's all my fault and that sort of thing for years and years. You don't show that you've got weakness or vulnerabilities, you're considered better if you put a lid on it and I have to show people that I'm human and that was all pretty scary. I did look it up on the Internet - PTSD - I thought that was pretty advanced.
>
> Psychiatric nurse, community

The focus groups (one of academics, the other of trauma specialists and practitioners) felt especially strongly about the imperative of reconnection to prevent vulnerability. One strong message given by the trauma group was encapsulated in the notion that victims must not have to deal with the incidents on their own, and that support can manifest in belief and in practical assistance as well as in therapeutic intervention. The power of the incident to split and to isolate can manifest in a number of ways, disbelief being immensely powerful. Divesting the environment of the responsibility to respond similarly places the onus of help-seeking on the individual at a time when they are least able, and may ordinarily find difficult.

Two strands of the need for closure emerged in the narratives; that of needing to tell the story and that of restoration processes with the perpetrator. The psychiatric nurse in Narrative One felt keenly the lack of an organised opportunity to tell their story:

> I didn't ask for, or take advantage of, or initiate any opportunity to sit down with one person to say what happened for beginning to end. And never at any time had I ever told anyone that 'I was on the phone and then [my colleague] said this and then this we went in and did this'. Nobody knows the sequence of events and accompanying feelings, and nausea, and everything that went with it. I gave a sort of brief clinical handover to a point in the morning and [my colleague] continued on, that same day in a very brief way, but that was the same amount of information that we would have given for a relatively minor event.
>
> Psychiatric nurse, community

The emotional intensity of the interview itself suggested to me that I was privy to a story not often told. Chapter Five's discussion of the importance of meaning and the development of narrative strongly suggests that emotional ventilation and the creation of a sequential account are some of the first steps to

creating a distance between the person and the event, and of making the transition between victim and survivor.

The imperative for closure also took the form of attempts to establish meaning through consideration of reconnecting with the perpetrator of the incident. The ability to see the consumer as a whole person, with reasons for acting that may have had nothing to do with the identity of the victim, was a further means of establishing a distance between person and event. For the worker in Narrative Three, they were able to use a positive piece of learning from the past that shaped their perception of the present:

> I know that the violence I experienced has come up several times for me in different ways, and I think one of the things I did in my recovery was go and make amends to my ex-husband, and I was talking to one of my colleagues about that yesterday and I just said that the healing for me was really good. Part of my journey was to discover it wasn't all his fault.
>
> Support worker, residential

Through this, they were able to intuitively understand that comprehension of the perpetrator's actions could assist their own recovery, to separate out their own reactions to the event from the meaning for the consumer, and to maintain a compassionate and professional regard for the consumer, a factor that surprised some involved with their recovery but which links with the concept of forgiveness as explored in Chapter Five.

A similar aspect of reconnection and reconciliation emerged in the narrative of workers dealing with the aftermath of a consumer suicide. Actions such as those depicted below offer symbolic processes of closure for both workers and families. In the complex emotional and operational environment after a client suicide, one social worker was deeply involved in the mourning with the family. Another worker described the team initiative of collecting knowledge about a deceased consumer, in order to give a 'pen picture' back to his young child:

> ... and I think that the good thing about that was [...] we set up a diary and a little gift for the daughter [of the consumer who died] and [...] every member wrote what they could remember about the client, and it was gift wrapped and it was sent and it was for her and so that way she could get a picture of what her Dad was like.
>
> Community support worker, specialist team

Learning from the incident

Herman's third stage of recovery is about reconnection, sense making, and re-integration into a non-trauma focused world (Herman, 1992a). Often a professional or political purpose may develop. The ethical, professional and political aspects that respondents described appeared to provide a sense of purpose, and a stress inoculation that protected from individualising the harm.

Some positive outcomes were noted for development of practice skills, perspectives and procedures:

> I learnt that I had to allocate a lot more, I had to be very particular and choosy about my time, the people I associate with at work; I refuse to hang out with those people who are in that negative mindset because they just drag me down. The other thing too is that I started getting into things like reading outside of work around subjects so that I was more informed about things.
>
> Community support worker, specialist team

A social worker similarly talked about determining to gain their social work competency[54] as a means of showing themselves and their detractors that 'that I'm okay at what I'm doing'.

In the long term after the experience, awareness of their experience propelled some of the respondents to direct their work towards violence and trauma issues, a psychiatrist doing a research study on violence towards doctors. This social worker was involved in a consumer suicide on their caseload:

> Now I do the Suicide in-services, based on my feeling that I actually probably hadn't done it as good as I could have done it. And you know, rationally, I don't know if that's true or not, I've over-prepared myself, and now give the in-services to a fair amount of the organisation. I haven't done [any avoidance]. If anything, I've moved into the riskier group stuff.
>
> Social worker, community

Intellectual and professional development, research, political and union activity were all cited as means of making sense and bringing resolution to the experiences of incidents. The ability to share with others and to pass over the acquired wisdom also emerged in reflections about the interviews themselves.

---

[54] Under the voluntary membership of the Aotearoa New Zealand Association of Social Workers (ANZASW), members undergo a competency assessment every five years.

The partnership between person and environment

The quotations above attest to the close relationship between individual recovery from a critical incident, and the willingness or ability of the environment to engage with the process. Clearly, individual backgrounds, personalities, experience and training will contribute to a person's coping styles and levels of resiliency, but so too will the receptiveness of the environment, the 'job context' referred to in Chapter Six.

Several comments were made in relation to the importance of recognising people as individuals within a system, the immigrant below suggesting a process, already in place in some agency environments, and identifiable as similar to *whanaungatanga*, but which they suggested becomes formalised into the life of an organisation:

> One thing that would have been helpful was something that we did where I was working [overseas]. We had a staff feedback regularly ... it was a place where it was expected that at the end of the day you would talk about what had gone on in your day and how things had gone. It let the whole team know how it was going, what their strengths were and what their difficulties were, and how they were interacting with each other, but as a staff member it also gave us a chance to breathe out, to let go, to be angry, or to be sad or to cry if you'd hurt something, and to leave it all at work. I've worked in two teams here and neither of them had anything that came close to staff support.
>
> Occupational therapist, community

Changing the human relationships within the organisation can also occur as a result of attention to critical incident support:

> I think that the really important part is the cultural shift, in terms of the organisation, that often we don't need the formal debriefings because people are much more aware of providing support to one another, and the defusings are right after a critical incident happens, pulling the people together and just letting them know what's around and what to expect and those kind of things is really good; so that's probably much more significant than actually having this team.
>
> Social worker, community

A support worker unpacked this further, describing that one impact of the incident upon their agency was some initial (but unfulfilled) discussion about the construction of a response process. However, this worker then commented that as a victim, they had not been consulted about what they had needed during and after the series of assaults that they had experienced, and so their

knowledge about the importance of timing for debriefings, and about support for casual staff was lost.

The shared responsibility and interaction between the person and the environment also manifested in debates over whether debriefings should be mandatory or voluntary, and the degree to which what is offered fits the characteristics of the particular environment. The review of the debriefing debate and the development of guidelines in Chapter Six suggests that international evaluations do not consider that debriefing should be mandatory, arguing that this may pathologise the participants into an expectation of negative impact, and may discourage natural coping strategies. The voices of some of the participants in these interviews appear to challenge some of these core assumptions. In particular, one participant felt strongly that they should have been offered a mandatory form of support. Their personality and self-imposed expectation of being seen as a 'coper' permitted the avoidance of some very crucial ventilation and processing opportunities that they felt unable to call for:

> For me personally it would have been [best to be] compulsory and I know it's shocking for me to say that. If it would have been superficially compulsory, that would have been easier. I've had four appraisals since that incident and it's never discussed whether you took advantage of it. Just making sometimes the [first] steps, that's the hardest bit. Well, that's when you are least empowered, isn't it, when you're close up to the incident.
>
> Psychiatric nurse, community

This respondent recommended that the use of debriefing or other supports be monitored and factored into performance appraisals, a process that would be compatible with the environment of the health and safety legislation in Aotearoa New Zealand (Chapter 6). They presented the argument that even if what is offered is a standardised format and therefore not suited to all, at least something has been done. Another participant, a support worker, talked of the experience of having had a manager who insisted that everyone attended what they called a debriefing. Staff were very happy with this and felt supported, but the process does presuppose a functional relationship between staff and management and is an approach perhaps best suited to smaller agencies.

Whilst the interview questions were not designed to elicit detail about the model of debriefing that may have been applied, the knowledge of several of the respondents opened up such discussion about the adaptability of debriefing models to particular environments. There was overwhelming support for

organisational responsibility to respond to the needs of those affected by workplace incidents, but less discussion about the shape this should take. Two participants made comment about the adaptations that overseas models, as taught by Australian trainers in this country, might require, a nurse commenting that 'the one size fits all, I can see how that isn't going to fit everyone'.

The following addressed the issues of uptake within different environments:

> It's interesting how groups do it differently. I would think our crisis team, who probably are the most likely to be affected, are the least likely to make use of it. Maybe [because] it happens so often that it's almost like 'this is what happens to us' and part of it may be about the profession - for the most part they are nurses, and so ideas around process maybe less ingrained, they're busy and they work irregular shifts. And they tend to probably be a more closely knit group in some ways, and maybe think they can provide their own support.
>
> Social worker, community

The issue of uptake of the service by the crisis team mirrors comments during my participation in the CYF Advisory group on CISM, where the residences (where many incidents of violence occurred) were also the hardest to obtain buy-in for staff support systems. The testimonies of several residential and ward-based nurses within this thesis suggest that the more enclosed and contained a work environment is, and where consumer behaviour and staff resources are focused around acute and often violent episodes and crisis intervention, the more resistant the staff within these teams are to the imposition of externally-driven forms of management and change. Teamwork and mutual dependence in these settings become more critical, and the development of oppositional behaviour towards 'outsiders' may be noticed.

The management of critical incident stress

Chapter Six outlined some of the literature and practice developments in the field of critical incident stress. A Critical Incident Stress Management programme, or CISM, was described, endorsed both from the point of view of some of the protagonists in the debriefing debate, but also as an ecological construction, reflecting the core principle that the environment bears a shared responsibility for maintaining worker well-being.

The realities for the participants in this study reflected a provision of services far less identifiable as a CISM package. Within the interview schedule, participants were encouraged to talk about their own personal and professional

preparation for critical incidents and traumatic events in the workplace, and to reflect upon the relationship of preparation to the supports and assistance provided at the time. Whilst the line of questioning did not elicit a specific review of the overarching provision of supports in the manner of a CISM programme, none of the respondents described a systemically-established and endorsed process that could carry them through a critical experience and out the other side.

The final contribution from Narrative Four (b) illustrates some of the perceived realities of coping with an incident as an employee of a large, multi-site organisation. It reveals how the psychological impact of an incident is embedded in the situation's systemic and operational processes, and how the emotional well-being of the worker required addressing in parallel to these other factors. For this person, some of the support processes worked well, and yet some seven or eight months after the incident, their interview with me strongly reflected many unresolved legacies of the incident of sexual exposure. They were planning to move on from their worksite when I spoke to them, and their interview transcript was returned to me unedited, as they appeared to have left the country. Their narrative suggests many of the inherent difficulties in the provision of a systems-based, ecologically sound support system. Previous excerpts from this interview have attested to the ongoing awareness of the offender in the same neighbourhood as the worker lived and practised, and to their ongoing sense of vulnerability that generalised into their everyday life. Key systemic opportunities for the containment of and response to their major emotional upset were lost by an apparent lack of overall monitoring and support of their needs. The participant told me, after the interview recording had finished, how much the sexual element of the incident had intruded upon their personal and professional life and relationships, preventing the closure that Herman's third stage of recovery suggests is so crucial.

For this respondent, and for many others interviewed, support for their recovery was variable in quality, sporadic and not supported by wider systems. No overall monitoring of wellness and recovery was apparent through partnership with their organisation, leaving the worker themselves responsible for signalling need.

Learning from the interviews

In Chapter Seven, there was discussion about the potential for re-awakening and retraumatisation of participants as a result of the content of the interview. Whilst no indication was received of any personal harm or upset, several

commented on the use of the interview as ventilation, or as a further tool for processing their experience.

> When I was thinking about talking to you about it, just noticing the differences between then and now, that's good.
>
> Social worker, community

In two interviews, the act of talking and recall assisted in the development of a critique of both the agency definition of critical incidents and of organisational preparedness to respond. Both participants expressed thanks for the opportunity to reflect upon the issues and suggested that their learning from the discussion would be fed back into their workplace. For a psychiatrist, the analysis that they made within the interview about one incident resulted in their reframing the meaning of two other occasions. For a few, the interviews emerged as a means of intellectually developing ideas that they could then utilise within their own workplaces and interests in critical incident support. One comment provided me with reassurance that the purpose of the study was worthwhile:

> I don't know how many people you've interviewed on this team, but we would have all experienced something but I don't think anyone has ever come and talked to us about what would be helpful in terms of managing that.
>
> Psychiatric nurse, community

This reinforced for me the value of asking people about their own experience, of finding out what worked (and what did not), and of using this information to build an understanding of the best practice possible in the wake of critical incidents and traumatic events in the workplace.

Conclusion

The experiences of incidents within the workplace emerge as deeply contextualised and complex processes for those interviewed, confirming the strength of an ecological perspective as a tool of analysis. Accounts of incidents resonated with both the potential for the impact of trauma and extreme stress, and the interface with cumulative stress. Strongly held views about organisational support and responsibility were expressed, along with heavy critiques of existing support systems. The following chapter draws the threads of the literature and the data together, and begins the process of constructing a framework for the provision of staff support from an ecological base.

Chapter Ten: Complexity and Context

Introduction

The narratives of the participants in this study provide rich description of critical incidents and also address the thesis question concerning the complex interrelationship between incidents and the environmental context of occurrence and recovery. Prior to an incident, each individual and each environment carries with it a unique set of features, characteristics of which interact over time to construct the complex world of mental health service delivery. Within the collapsed timescale of a critical incident, a combination of these features and those of the incident itself produce a reaction, the features of which determine the short and long term outcomes. This interaction of person and environment provides the challenge for staff support that I argue is best addressed by an ecological framework of understanding.

This chapter first presents the findings of the research in an ecological matrix designed to honour the complexity of the incidents, the organisations and the systemic nature of the intervention and recovery process (Table 10). The related discussion combines the findings from the data with the literature, to reveal a strong argument for an ecological basis to the development of staff support systems. As an adjunct to this discussion, the integrity of the theoretical approach used within this thesis is considered, prior to concluding comments concerning an ecological framework for staff support systems after critical incidents and traumatic events.

Conceptualising staff support systems

The framework for support systems within Table Ten is constructed through the combination of two ecologically sensitive tools chosen for their optimum recognition of the autopoietical principles of structure, relationship, identity and change (Chapter 2). On the horizontal axis, acknowledgement of the contextually bound, developmental nature of incidents is addressed through a focus on pre-incident preparation and planning; on issues concerning the time around the immediate incident; and on the contextually embedded processes in the post-incident and follow up environment. Consideration of primary interventions, prior to the occurrence of incidents, and to what might be considered as tertiary initiatives focused upon follow-up, are both given a

Table 10: An Ecological Framework for Staff Support Systems in Mental Health

	Issues in prevention and preparation	Issues in the response to the incidents	Issues for follow-up and support
Ontological	Prior personal and professional experience: • Awareness & articulation of experience • Quality of recovery experience Perception/cognitive appraisal of stressors Skills level – personal & professional Risk awareness: watchfulness & complacency	Awareness of staff support systems The event is acknowledged by the individual The individual defines the event as critical Identification and management of immediate symptoms Emotional distress is accorded equal weight to that of physical injury	An ongoing sense of loss of control may linger substantially longer than organisational awareness Personal impact may affect ongoing professional practice Attention falls to the ability to develop a narrative and a sense of meaning The meaning of an event may become affected by the ongoing, related sequelae of the incident
Micro	Orientation and induction includes attention to stress, safety procedures and critical incident response Clarity over professional identity Clear enunciation of roles and tasks within multi-disciplinary setting Degree of control over own work Existence of support processes for cumulative stress – e.g. supervision Structural and systemic environment is safe Monitoring of caseloads and workloads	The event is acknowledged by the team Peer relationships and support Supervisors are trauma-informed Managers within teams may require their own form of critical incident support Team cooperation in affected individual's need to: • focus on events • tell their story • take time out Obligation of workers under the Health and Safety legislation to signal stress levels Clinical review forms part of any response process The nature of relationships within small agencies may be a strength in the support of affected individuals, but may also restrict access to necessary resources	Acknowledgement of differential outcomes for incidents over time Incidents involving more than one worker may feasibly be responded to on a collective as well as an individual basis The ongoing involvement with cases means that issues other than the initial event may produce stressors Monitoring of and support for workers on both a personal and clinical level is necessary Supervisors will need to be trauma-informed The impact of external inquiries and public scrutiny may result in defensive practise and an erosion of team-based support
Meso	Relationship between education and service delivery providers pays attention to stress and critical incident issues: 'training in principle' Relationship between work team and professional affiliations Relationship between work team and other teams and agencies Communication procedures and allocation of resources between teams is open and equitable Accessibility of support systems	Coordination between teams in order to provide support and equitable access across the breadth of an organisation Interagency communication and cooperation Agency awareness of the interrelationship between stressors at home and at work Response services may be fragmented between different geographical sites, arms of the organisation or different service purposes Team may need to 'borrow' leadership from other areas Small agencies may need to plan for events that may overpower their limited resources	External supports such as EAP and supervision will need feedback loops built into their functioning Organisational goals may be at variance with team or clinical goals in the face of inquiries or media scrutiny

Exo	Prior 'training in principle' • Existence of appropriate training • Effectiveness of training • Identification of personal stress & trauma issues Selection • Acknowledgement of risk environment in mental health • Exploration of personal stress management coping strategies of applicants Orientation and induction – support systems in place and available at an organisational level Orientation to mental health presentations and consumer issues Orientation to occupational roles within mental health Casual, temporary and part time staff are included in systems Attention is paid to recruitment and retention Management support is available Support processes for management In-service attention involves stress management and critical incident response suited to modes of working Safety systems and procedures are audited Physical environment is audited for safety Monitoring of caseloads and workloads	'Training in practice' occurs Agency environment allows for workers to define critical incidents and to call for assistance Environment has ability to audit workers for traumatic impact Early alert signals are established for major events deemed likely to create distress Environment takes responsibility for construction and maintenance of support processes The ability of small agencies to handle major events is scrutinised Response provision is inclusive of both trauma and stress symptoms Defusing processes included in management plan for incidents Disparity between the 'Mitchell' model and its application in practice in psychological debriefing Support processes achieve a balance between operational, support and clinical functions Resource availability of support Supervision can provide a model of an embedded support service Responsive management structures Obligations of employers to provide support under health and safety legislation The organisation implements protection from inappropriate media and public attention	Development and maintenance of a management plan for incidents is necessary Existing support services such as supervision, EAP or management structures may not necessarily provide the level of critical incident support required Small agencies, connected to parent bodies with little knowledge of critical incident support, may need to extend their functional relationships beyond their organisation The instigation of public inquiries (etc) should signal the implementation of an additional level of support for workers involved in the initial incident and its sequelae
Macro	Attitudes towards consumers Motivation to work in mental health Effective dialogue over potential cultural differences in expectations, work role and level of support available	Organisational denial that incidents of a major nature could occur Understanding about trauma and stress are inclusively contained within responses Assumptions and confusions about what is meant by debriefing Cultural compatibility of response	Organisational denial of longer-term impact needs to be challenged The focus on the initial incident should not mask the understanding of how impact changes and develops over time

greater ecological prominence than is provided within many accounts of critical incident intervention as described within Chapter Six. On the vertical axis, the ecological approach provides an analysis that recognises that the impact of events, and any response or recovery process, will occur at many different levels from the ontological through to the macro (Bronfenbrenner, 1977 & 1979; Chapter 2). These dimensional tools both honour and include the thematic strands of *Te Whare Tapa Wha,* the framework that provided the format upon which Chapter Five was based, and develops its principles to include consideration of workplace context and an emphasis on organisational responsibility.

The following discussion follows the three part format of pre-, peri- and post-incident issues, and combines the knowledge that this research has gained through consideration of the participants' experiences with the themes inherited from a review of the literature concerning the mental health environment (Chapter 3), the conceptualisation of extreme stress and trauma (Chapter 4), the impact of trauma (Chapter 5) and the organisationally based responses to critical incidents (Chapter 6).

Planning for the unpredictable: the case for preparation

A central research question has been the degree to which the ecology of an incident - its environmental context, its antecedent circumstances and the interactions of those involved - will influence outcome. In this stage, the focus includes both the notion of prevention (the ability to anticipate circumstances so that incidents can be eliminated, thus meeting the first goal of the health and safety legislation considered in Chapter Six), and the awareness that may reduce harm from any incidents that occur. On personal, professional and organisational grounds, the ability to anticipate that the work environment of mental health may bring with it the experience of critical incidents and traumatic events emerges as a crucial piece of learning in the narratives of the participants. Key issues in prevention that emerge are those of the influence of prior experience and its relevance to the selection and screening of mental health workers; the role of occupational identity and training in stress inoculation; and the contextual environment of mental health in relation to the occurrence of incidents.

Past experience, selection and the relational imperative

In the mental health environment, the unique characteristics of individual workers become active ingredients in the context in which incidents occur. Qualities and imperatives that the participants brought with them into the

workplace introduced both strengths and vulnerabilities into their preparation for challenging events.

We know, from the discussion concerning the nature of the stressor in Chapter Four, that events involving human interaction create unique and potentially damaging impact upon those involved (Breslau et al, 1991; Dyregrov & Mitchell, 1992; Gould and Ryback, 1999; Freyd, 1996; Janoff-Bulman, 1992; Smith & North, 1993; Weisaeth & Eitinger, 1993). The occupational health and safety legislation and policy guidelines within Aotearoa New Zealand recognise that it is the human services that are inherently stressful environments (Chapter 6). The experience of stress, either cumulative or through a critical incident, therefore emerges as a significant factor in the potential for mental health workers to lose commitment and desire to work with consumers. Because of this, the nature of the motivation to work with consumers contributes significantly to a framework of staff support.

Clearly emerging from the narratives was the personal and career imperative to engage with people. For most, entry into mental health had been a meaningful decision; generic training preceding either appointment within mental health or a period of specialist education. For support workers, their choice of occupation was determined by a desire to have a meaningful job in terms of the elements of relationship and change that are inherent within mental health. Liking for, and interest in, the consumers for whom the services exist, was raised as an ingredient both in entry and in maintaining motivation. Without this, a job within mental health retained little attractiveness and tenure, but the same dynamic implies that conditions within mental health may serve to undermine such commitment (Macdonald, 2003).

For some workers, the direct exposure to mental health issues in their personal and family lives had clearly created the imperative to work in this environment, and had contributed dynamics for the duration of an incident. Within the one experience (Narrative 3) we read testimony of entering the mental health workforce as a process of discovery, of core ontological security threatened by the incident and its sequelae, and of politicisation and burnout as a result, a significant illustration of the stages described by Herman (1992a) in Chapter Five. Yet this participant, and many of the others, had remained in the work, and the quality of their work performance cannot and should not be judged by their commentaries within one interview. The key emergent issue is that of awareness of vulnerability, and the ability of an incident to penetrate to the core of their sense of security.

Should we then screen for vulnerability? Should we, more crucially, screen *out* those with particular histories? Or to reframe the question, should we, within training and selection processes, provide some opportunity for those seeking work in the area to assess their own background, motivation and resilience? The literature on traumatic stressors and their relationship to impact and recovery suggests that to identify elements in job applicants' histories with a view to screening out those with experience of major incidents would be a crude tool indeed. Aside from legal issues of privacy, and reliance on honesty of disclosure, to make a link between severity of impact and permanent damage is psychologically and ecologically inaccurate, and addresses the 'dose-response' explanation (March, 1993) without considering the mediating factors of time and subsequent experience.

For some issues, there is clearly a need to explore with applicants the relationship between their own personal experience of recovery and their current level of well-being. This comes clearly into focus as a key issue for those working in the alcohol and other drugs field, which has an ongoing interest in the needs of 'two-hatters', that is, those with personal histories of addiction and recovery. This issue is also one thrust into prominence by the evolution of the CSW role. CSWs may enter the field on the basis of 'heart' rather than 'head', out of personal commitment or attributes that are not related to professional education in the area, but perhaps to personal or vicarious experience of mental illness (Chapter 3). Mental health services are now facing more openly the issues of the mental health of their workforce (Curtis & Hodge, 1994). This is not to say, of course, that direct personal experience of prior mental health issues occurs only in CSWs: in many cases it is the emergence of this occupational group that has raised this issue, and in the increasingly open, recovery-focused environment of mental health, it is becoming easier for others to disclose their own personal experiences.

The emphasis in selection procedures, on an ecological basis, needs therefore to shift from the ontological towards the exo-level of responsibility, from an emphasis on screening, to an emphasis on alertness and preparation for the nature of the work. Whilst individual job applicants are in the best position to cite and establish links between past experience and current wellness, our understanding of the trauma literature and the testimonies of several participants in this research suggest that no system of screening will be able to exert other than a crude influence on the selection of resilient candidates. Prior training, an appointment process in mental health and thorough orientation and induction can begin a process of stress inoculation through exploration of

candidates' awareness of, and preparation for, the kind of incidents that may occur, and for their own known processes of handling stress.

Motivation is fundamentally linked to resilience. It is clear from the length of tenure of some of the participants, and their comments in regard to their motivation for the job, that they gave considerable weight to the relational aspects of working with consumers: to a liking and respect for them; to identification in terms of background and culture; and to the possibilities of contributing to improvements and change in their lives. The meaning of the relationship therefore can lie at the core of a person's commitment and role performance, and events that intervene in this relationship can have a major impact (Chapter 5). I would suggest that there is a key opportunity here for ongoing induction, training and supervision to provide a forum for consideration of the connection between the nature of the relationship with consumers, and the expectations and motivations of workers. Where a worker's well-being is connected to the expectation of seeing incremental change and improvement, or to their organisational opportunity to exercise interventions aimed at this, incidents that demonstrate otherwise may have a detrimental impact on recovery from incidents, and on morale in general (Valent, 1999).

The role of occupational training and identity in stress inoculation

It is argued here that preparation for the nature of mental health work can add a layer of resilience over any pre-existing personal stress management and coping strategies, by serving as a collective meaning making process that binds cognitive, social and cultural processes together within organisational contexts (Chapter 5; Meichenbaum, 1985). The call for the certificate in Mental Health Support Work can be interpreted as part of this strategy (Chapter 3; Curtis, 2004). Professional training may alert workers to the nature of mental health, consumer behaviour, role expectation and coping strategies, and may reduce dissociation (Morgan et al, 2000). It may suggest, for instance, a level of knowledge about the aetiology of behaviour, skills for communication and defusing volatile situations, and the use of networks of support such as supervision.

Several major issues emerge from the consideration of professional identity. In the first place, a review of the literature in Chapter Three, confirmed by the cross section of participants in this research, suggests that not all mental health workers are professionalised, clearly indicating that preparation for critical incidents and traumatic events in the workplace cannot rely solely on pre-selection training. Alongside this, the existence of untrained, casual or locum staff suggests that a systems-based, post-selection process of incident training is

necessary to ensure that the mental health environment has any degree of quality assurance in the preparedness of its employees.

Whilst not all mental health workers will have a background of professional education and training, the majority in many settings (especially in the DHBs themselves) will have both extensive training and a professional affiliation. From the words of the participants, it cannot be assumed that all their training courses will have paid appropriate attention to stress, trauma and management of incidents. Where there was training, it focused on stress management and not on traumatic impact, secondary traumatisation or the management of incidents. Several participants suggested that any level of training, prior to their employment within a particular context, would have had a limited effectiveness, as many of the ways of getting support and resolving issues are contextually defined. The emphasis of the education providers can therefore only be 'training in principle', with a focus on preparation of the individual: the service providers' responsibility is to the preparation of the worker within context, or 'training in practice'. The systemic and environmental processes embedded in the experience of critical incidents, as attested within the narratives in this study, emerge as employer responsibilities.

The connection between cumulative and acute stress has been explored within Chapters Four, Five and Six, the thesis argument maintaining that the impact of exposure to events will be mediated by pre-existing and ongoing exposure to cumulative stress. The participants highlight, in particular, that the issues of job context (the stressors inherent in the environment, in work relationships, perceived level of management support and so on) interface actively with the quality of the critical incident experience (Chapter 6). Development of successful strategies of stress management, along with an ecological assessment of the sources of stress, needs therefore to be a meso-level partnership commitment with training schools that could include a heightened awareness of, and skills in using, advocacy, supervision and conflict resolution. Some education about the ecological impact of trauma is appropriate here, as there is some indication from the words of the participants that familiarity with posttraumatic symptoms can ease the sense of isolation and loss of control that an incident may produce, thereby potentially mediating outcome.

Identification of mental health as a workplace of risk is likewise an issue of partnership. Whilst it is probably unrealistic to expect that organisations overtly address issues of traumatic events and critical incidents whilst at the same time struggling to recruit and maintain adequate levels of staffing, it is essential to ask selection questions which signal the nature of the work

(Hatcher et al, 2005). Within the child protection field, for example, the CYF appointment protocol specifically asks referees to describe the applicant's approach to stress management and other related work practices. Similarly, the meso-level introduction of current workers into pre-entry training courses can break down the barriers between 'training in principle' and 'training in practice' by providing students with the opportunities for vicariously learning about direct practice, engagement with other occupational groupings, and some indication of the professional relationships between these groups. These strategies serve the purpose of changing the attitude of denial and stoicism about the experience of critical incidents (Hart & Warren, 1997) and of re-focusing attention on the possibility that incidents may occur.

When attention was paid to training concerning incidents within the workplace, participants appeared to suggest that the emphasis in some organisations was upon the training such as 'breakaway techniques' and calming and diffusing processes. A comparison of the literature and the data suggests that this is both an example of the historical notion of harm as physical injury (Chapter 6) and a misreading of the nature of critical incidents. As defined by the participants in this study, many of the incidents with the greatest effect upon them were not incidents involving physical force, but were situations of threat or helplessness with psychological, emotional, spiritual and existential effects.

Pre-appointment preparation for incidents emerges as a necessary but not sufficient element of stress inoculation and preparation. Its existence and quality cannot be guaranteed, and the unique characteristics of organisations suggest that the shape of incident support may need to reflect these local characteristics in a way that professional training alone cannot achieve. Processes that enhance the development of clear identity and role performance, such as supervision and the development of systems protocols about accountability and clinical management of cases, underpin the effectiveness of staff support after incidents.

Conditions in mental health: the creation of risk

The previous discussion has drawn attention to the environmental context of mental health as a potent factor in the experience of critical incidents and traumatic events. Structural and systemic conditions, located largely at the meso and exo levels of the ecological framework, make a major contribution to the processing of experience and suggest that much of the responsibility for intervention and support will need to be located in the service delivery

environment as described in Chapter Three. In this section, the role of the environment in preventing and creating incidents is addressed.

In the views of several participants, the physical environment itself clearly contributed to elements of safety and risk. The processes of deinstitutionalisation and care within the community at times created a poor fit between physical location and utility. Few wards, offices and community houses are purpose-built, and participants cite several examples where risk was created by the physical structures around them. Changes to the physical environment thus provide one level of prevention that works to reduce or eliminate many incidents.

Structural elements of safety then interface with the systems that work within these environments, signalling the link between micro, meso and exo-levels in the framework (Bibby, 1994). Several participants reflected that the systems set up to provide security, such as the provision of cell phones and check-in procedures were only as good as a team's preparedness to use them, and that rigorous protocols may be inclined to be interpreted as challenges to staff autonomy of practice. It was also suggested that attention to safe practice might only appear valid to those who have already experienced critical incidents, suggesting that awareness of risk was not always present in daily operational functioning. It can therefore be suggested that an organisational goal will be to sensitise staff without having first had a major incident. This can be achieved, as discussed later in the chapter, by processes such as supervision, stress and trauma audits, and through the use of table-top exercises.

Embedded in the participants' critiques of their organisation were other issues of structural and systemic importance, issues which are embedded in an understanding of the service delivery environment described in Chapter Three. Several talked in terms of the management of caseloads, with descriptions of work overload and mismatch of consumer to worker being identified as problematic. Short-term problem solving rather than intervention at family, community or structural levels was cited as contributing to consumer and worker frustration and as a dynamic in the creation of defensive practice and tension. Diagnosis and the focus on mental disorder and the gathering of statistics were seen by some as a constraint rather than an aid to good practice. Tensions between worksites highlight the importance of effective communication processes. Given the interdependence of behavioural, social and organisational factors for the transmission of trauma, and for effective response to it, examples such as these serve to illustrate the pathways through

which the impact of incidents may evolve, and the site for strategies of preventive action.

As a people-focused activity, mental health work is intimately connected to people at all ecological levels, and contains high levels of demands for skills in interaction, negotiation and dealing with competing demands. All but one of the incidents described in this research occurred through the interaction of the worker with consumers, through threat, attempted or completed suicide, indecent exposure or acts of physical aggression. Many contained elements of conflict or disagreement with, and lack of support from, colleagues. Several participants talked of their need to be competent at both interpersonal and structural levels of communication recognising risk, balancing privacy and confidentiality in decision-making, acting as a container for the frustrations and aggressions of others, allocating resources and balancing the competing agendas of different teams. The challenges of being alert to the multi-level dynamics inherent within the environment all potentially contribute complexity to the notion of critical incident support.

Embedded within the mental health workplace, too, are some ingredients for effective management and support processes. Participants talked about the effective support received from managers, which was often identified as being personal rather than systemic in nature, suggesting that personal relationship can act as a conduit for the management of workplace stress, a process omitted from the evaluations of CISD in Chapter Six. Peer support from colleagues on both a casual and semi-formal basis figures prominently in the narratives, as did effective supervision that incorporated personal and professional development as well as clinical accountability. Respondents emerged as astute observers of healthy processes within mental health, and their comments overwhelmingly endorse the hypothesis that the environment has a significant role in the enabling of healthy work practices and successful recovery from critical incidents.

Attention now turns to the issues arising from the participants' experiences of incidents and their immediate response.

Responding to incidents: issues arising from the experience of incidents

Within the framework of Table Ten, the following discussion combines the experience of actual incidents and the response made to them with the knowledge gained from the literature. The text addresses issues embedded in all levels from the ontological to the macro, and indicates a complex

interweaving of person and environment in the response to incidents that endorses the ecological approach taken. Through exposing the philosophical identity of current classification systems in Chapter Four, and by placing the impact of trauma in an ecological framework in Chapter Five, this thesis has suggested that tensions in how events are perceived, interpreted and responded to will determine the ability of those workers affected by organisational events to effectively manage them. This is illustrated by the following discussions concerning the relationship of body and mind, and the power to define critical incidents. Discussion then turns to the nature of the response to be made at an organisational level, with particular reference to how the narratives of the participants shed light on the debriefing debate addressed in Chapter Six.

Breaching the Cartesian divide: the impact of incidents on body and mind

A key component of the research question is the degree to which conceptualisations of extreme stress and trauma provide adequate explanatory models for the comprehension of critical incidents within the workplace. Underpinning this debate lays the core philosophical question of the relationship between body and mind, and how our explanations concerning this relationship determine the manner in which we interpret critical incidents and traumatic events.

Consideration of the relationship between body and mind in the participants' experience opens the possibility of integrating the narratives with a key discussion within the literature. The question concerns the role of the environment in mediating the impact on the body. This is of key importance to the construction of appropriate support systems and in the identification of posttraumatic symptoms within these. This thesis has argued that the effect of biomedical dominance has been to focus attention, and intervention, on the neurology, physiology and psychology of trauma and extreme stress, with a parallel under-emphasis on how complex environments and changes over time impact upon recovery.

Several participants identified symptoms suggestive of key criteria of the DSM diagnosis (arousal, intrusion, avoidance and dissociation) as immediate and longer term characteristics of their experiences. Several clearly revealed symptoms, current or historical, that would have met many of the criteria for ASD or PTSD. Whilst the thesis did not seek to establish epidemiological data, or to test the validity and reliability of diagnostic criteria, the narratives of participants attest to the potentially overwhelming power of incidents to create

major physical and psychological response. Incidents in the mental health workplace, then, can provoke conditions in which (within the DSM nosological system) major psychiatric disorder can result. Events may determine life decisions such as where to live or work, with whom to associate, and may affect ability to trust, to practice assertively in complex environments where triggers and future stressors may create further vulnerability (van der Kolk & McFarlane, 1996). Enduring sensory reminders of an incident, whilst not preventing the majority of participants from continuing in role, continued to intrude and demand response, and confidence and flexibility in decision-making, long-term planning and moral and ethical choices were reportedly compromised in some cases (Gersons & Carlier, 1992). Several participants clearly identified an ongoing struggle to establish and maintain a liveable relationship with these new sensitivities within ongoing job demands.

On the basis of the narratives it is possible to suggest that unprocessed or unresolved experience at a physiological level can have emergent properties at behavioural, social and professional levels of functioning. An environment that actively works to suppress acknowledgement of the impact (one that either offers little support or whose support services are fraught with mixed messages) may stifle the development of the all-important interpretive and narrative processes (Reid & Hoffman, 2000). What begins with a self-preserving silence or flatness of affect may metamorphose organisationally as denial of impact or the individualising of responsibility, creating a social layer to the commonly experienced search for meaning and responsibility.

A heightened organisational awareness of the likely impact of traumatic events and the nature of the stressors most likely to produce the surges of fear and loss of control is mandated out of this knowledge. The mental health environments described by the participants included those situations and roles where the work was conducted either on their own or was isolated professionally. In these cases, the physical effect of the overwhelming situation is potentially masked from the immediate observation of others, and organisational awareness of the likely impact of events may have assisted more immediate and sympathetic attention to the arousal states that occurred.

One further question occurred to me during the formulation and creation of this research, and it is one to which I have not found a satisfying answer. In working through the issues of the positivist hierarchy of knowledge (Chapter 2; Young, 1995), with the inherent assumption of the primacy of physics and biology (the science of small things) over psychological and social elements (the science of larger things), I began to struggle with the issue of the relationship

between genetics and the environment. My focus of concern is not so much the age-old issue of nature versus nurture, but of the very ability of genetic change through the impact of the environment, the fundamental relationship, of course, of evolution itself. In relation to trauma, for example, this question manifests as investigation of the degree to which a pre-destined sensitivity to traumatic impact can be conveyed through genetic coding. What I am curious about is the degree to which sensitivity to traumatic impact (for instance, susceptibility to 'acquire' PTSD), if indeed genetically coded, can be undone by the impact of a benign and safe environment, and how long this may take. To date, this is an ongoing inquiry.

Discussion now turns to the relationship between trauma, stress and the definition of critical incidents.

A defining experience? Trauma, stress and critical incidents

Set the task of defining a critical incident, participants demonstrated the fluidity of the definition along continua of impact, from physical to spiritual, from direct to secondary, from a 'dose-response' to an interpretive understanding, and from self-definition through to that influenced by training and agency. Unlike the focus of the diagnostic criteria for post traumatic impact, issues of environmental support, role performance and relationship with others were often included in the definition of critical incidents. Whilst many narratives addressed the physical and emotional upset of the immediate impact, the contextual consequences of the event also contributed to the definitions of critical incidents, introducing elements of meaning making and the accumulation of stressors. No participants described incidents in isolation from workplace environments, clearly illustrating the tension between the conceptualisation of trauma support and that of critical incidents within the workplace context.

The clinical distinction between trauma and stress is of relevance here, and serves as an illustration of the tensions between knowledge bases that continue to play out in the workplace. Knowledge and definition of trauma was described in Chapter Four as originating from physiological, neurological, psychiatric and psychological knowledge bases. Knowledge of stress postdates the origins of the medical description of trauma, and through its use of biological, engineering and ecological metaphors, dates from the mid twentieth century, and is explored largely through the realm of psychology and social science. Nosological systems such as the DSM consider the impact of trauma as distinct disorders but the effects of stress, especially the notion of cumulative

stress, can be subsumed as components of other disorders, namely anxiety and depression. Whilst recent changes in health and safety legislation signal a movement towards greater acknowledgement of environmental complexity, Chapter Six argued that tools used in the evaluation of critical incident stress have not developed equivalent sophistication and as a result, deny the synergistic relationship between the environment and traumatic symptomatology outlined by means of *Te Whare Tapa Wha* in Chapter Five.

The narratives of the respondents in this study presented a very different and less clear-cut relationship between the experience of stress and of trauma. One hallmark difference, the physiological impact, clearly suggests that for some of the participants, a full traumatic diagnosis may have been possible, in terms of having met the criteria in the DSM. Even for these individuals, however, the management of the symptoms was presented as having been compounded by environmental stressors unrelated to the original incident, and to have played out through complex personal and employment conditions. The passage out of impact was governed as much, if not more, by the conduct of peers, management and the organisational system as by the initial severity of the stressor. There is therefore a discussion to be had in regard to the relationship between the experiences of acute and cumulative stress. The subjective appraisal of being overwhelmed by experience is intimately related both to the degree of pressure that a person experiences at any given time and their level of resilience and environmental support (Falloon & Fadden, 1993). Cumulative stress, or the repetition of stresses consequent to a single initial event, has the potential to create major coping challenges after critical incidents.

For the workers affected by events, there was no expectation that their 'symptoms' were to be triaged according to diagnostic category. Rather, the expectation was that their environments provide a set of practical and emotional supports and recognition of impact. Support around the time of the event may be key to the prevention, mitigation or exacerbation of impact. Simply put, the narratives of the participants suggest clearly that a definition of critical incidents may or may not include traumatic events and posttraumatic symptoms, but that the act of their defining the event as critical should be sufficient to produce an organisational response of support (Chapter 6).

Participants were able to define characteristics of critical incidents that lend weight to this argument. Focusing less on the nature of the stressor and more on its impact, emergent features were elements of helpless and being overwhelmed; of things being out of control; of feeling cut-off from normal sources of control or resources to cope; and of having professional skills and

expertise stretched beyond capacity. Many of these experiences are embedded within professional roles and identity. The narratives of the participants, then, can be utilised in a case for the development of a sensitive and responsive environment that while actively supporting the immediate physiological and psychological impact, translates into behavioural and social recovery. Furthermore, an ecological perspective, in suggesting the holistic relationship between body, mind and relationship, can serve to highlight that not only can body experiences of extreme stress have a bearing on a person's interaction with the environment, but that the environment, too, can potentially have an influence on the duration and intensity of physiological symptoms. Training and support systems, through heightening awareness of body sensations and by the early identification of difficulties, can allow these to be addressed rather than suppressed. Connection with support services, peer support and other informal acts of affiliation, may reduce stress levels and the effects of physiological arousal.

Interface issues between the worker and the outside influences of home and culture emerge as important at a meso and macro level. Participants demonstrated the ecological impact of stress and trauma through accounts of the effect on their home life, and their narratives strongly suggest that the boundaries between different microsystems are porous indeed. Given an understanding of the ripple effect of traumatic impact (Taylor, 1996), an effective response to incidents within the workplace will be required to pay some attention to the relationship with a worker's location within family and community. On a cultural level, cultural diversity produces another layer of potential stressors, into which the effects of critical incidents can play out. Agency and environmental responses to an initial incident appear to be powerful determinants as to whether a person can use established cultural processes of crisis resolution and grief, or whether they are isolated from these by a mono-cultural approach to the processing of events.

Some principles emerge from this discussion to guide the construction of appropriate staff support systems. Firstly, the narratives do suggest, as previously acknowledged, that there can be a positive relationship between the severity of the event and the likelihood of post-traumatic symptoms. This suggests that for some categories of event in mental health, such as direct exposure to death, suicide attempt, threat of violence and so on, the nature of the stressor itself should be sufficient to signal an alert to the activation of the need for support. More subtle and subjective, but intrinsically bound up with this, is that situations that are perceived or described as having overwhelmed and being out of control - such as a situation of having been stripped of all

professional ability to act effectively - should be considered as potentially damaging. In these situations, a clinical distinction between trauma and stress may become apparent.

Secondly, watchfulness on the relationship between the level of skills and experience and the demands of the situation can suggest that there will be inherent vulnerabilities for some people, in their subjective and practical ability to cope with the demands of a situation. A new graduate or an untrained support worker, for instance, will not be expected to have the same degree of practice experience and wisdom, or organisational knowledge, to successfully navigate situations of extreme pressure. The role of the environment (including family, community and culture) as a source of strength may be overlooked.

It appears from this discussion that to attain the operational ability to distinguish between traumatic impact and other situations of acute stress is possibly a false goal. We are perhaps too wedded to the need to provide a clear-cut classification of trauma by which to determine intervention (a bond, I would suggest, still fundamentally connected to the requirements for diagnosis and compensation). One incident may provoke a spectrum of reactions in those involved. Whilst environmentally located supports will need to be able to identify traumatic symptoms, they may not be able to provide triage explicitly on that basis, but will initially need to be inclusive. Where the appraisal of a situation is so dependent upon the matrix of person and environmental characteristics, initial responses may need to be informed, but not determined by, diagnosis of posttraumatic symptoms. It follows, therefore, that evaluation of interventions be aware of this. These issues are discussed further when the experiences of the participants in relation to post-incident support and debriefing is assessed.

The question then arises, if the relationship between trauma and stress is obscure and operationally not feasible, then should we treat all incidents as potentially traumatic, and respond accordingly? Or, as some feared after the storms of the debriefing debate had threatened employer engagement with the provision of staff support, should little be done until traumatic symptomatology or occupational problems arise? Both of these approaches, I suggest, are pathogenic in nature, in that they either view all workers as potentially vulnerable, or locate any response as a reactive action once damage has begun to manifest. An emphasis on trauma alone, and, I would suggest, the casualising of the term so that it applies to many clearly non-traumatic situations, will diminish the impact of those experiencing high levels of acute stress. A salutogenic response informed by ecological principles would suggest

that the environment needs to be empowered to respond appropriately, and that interventions and support be trauma-informed. Awareness of the crucial trauma symptoms that may serve to distinguish between traumatic and 'mere' stress reactions, can serve to sensitise the supports so that individual needs are identified.

The environmental response to the occurrence of critical incidents is now the focus of discussion.

The shape of organisational response

Having explored the close relationship between the individual and the environment, and between the experience of trauma and the interpretations of stress, the discussion now focuses upon the shape of the organisational response to the occurrence of incidents, arguing that this must inclusively contain the range of possible impacts whilst simultaneously acknowledging that these will evolve in a variety of configurations over time. The discussion therefore centrally grapples with the literature in Chapters Five and Six.

This study encountered a range of organisational response to incidents, and in light of the literature, commentary can now be made in relation to what workers found to be effective, and what they experienced as ineffective, counter-productive or undermining. Major questions that emerge here are related to the fitness of debriefing and other supports to flexibly address need and the resultant issues of how any response is structured. Issues related to longer-term support processes are addressed subsequently.

The collective voice of participants located the provision of incident response within a temporal context, illustrating encouragingly that awareness of the impact of incidents has grown both for individuals and for organisations over time. This has made acknowledgement of affect progressively easier (thus reflecting the social determinants of traumatic impact - attachment, affiliation and alienation - explored in Chapter Five). However, several comments were made to the effect that the work itself seemed to have developed more risk, signalling a relational link between service delivery policies and structures and the experience of incidents. Since the inception of CISD processes within some of the larger organisations (within this study, exclusively the DHBs), there was also more familiarity with the concept and process of debriefing, which many viewed as necessary and welcome for raising the profile of worker assistance and organisational commitment, whilst at the same time operationally flawed and at times detrimental to recovery in the way that it was conducted. Debriefing, the use of EAP, and supervision were the only named processes of

formal support, and out of these, it is debriefing that exclusively refers to support to be provided in the immediate time around the incident, which is the focus of this part of the framework.

The time immediately surrounding a critical incident tends to be dominated by the characteristics of the incident itself. In this sense, the incident becomes the client, the needs of the workers subsumed within the imperative to resolve the emergency. Severe stressors assist with identification of immediate need. It is however in those areas where the possibilities of interpretation intrude, where the meaning of an event may differ from one person to another, or where the impact is masked by the sequential nature of events, that the organisational response became more ambiguous, and individual need may be overshadowed by organisational need.

Whilst feelings of helplessness and loss of control appeared to be addressed relatively well by demobilisation processes such as practical assistance, removal of the stressor and in some cases, removal of the worker from the stressful environment, the physical, emotional and social legacies remained in many cases for months afterwards. It leads me to suggest that whilst demobilisation was achieved operationally well in many cases, attention to the processing of experience - the defusing and other more formal processes such as debriefing that paid attention to the recovery needs of the worker - was more haphazard and not universally adopted. Where this occurred it was usually in the form of a 'negative' intervention, that is, one offering personal time for the worker but no active intervention to address the impact on them. Effectively, for many respondents, they were left to process an event on their own, thus potentially reinforcing both the isolating effect of an incident and the individualising process of recovery acknowledged within Chapter Five.

Time out, of course, may let the impact of an event unravel in time and be absorbed into a cognitive schema (Chapter 5). But there is a risk that the psychological processes of denial can become established behaviourally and block recovery. Organisational behaviour can reinforce this denial process by drawing participants back into an environment in which they continued to experience high levels of stress. There will undoubtedly have been incidents from which all participants will have bounced back, but the interviews do suggest that where the lack of positive support occurred and only personal resources were available, the important relational processes of recovery were delayed or prevented. From an ecological perspective, attention to the operational requirements of the incident, or to identified individual needs,

ignores the third party in the responsibility relationship, that of the environment itself.

Amongst a considerable majority of the respondents there was an overwhelming sense of organisational obligation as a human right, leading to the positive regard with which the concept of debriefing, discussed below, was considered. 'Positive' intervention, that is, a deliberate and designated support process for the immediate addressing of critical incident impact, was largely represented by the use of EAP, supervision and formal debriefing processes. Whilst the individual components of EAP (counselling and occupational health advice and advocacy) were found to be useful, it emerges as a systemically vulnerable response in terms of its organisational situation away from incidents and affected teams. Representation of the needs of an individual was often in these cases left up to them, providing institutionally created opportunity for further isolation and retraumatisation as a result. Supervision in relation to critical incidents is addressed in a section below: the conceptualisation of debriefing support is now considered.

Conceptualising debriefing

Aside from practical demobilisation, the main form of peri-incident support received by participants in this study was that of debriefing, a term conceptually familiar to all those interviewed. Proportionately, about one third of participants had had experience of debriefing; another third knew of its availability somewhere within their organisation; and the remainder knew of it theoretically but had no access to it. These proportions had surprised me, as my hypotheses and knowledge of the mental health environment had not prepared me for the extent to which debriefing had become familiar. Whilst I had focused upon the literature on debriefing and CISD in Chapter Six, I had done so in order to tease out the characteristics of support and the issues in the evaluation debate, and in order to establish a sense of guidelines for practice. Initial inquiries had not produced a sense of widespread and active implementation of this procedure. In retrospect, there would have been research mileage in examining in depth the experiences of those who had in fact experienced debriefing.

The term 'debriefing' has become a term loosely applied to a raft of support initiatives that can take the form of simply having the opportunity to talk over an incident (akin to a defusing procedure), or of attending a team meeting discussion that may include affective as well as clinical and operational aspects. The suggestion then emerges that much of the confusion and acrimony in the

debriefing debate has been the over-generalisation of the term to include any initiative promoted by an employer. Underpinning this is the opinion voiced by many of the respondents in this study, that despite its perceived faults, anything offered by the employer to meet their obligations is better than nothing.

What, then, was offered in the way of 'debriefing'? An analysis of some of the incidents where participants reported being debriefed would suggest that theirs was not a formal process following any established process akin to the 'Mitchell' model, but was, in terms of the construction of interventions described in Chapter Six, one of defusing, and was in addition offered to them individually as a response to the situation that they alone had experienced.

The respondents for whom psychological debriefing was a possibility but who did not report its use, explained its lack of uptake in two ways. Firstly, several reflected that the establishment of a CISD team (here the mental health workers referred explicitly to teams set up along Mitchell lines) had reached a certain point of development in their organisation, but that it had not been established in their own team but was available elsewhere across the city. This provided structural and systemic interpretations of its lack of use. Unfamiliarity with its facilitators compounded the lack of immediacy in obtaining support. A sense of complacency was commented upon, acknowledgement being made that the existence of support somewhere in the organisation could be called upon in the event of a crisis. It would be left to individuals within particular teams to call for a debriefing team from another area, suggesting that the organisational impetus to have a universally available service was weak.

Secondly, several participants reflected that the training in regard to CISD, and the increased level of awareness of the impact of the work, had perhaps sufficiently raised the collective consciousness within a team to the point where formal debriefing had become unnecessary for the majority of critical incidents. This is an observation confirmed within the CYF process (Chapter 6) and acknowledged within the debriefing commentaries as part of a political agenda of organisational change (for instance, Hart & Warren, 1997). Nonetheless, those not using a psychological debriefing format were adamant that its existence within an organisation was a positive step both for individual support and for team well-being, and the opportunity to utilise it represented organisational commitment, despite the structural and systemic concerns that suggested that this was a commitment in principle rather than in practice.

The learning from those for whom debriefing was not cited as part of their recovery from critical incidents raises some key principles for the development of appropriate staff support systems. It suggests that for some team environments and after some incidents (small agencies with 'hands-on' management, and where incidents involve few staff members, for instance) a process of defusing and active management of needs is possible, on a smaller scale. From a reading of the trauma literature, natural relational processes of support are logically the most favoured way of crisis resolution, and it was gratifying to be told that in many cases, this was perhaps some of the most effective support received. What was not explored in the experiences related within the interviews were those situations either where the stressor itself was so severe, or the whole of a small team was deeply affected by an incident. It would be at this point that some of the natural social processes would potentially be exhausted. This suggests that the available models need some expansion, to include both preparatory planning for meso- and exo-level supports that may be required, and that the actual models available may need to be articulated and adapted to meet the needs of a small agency. Similarly, where formal psychological debriefing was established elsewhere in an organisational structure, the lack of uptake by one site may be informed by systemic and structural reasons, factors that may work against an organisation or its employees should there be legal action under the Health and Safety in Employment Amendment Act (2002). Lack of organisational will to provide equitable access to services may become a major factor.

Psychological debriefing processes were available and utilised by several participants in the study, offering opportunity for insight into the nature of the process experienced, and providing critique in relation to key areas of the debriefing debate and the development of responsive support systems. An overview of the experiences suggests that the implementation of debriefing, limited in this study to the larger DHBs, was in early stages of development. Those trained to facilitate debriefings, at least two of the participants in this study, talked clearly about the application of the Mitchell model, a term seen as synonymous with debriefing itself. A question worthy of further exploration would be the extent to which actual debriefings followed the process and guidelines established in this training, and whether, despite sending staff on training, the facilitators themselves had actually been trained. It appeared, from descriptions within the interviews, that some processes, named as debriefings, could more accurately be described as review meetings, and did not follow (for instance) the seven stage model with a focus upon personal and team integration of thoughts, feelings and event (Everly, 1999). This raises major

implications, both for practice and evaluation, for the perceived purpose and nature of debriefings.

Support, operational and clinical imperatives

The literature reviewed in Chapter Six stressed the need for a distinction between debriefing and operational reviews. The experience of the respondents with experience of a 'debriefing' suggests that this distinction was not made. In particular, environments already hypersensitively shaped by defensive practice as a result of inquiries (Chapters 3 & 6) were able to focus only on covering any operational deficits rather than supporting emotionally affected staff members. By mixing operational and affective elements, these participants suggested that the debriefing process failed, and potentially added to the level of distress that had originated from the initial incident. On an organisational level, this would appear to put the entire support process of debriefing at risk, as negative feedback about the process would undermine any level of trust and goodwill, and may exacerbate any tensions that already existed between levels of management and those in direct practice with consumers. In one case, the Clinical Director (the psychiatrist with legal responsibility under the Mental Health Act) conducted the debriefing, a role that clearly confuses the legal, operational and affective components of any meeting. In this study, however, none of the respondents voiced disillusionment with the concept of the organisation taking responsibility for supporting staff; rather, disappointment and critique was levelled at the process of individual meetings that they had experienced. Conviction that the organisation should share responsibility for recovery was universal.

Participants also added an element to the discussion that I had not detected within the literature. As well as making a distinction between support and operational issues, the mental health workers introduced the importance of a clinical dimension, reminding me that there is a third party in this debate, that of the welfare and well-being of the consumers for whom the services exist, and for whom the workers have often extensive professional training. It is clear from the narratives that the nature of many of the incidents was such that workers could be indirectly affected by events as well as being direct recipients of violence, threats, or the need for crisis intervention in situations of self-harm. In these situations in particular, the needs of workers in the hours and days immediately after an incident was not only to be able to discharge emotional reactions to the event, but to be able to examine the clinical issues surrounding the management of incidents that almost without exception had intimately affected the lives of consumers. This professional focus derives from the nature

of mental health work and is distinct from operational issues of attention to systems performance and individual and collective accountabilities. Clinical discussion was sought or expected by several participants who had experience of debriefing, the focus here being not on the welfare or performance of the workers, but on the needs of the individual or family concerned. This imperative reflects the interactive nature of mental health work, and in particular, the behavioural, social and cultural dimensions of the interactions, which were not always clear-cut but which involved elements of informed decision-making and judgement.

A clinical focus would therefore be outward looking: furthermore, those wanting to be involved in such a process as a best practice initiative looked at the potential for improvement and learning, at the possibility of debating the options for future practice, and as an opportunity for professional development. Instead, what they found was that a defensive organisational brief of accountability superseded the collective opportunity to be 'other' focused. Such a protective, closing down of expression became not only counter-productive in terms of attempts to work within a learning organisation, but effectively became another area of secondary stress that could undermine resilience in later incidents.

The learning from these experiences is profound. Out of the group of respondents, none of those whom I deemed to be the most severely affected by the incidents to which they had been exposed were involved in a group debriefing process. For these workers, largely those who were the direct recipients of incidents rather than those secondarily affected, support was offered either by a 'negative' process of time out, or by elements of demobilisation, defusing and individual support (or by organisational ignorance that the events had had major impact), processes which were largely helpful in the short term but which the institutional setting did not match with more thorough attention at a later point. (Elements of this argument are extended in the following section of this chapter.) For those workers with a debriefing service available within their wider organisation, issues of familiarity with and distance from the source of this support balanced against the immediacy and the severity of need, and in most cases, staff needs were met here by informal processes of peer support, the existing ecologically embedded, therapeutic and relational skills of co-workers, rather than by calling in a formal debriefing process. In the cases where a debriefing was called, it manifested as a different process than was expected either by those trained in the 'Mitchell' model, or by those deeply involved in the cases in question. It became potentially punitive or recriminatory, and did not address

the psychological and emotional legacy of the incidents, or the collective learning and support for which debriefing is promoted.

Participant concern over the mix of support and clinical goals of debriefing appeared to overshadow the concerns about iatrogenic harm, which was one of the main focal points of the debriefing debate addressed in Chapter Six. Detailed research over the content of each debriefing may reveal the extent to which participants were encouraged to ventilate their emotional response to incidents. However, the scale of the concern that the workers voiced over the unsafe environment of the debriefing process leads me to tentatively conclude that significant levels of emotional ventilation may not have been forthcoming. In addition, it would appear that several of those workers who reported high levels of traumatisation had not had a formal process of debriefing offered to them.

One of the key debates within the development of guidelines concerning debriefing (Chapter 6) is that of whether such support processes should be mandatory or voluntary, with initiatives withdrawing mandatory provision linked to this concern over iatrogenic harm (Avery & Ørner, 1998). This does not, of course, suggest that there should not be any supportive intervention, but, as in the case of Lincolnshire, that the call for intervention should be made by managers. The concern that I have developed in relation to this strategy, informed by the narratives within this study, is that the relationships within line management in mental health services cannot always be perceived as open, positive and two-way, as evidenced by some of the narratives in Chapter Eight and Nine. Reliance on workers to signal a need for a debriefing or other supports for themselves, resentment at management's perceived hijacking of the purpose of a debriefing, and the existing relationships between different professional groupings and management levels, all suggest potential tensions here. The participants in this study appear to suggest that they see a management responsibility for ensuring that support is available. This is different from there being a management responsibility to *conduct* a debriefing, or even whether management should be the decision-maker in terms of judging when and what support processes should occur. In DHB structures in particular, a better model may be one that offers crisis support and follow-up services in the same way as existing supervision systems operate. This issue is addressed below.

The experiences related in Chapter Nine suggest a major crisis of confidence in terms of the definition, implementation and acceptability of debriefing. There is disparity between the conceptual definitions and the actualities of processes

that bear this name, and a significant lack of appreciation of the ingredients for successful negotiation of the time immediately after the occurrence of a critical incident. Such lack of clarity does little to contribute to the evaluation of critical incident support, and further adds weight to the development of an ecological framework of critical incident stress management and evaluation. The framework provided in Table Ten would, I argue, provide the ecological auditing necessary for comprehensive staff support at the time of an incident.

Supervision and critical incidents

A structured ecological approach suggests that supervision may provide a model of support upon which critical incident support can be partly based. I have argued elsewhere that there are some fundamental differences between the immediate trauma-focused needs of those in incidents, and those within an ongoing, developmental process of supervision (Adamson, 2000). As a primary response to an incident, supervision is inadequate. Supervisors may be unavailable or located off-site from an incident; they may not be professionally equipped or organisationally located to respond to a crisis, or may themselves be caught up with the emotional processing or casework requirements of a situation. The attention to longer-term development within supervision may be at odds with the immediate needs of an incident.

Nevertheless, the conceptual basis of supervision, centring on reflexive practice, dovetails in with critical incident support in several ways. Several participants suggested that supervision's blend of attention to personal support and accountable practice satisfied the reflection on clinical skills and strategies that was missing in the accounts of debriefing. One of supervision's core components is to assist in identifying and managing stress (ANZASW, 1998). By its focus on cognitive processing and the development of meaning, it may serve an important triage and follow-up function in the aftermath of an incident. By the supervisor's location within an agency, a link to systems and structures that facilitate recovery can be established. By the personal and professional relationship that may develop between supervisor and supervisee, a monitoring and support function can be utilised, whereby a supervisor can play a role in the early identification of traumatic impact, of coping strategies and stress-oriented behaviours. What emerges here is a strong argument for supervisors to be 'trauma-informed' and able to participate in a trauma and stress audit with those for whom they have responsibility. An educational role can serve to inform and normalise prior experience and its cognitive, emotional and social sequelae.

Similarly, external supervision can create opportunity for reflection and consideration of 'bigger picture' issues free from the constraints of organisational influence, but it reflects similar constraints on its application to critical incidents, as does the provision of off-site or external EAP services. External supervision may produce issues of accountability and variance with organisational goals.

Within a comprehensive work-based programme of support, supervision may therefore provide both a model and a function of follow-up after an incident. Without such a programme, supervision's opportunities may not be maximised, and its constraints may be magnified. Furthermore, as an established process of support, its prime function is often seen as having a focus on the development needs of frontline practitioners, and may overlook the support needs of managers and team leaders, an issue now discussed.

The needs of managers

All of the participants in these interviews had hands-on roles with consumers, and whilst some had supervisory responsibilities and took project management roles, only one was also a manager. In their initial painting of a picture of the mental health environment in which they worked, many highlighted the important and often fraught relationships that they and their colleagues had with their team leaders and middle managers. Comments ranged from frustration at their lack of availability, and anger at their seeming emphasis on outputs and defensive practice, to solid praise for those managers who made themselves available at times of stress. Within mental health, too, managers had a role in determining the initial response to critical incidents, for granting time out and away from direct practice, for accessing EAP or other supports, and in some cases for calling and conducting debriefing processes. Managers therefore took administrative, pastoral and clinical roles.

Such a multiplicity of roles and relationships illustrates the complex contexts in which incidents occur. Dependent upon the quality of pre-incident relationships, it is not surprising that the presence of management can either assist or exacerbate the recovery from incidents. Where trust existed, managers emerged as an important lynchpin to a worker accessing time off, receiving empathic belief in their own resilience, and in calling in necessary resources. Where their presence and past behaviour had created barriers to communication, these became more marked and rigid during the passage through an incident. Pre-incident environments may well determine the

efficacy of management involvement in such events. Line managers may well not be the right people to have direct involvement in critical incident support.

In addition, the needs of managers may be overlooked. Involved either directly or more often, on a secondary level in the management of an incident, managers may be expected to shoulder the responsibility of the practical aspects of the incident, and to weather the emotional impact without direct assistance. Whilst the question of support for managers was not directly elicited from participants because of their own location within organisations, the question remains an important one for future consideration. In some situations, the leadership role of a manager may be compromised by their own involvement in the impact of an incident. In the construction of a comprehensive critical incident management plan, support systems for all levels of the organisation are required. This discussion therefore suggests that the context of the work has important ramifications both for the acceptability of management involvement in critical incident support (Avery & Ørner, 1998), and in the support for managers themselves. A pre-event contextual audit that may highlight potential issues for management appears warranted.

The needs of small organisations

Several of the participants in this study worked in small agencies within community settings. They were commonly involved in the provision of support work, and were largely untrained in either a mental health profession or in critical incident support. As Chapter Three attested, the shift of focus from institution to community as the locus of care suggests that significant numbers of workers (and one might suggest, high incidences of potentially harmful incidents) may occur in this area. What was found within this research was a relatively high level of satisfaction concerning the degree of support received following critical incidents. As argued above, this may be due to the closer and more personal relationships between workers, supervisors and managers: in one agency, for example, all staff occupied two rooms and support in these conditions was essentially underpinned by personal relationship. It can also be hypothesised that the common identities shared through culture or religious affiliation may work towards positive advantage under situations of stress. It can also be speculated that small agencies, because of their lack of personnel resources, can become entrapping niches should relationships sour; however, this was not reported within this study.

However, in the matrix of factors contributing to the impact of events (for instance, Weisaeth and Eitinger, 1993), the incidents experienced in these

situations were not the most severe of those reported. In these eventualities, the capacity of the agency to contain and address the needs of workers may become stretched, either by the severity of an incident or by the numbers of workers initially overwhelmed by its impact. It is here that a meso and exo level analysis suggests the need for small agencies to form alliances of support. Their existing functional relationships, with a church board or iwi structure, may not provide the trauma-informed support necessary for the management of these events. In these situations, agencies can become potentially isolated, and the need for preparation and anticipation of events emerges as a major imperative.

The focus of the discussion now shifts from the management of the immediate environment of the incident, to that of the long term needs of those affected.

After the event: issues in follow-up and support

Within the ecological framework presented in Table Ten, the period following the immediate impact of the incident is conceived as the time when the longer term management of impact has the potential to occur. Discussion here first focuses on an ecological rationale for the inclusion of ongoing support and follow-up within any programme of staff support for critical incidents. It is acknowledged that as the importance of meaning, the activation of coping strategies and the utilisation of personal and environmental strengths emerge in importance in the processing of experience, so does the uniqueness of the recovery process emerge as a factor about which organisations need to become aware. The section concludes with a structural reminder that for many incidents within mental health, recovery processes will be determined by the policy and public profile of the events as much as by individual and organisational determination.

The ecological rationale for ongoing support

The central argument of this thesis has been the importance of an ecological approach to the management of critical incidents and traumatic events. The narratives of the participants attest to the complex relationship between their past, the incidents and the recovery process recognised within the workplace (Durie, 2001). At the forefront of this chronosystem influence is the clear message that the impact of critical incidents and traumatic events can endure significantly longer than many organisational support systems anticipate. Incidents play out their meaning over time. Furthermore, the lineal relationship of an incident to its impact can only be charted retrospectively in that it can be assumed that those traumatised by an event may have been have been exposed

to a severe stressor, whereas what appears to be a major incident may not lead to trauma. Context therefore has an implicit relationship with time.

Time appears to have a relationship with the event in two main ways, through the relationship of the incident to the future and the relationship between past and present.

The experiences of the participants, reinforcing the theoretical knowledge that sequential events can compound stress, highlighted further that the embedded nature of incidents within mental health does not allow a clear demarcation between one event and its sequelae. This has implication for the development of defensive or avoidant behaviour, and ongoing vulnerability and risk (Chapter 6). The narratives, in talking about the passage of time and its influence on recovery, suggest that recovery, as outlined by Herman (1992a), requires phases of safety, sense-making and reconnection. The implication here is that interventions provided within an organisational setting will need to be responsive to these different needs.

The immediate impact of an incident, for example, is less dependent upon the construction of meaning and far more focused upon emergency management and organisational and clinical requirements. As external perception of safety and stability are re-imposed, not only did some participants attest to the withdrawal of the environment as a significant player, there was the expectation that narrative can be applied as a recovery tool. The unpredictable effect of an incident, and the variable receptiveness of the environment, teach us that for some, the opportunity to develop a narrative will not be met. In an ecological understanding of phased recovery processes, we can see that there is not a lineal progression through time. Instead, as recall and meaning of events are buffeted by ongoing environmental contents and conditions, so the developmental process of recovery over time will oscillate between phases. The role of the environment over time thus changes from the initial imperative to provide safety, through to a requirement that it offer opportunity for reflection, integration, the development of meaning and the chance to develop new practice approaches and policy initiatives. Physiological and psychological impact transmutes into emergent properties of social interaction and organisational behaviour.

The second facet of the relationship with time is in the influence from the past. The implications of this have been located in the first part of the ecological framework of Table Ten. Our trauma knowledge, outlined in Chapter Five, suggests that significant sensitisation and generalisability can occur through

exposure to extreme stress, especially where the experience has been chronic rather than a single event (Terr, 1991). An individual's chronosystem can provide both resilience and vulnerability. Previously learned coping strategies, be they problem-solving or emotionally based, may be able to be replicated and used to cushion the impact of later events, so that prior exposure to critical incidents becomes part of an action-reflection process. Cognitive processes of reflection (for example, in supervision) and practice (for example in skills training) are examples of the means by which active recall of previous successes can be harnessed as resources for the future, and within the framework of Table Ten, there is scope for this principle to be applied to critical incident support. Support, adequately and timely provided, may be able to be internalised and called upon in similar future events (Bremner, 1995; van der Kolk, 1996b). Given the context of mental health, there is therefore an environmental responsibility to provide opportunities for integrating and developing adaptive coping.

Similarly, where previous events have been inadequately supported, where a person's recollection still has the power to overwhelm, and where their abilities (and that of the environment) cannot be harnessed, a new incident will not be met with maximised energy and resources, and the stress incurred may produce an undifferentiated but extreme stress reaction. The ability to grow from an experience comes with the resolution (on many levels) of the experience.

The narratives of the participants in this research strongly confirm this argument. The events they relate often had indistinct boundaries and points of closure. Clinical accountabilities and location within particular work environments continued the potential for the impact to persist and to develop contextual aspects not immediately associated with the original event. Issues of meaning were often delayed or constructed at a later date because of the ongoing barrage of information and new emotional demands. Many participants, whilst positive about the immediate support received post-incident, felt that they were abandoned to sort out the ongoing legacies of the events on an individual basis without the acknowledgement or institutional support that they wanted. The lingering and compounding contextual effects of an incident perpetuated the need for someone to remain in an advocacy or management role over a period of time, to maintain the integration of personal and professional recovery. If safety issues were not addressed, or if the individual was left to sort organisational resource issues alone, without tangible support or feedback, a sense of lack of safety was perpetuated.

This sense of needing someone other than those affected to have an overview of what was needed was manifest in several narratives, the most successful management of the ongoing impact of events exemplified by a small support agency setting where the manager was able to have hands-on association with those affected, and who was able to provide empathetic and resourced opportunities for recovery. Within larger organisations, where several tiers of management existed, the picture becomes more complicated, with support sought from a variety of sources.

The focus of this research was on the experience of participants after critical incidents, and less upon the perceptions of others about what they needed. It is harder, therefore, to extract an understanding of the degree to which the mental health environments were able to provide effective monitoring of the effects of incidents on those to whom I talked. Their own testimonies suggest that several participants felt as if their clinical performance, for example, was compromised and undermined by organisational ignorance or unawareness of their needs. Withdrawal from effective clinical engagement and defensive practice may have resulted from incidents, and this is of concern both on personal and operational and clinical levels. An absence of positive monitoring and support processes and a reliance on the healing power of the individual may create further situations of uncertainty and risk.

Similarly, fundamental opportunities for sense making emerge out of the nature of the incidents in which workers found themselves. Not all incidents happened to individual workers working alone. Shared experience suggests levels of sense-making and processing of experience that can occur on a relational basis, supplementing the initial bonding that may have occurred between joint participants with organisational endorsement of their shared experience. In the narratives within this research, these opportunities were largely lost, collective meaning-making (which as Chapter Five suggests is an important component of recovery) being limited to the formal debriefing process that emerges in the previous discussions as fundamentally flawed and potentially re-traumatising.

A fundamental conclusion arising from this discussion is that organisations have an opportunity to implement ongoing and embedded critical incident response once an initial alert has sounded, and to provide monitoring and support beyond the immediate de-escalation and incident management. This opportunity is substantially ignored in the experience of the participants in this research, and is put into sharp relief when the implications of reviews, inquiries and media investigations are taken into account.

The legacy of Dr Skae: reviews, inquiries and the media

The management of inquiries and reviews emerged as a major issue for several participants within this study. Mental health work is located at the cusp of private and public worlds, its events scrutinised by consumers, families, neighbourhoods, unions, funders, the Ministries of Health and Justice, and by the media (Chapter Three). Awareness that interaction with consumers with whom they work may at any moment precipitate their own safety and that of others, their clinical practice and their job security into public prominence emerged as real issues within the narratives. The ongoing nature of commitment and case involvement in mental health was highlighted in several narratives, workers suggesting that the embedded nature of inquiries, coroner's inquests and family involvement changed the nature of the initial impact of events, attenuated the recovery period, and fundamentally altered the nature of the stressors. I did not detect within the narratives a sense of collective support and monitoring of stress levels over the time that these inquiries took, yet the organisational responsibility suggested by the ecological framework of Table Ten argues strongly that like the initial incidents themselves, these events require specific attention and management. These pressures fundamentally slowed recovery and in some cases, exacerbated and altered the stressors to the point that it was the defensive practice or the management processes that became the issue with which workers grappled. In Chapter Three, the death of Dr Skae in 1881 was described as one of the first casualties of occupational stress within mental health. It appears that there remains a significant level of learning to be achieved about the longer term pressures that a system may endure as a result of a critical incident. The instigation of any formal or public process following a critical incident or traumatic event should be sufficient to signal an alert for the ongoing support of those affected.

The emergent principles for staff support thus span the preparation for adverse events, their immediate management, and the often lengthy post-incident period of follow-up and support in the complex environment of mental health service delivery. The following summary provides an exploration of the validity of an ecological framework for critical incidents and traumatic events.

An ecological framework for staff support systems in mental health

During the course of this thesis, a strong argument has been made for the implementation of an ecological perspective in regard to the preparation for and management of critical incidents and traumatic events in the workplace. In this concluding section, the integrity of the ecological approach is first

addressed, through acknowledgement of the ecological tools employed within the thesis to carry the central research questions. Imperatives arising from the principles articulated in Table Ten are then presented, as indications of possible organisational developments that will honour the ecological foundation of strong staff support systems.

The integrity of the ecological approach

The ecological perspective in this thesis satisfies both intellectual rigor and the practicalities of spanning knowledge generated by a variety of paradigm traditions. Key to the use of this perspective is the notion of autopoiesis, and the four central elements of structure, identity, relationship and change that derive from this. It is these dimensions that have suggested the imperatives of the thesis inquiry and which have provided an ethical checklist for both the manipulation of the available knowledge and the subsequent construction of principles for staff support systems.

To this end, three holistic frameworks in particular were utilised. Chapter Two introduced and outlined the ecological perspective as defined initially by Bronfenbrenner (1977; 1979) and subsequently developed and articulated in a range of psychosocial fields of practice. As a model of Western origin, it has contributed a language of description to this research that is utilised within the final elements of discussion in this chapter, and within the summative Table Ten. In particular, its close affinity to systems perspectives symbolises the intellectual location of this inquiry, considering as it does the issues of activity within and between the various systems that comprise the mental health workplace. The ecological perspective, diagrammatically portrayed in Table 2.1, also extends the use of the approach beyond purely a systemic analysis, to one that by representing the relationship between structure, systems and change, addresses knowledge that originates from positivist, systemic and constructivist perspectives.

Portrayed within Table 2.2 is the importance of the chronosystem in depicting changes in relationship and emphasis over time. Acknowledged as a factor within Chapter Five, the temporal location of incidents and response is considered as a factor within the development of principles for practice subsequently considered in this chapter. Given the heightened importance of prevention that emerges within a salutogenic approach to the management of incidents, the dimension of time is here described in terms of both prevention and postvention, using notions of 'pre-', 'peri-' and 'post-' as means of

describing attention to preparation, management of the incidents themselves, and their follow-up.

Chapter Five was structured around a Pakeha application of *Te Whare Tapa Wha* (Durie, 1994). The choice of this model was suggested by the need to organise the impact of trauma and extreme stress in a manner that not only honoured the positivist knowledge of the impact on the individual's body, mind and spirit, but also addressed the fundamental holistic imperative resulting from a person's embedded location within contexts. *Te Whare Tapa Wha* allows the focus to fall on body, mind, relationship and identity in, I feel, a more specific manner than does the ontological level of the ecological perspective in Table 2.1. The addition of the notion of *whenua*, not so much omitted as underpinning *Te Whare Tapa Wha*, provided scope for the necessary incorporation of structure and human rights.

The utilisation of Tangata Whenua concepts within a Tauiwi framework is not, of course, without its tensions. Understanding of its components and the full integrity of its holistic unity can only be demonstrated by the robustness of the arguments that utilise it as a framework. The use of Maori concepts within a discussion based in Western epistemology can potentially be colonising. This issue resonates with the methodological debate in regard to the inclusion of Maori participants and Maori agencies in Chapter Seven. The rationale for the stand taken - the inclusion of Maori concepts and of Maori participants within the study, but the exclusion of explicitly Maori frames of reference and Maori organisations - is provided by my experience and location within Aotearoa New Zealand and an academic and practice imperative to negotiate these relationships.

The third ecological approach utilised within Chapter Nine is Herman's model of trauma recovery (1992). Its particular strength, and the reason for its application here, is its use of the concept of time. Rather than a lineal progression through its three stages, as might be suggested by a cursory textual reading, it is best envisaged as a spiral, an individual (or team, family or community) process of recovery that needs to re-visit issues of safety, integration and reconnection at different points along the journey. Thus the passage of time - the autopoietical notion of change - is intimately related to the concepts of structure and identity that define the context in which recovery occurs. Each stage of recovery, it can be argued, will place a different emphasis on knowledge located within ecological levels.

The use of an ecological perspective allows for the viewing of knowledge from different traditions, and the interpretation and application of this knowledge in the light of the relationship with other pieces of knowledge. Out of this theoretical and practical triangulation emerged a set of key issues in relation to critical incidents and traumatic events, examination of which has formed the discussion within this chapter, as synthesised within Table Ten. These relational, ecological concepts provide a foundation for the development of safe and sound staff support systems, their use and their evaluation. In a nutshell, I am arguing that these should be embedded within existing systems and structures; responsive to the identity and variations in function of the various components of the mental health system; visible, accessible and acceptable for use by a variety of staff and disciplines; and able to track both individual and collective need over time.

An ecological approach determines that all facets of support be presented and available to staff as an integrated system. The viability of the concept of critical incident stress management is now considered.

The shape of critical incident stress management

In Chapter Six, the notion of critical incident stress management, or CISM, was introduced, as an umbrella term to describe a system of organisationally based staff support systems that spanned proactive and preventative processes, interventions around the time of an incident itself, and follow-up processes that cater for developments of impact overtime. In a generic and conceptual form, removed from the specifics of the 'Mitchell model', it appears to address many of the key emergent issues cited by the participants in this study and in the literature review. Importantly, it may require adaptation to dovetail with the characteristics of the mental health environment.

My reading of the debriefing debate suggests that the arguments surrounding the effectiveness of debriefing, the claims and counter-claims in regard to trauma-prevention and mitigation of PTSD symptoms, have served to mask any consideration of context in the design and testing of viable support systems, disabling any potential for a growth in environmental responsibility. Debriefing's relative youth as a tool for psychological assistance in conditions of extreme stress, and the location of the evaluation base within positivist traditions, has contributed to a blinkered approach to the establishment of support systems. The participants in this study did not use 'CISM' or similar terms with the frequency with which they referred to 'debriefing'. Whilst able to describe degrees of pre-incident awareness and training (none of which had

developed to a sophisticated extent), there appeared to be little organisational perception of an overall package of staff support, into which a worker could connect at any point of their journey of incident and recovery. Within this thesis it has been possible to identify some of the key features that would bind a series of initiatives and processes into such a recognisable whole, which was then able to be recognised as truly greater than the sum of its parts.

First of these is the preparedness for incidents that comes from having a salutogenic approach to wellbeing with an organisation. This places the emphasis on preparation, anticipation and proactivity, utilising the opportunities to develop worker strength through knowledge gained from exposure to education and training, and other stress inoculation processes. Such anticipation and preparation will be required to operate on both individual and collective levels, in order to be able to respond to variation in training and pre-recruitment awareness amongst mental health workers. It is indeed possible to track the pathways into mental health taken by each worker and to then assess what information and preparation is required at particular points. The notion of an audit is explored in the following section. Initial strategies that alert and strengthen individual resilience will serve to platform the other initiatives specific to the occurrence of an incident.

The package of initiatives described within CISM that concern the immediate response to an incident takes the form of individual crisis support, demobilisation, defusing and debriefing. Describing as they do the event-determined response that enables an immediate de-escalation of harm, safety to be re-established and some immediate form of ventilation and support to be achieved, the experiences of the participants in this study suggest that the mental health environment, whilst not perfect, does have structures and systems in place to deal with the contingencies of the immediate peri-incident situation. A level of crisis awareness, for example, was reported, although at times let down by structural and systemic failings. In a sense, this is unsurprising, as the contingencies of many incidents will have immediate needs and imperatives to which those in immediate proximity have clarity in responding, and the mental health field itself is one with clinical familiarity with notions of crisis.

The stage at which participants began to feel let down by their organisation was at the point when Mitchell and Everly would suggest that a debriefing process might kick in, where the system may have already responded to the immediate needs of safety and of personal, collegial and consumer wellbeing. Debriefing requires active arranging, an assumption of organisational

responsibility. Debriefing, in the 'Mitchell' model, becomes an opportunity for a structured discussion, a sense-making review, and it is perhaps its very structured nature that has attracted the problems described in this thesis.

As a structured intervention and perhaps the first recognisable and organised initiative taken by the employer (other processes of demobilisation and defusing may have been informal, or conducted by outside agencies such as the police or security guards), a lot of responsibility rests on debriefing to be all things to all people. Those participants who experienced a workplace debriefing found that it mixed operational and clinical concerns, within environments loaded with potential recrimination and fault-finding. Expectation of the workers, too, diverged from each other, some requiring a focus on ventilation of grief and anger, whilst others also wanted an outward focus on clinical performance, review and planning.

In one way, there has been a forced focus on debriefing through an under-emphasis on proactive processes such as signalled above, reflective of a lack of environmental commitment and articulation of support. The promotion of debriefing as a structured intervention, and in some cases, its wholesale adoption as a solution to legislative requirements of health and safety, has been at the cost of the development of other approaches that might precede it. The inability of any one form of intervention (and a single event at that) to address the complex impact of traumatic events and critical incidents has perhaps proved damaging to the credibility of the debriefing concept and to the development of comprehensive workplace support.

The concern expressed by the evaluations considered in Chapter Six also addressed the difficulty of determining the effectiveness of psychological debriefing in the mitigation of trauma symptoms. Within the thread of this argument, it is thus possible to suggest that attention to prior processes, both before and around the incidents in question, may well have provided the preventive approach and triage possibilities so that those clearly identified as experiencing acute symptoms of traumatic stress would not be exposed to the cognitive-emotional processes of debriefing and the possible iatrogenic risk of retraumatisation.

The participants in this study teach us, too, about the shape of a psychological debriefing process. The incidents that they describe, and the variation in work roles (so that many would experience the direct impact of an incident on their own) teach us that a group process may not suit all situations. The degree of emotional proximity to the event - in particular, the level of control or

helplessness experienced - may determine the extent to which the component of emotional ventilation, embedded in CISD, is necessary or wise. The level of commitment to consumer welfare and clinical best practice, too, introduces new dynamics into the perception of a debriefing process by many of the mental health workers. I would suggest that the establishment of a more thorough preparation of a systemically embedded system of support, beginning with education and training and alertness within selection and orientation, would enable greater clarity in regard to how formal processes such as debriefing may be constructed. In particular, the greater use of trauma-informed defusing is encouraged.

One of the most significant disparities between the testimonies of the participants and the structure of a critical incident stress management programme is the degree to which follow-up and longer term support was not experienced by those in the study. The isolating effect of extreme stress (the splitting described in Chapter Five) appeared to be compounded at an organisational level by an apparent lack of attention to the recovery process over time. Reverberations of impact endured far longer than others appeared aware. I suggest that the most scrupulous intervention and support around the time of an incident can be undermined by an individual being made to feel that they are left to recover on their own. The impact of trauma and of acute stress may play out over months and years, and as Chapter Five attests, the behavioural and social adjustments and anxious accommodations may become professionally dangerous or compromising to worker and consumer wellbeing. This personal process needs to be matched organisationally. In particular, where characteristics of the event metamorphose into ongoing case management responsibilities, and where inquiries, inquests, intense family involvement or media scrutiny occur, organisational alerts and supports should be implemented.

The embedded needs of workers in mental health therefore require a structural location and a systemic operation that signifies agency and employer consent. I see the establishment of this sort of monitoring and support as the next logical step after the paradigm shift represented by the Health and Safety in Employment Amendment Act (2002), in which cumulative stress and the concept of the high risk environment was established. The shared responsibility for wellbeing between employer and employee, combined with the ethical and moral obligations of education providers, suggests the possibilities for the design of comprehensive staff support packages. Models of embedded support are already in existence. I have cited the example of supervision within the social work profession, a model that suggests that some form of support has

historically gained traction and acceptability within organisational and professional functioning. Assumption of responsibility by an organisation for critical incident support satisfies the participants' call for someone to have overall control of the process. One suggested model of support could be that of the practice manager within the Department of Child, Youth and Family, a developed role which spans clinical and management responsibilities. A system of alerts, informed by a knowledge base of stress and trauma, can activate a set of responses at various phases in the life of an incident, in a manner similar to the Sentinel Events system described in Chapter Six. Whatever model that evolves, the creation of which will need to be sensitive to the range of service delivery options within mental health, the knowledge base that it will require is that of the ecological impact of trauma and extreme stress.

Conclusion

The ecological framework for staff support systems has drawn together both the findings from the literature and the salient themes from the participant data. The creation of an ecological perspective, with its principles of structure, relationship, identity and change, provides the impetus for a re-dressing of balance, from the inherited biomedical approaches that isolate an incident from its context, towards a balanced approach that recognises the intrinsic logic of establishing firm foundations upon which to build interventions and support. The integrity of an ecological approach to critical incidents has been demonstrated.

Chapter Eleven: Conclusion

The introduction to this thesis expressed the personal and political conviction that organisations should share in the responsibility for the impact of the experience on those employed within mental health settings. The conviction is about human rights, both for those who elect to work within the area through a passionate commitment to the wellbeing of others, and for those who by virtue of their own personal journeys become identified as consumers. It is about the notion of *whenua*, of having a place to stand that both identifies and protects.

To this end, an ecological perspective that honours a holistic process of belonging, relationship and function over time has been promoted, with ecological frameworks presented upon which to locate the transtheoretical knowledge explored within this research.

Central to the argument has been the process of revealing the discrepancies within debates over the nature and evaluation of existing models of staff support (Chapter 6). In the last weeks of writing this thesis, an article in the British Medical Journal caught my attention, reminding me yet again of the importance of the arguments explored in this study. Mayor (2005) reported that the guideline for PTSD, published by the British National Institute for Clinical Excellence (NICE), had concluded that:

> After reviewing all the available evidence, including unpublished data from drug trials, the group that developed the guideline took the unusual step of recommending against a common practice used to treat the disorder. They advised that people who experience a traumatic event should not be given brief, single-session interventions, often termed debriefing.
>
> Mayor (2005)

The NICE guidelines, of course, reflect, in part, the thesis conclusions; brief, single-session interventions should, indeed, be viewed with caution, and in many cases, the evidence suggests that such interventions should not be used at all, or with considerable caution in regard to content. My initial reaction, however, was 'duh, they still haven't got it, have they?' Debriefing has been misconstrued and misrepresented as the appropriate (and in many cases, the only) workplace-based staff support system for use in the context of critical

incidents. The disproportionate focus upon debriefing as the solution to critical incidents and traumatic events has misled and perhaps delayed the construction of comprehensive support systems. Its definition and status has been distorted by the debates and tensions in which it has become caught up, much of which are not of its own making but which lie in the cultural and social evolution of ideas.

This thesis is, of course, not about debriefing. Instead, its arguments have concerned the way that our knowledge of extreme stress and trauma has been constructed within existing paradigm traditions, the medically and psychologically dominated domains of mental health and classification systems, and the resulting focus upon reductionist determination of both cause and response. Set against this discussion are the voices of the participants in this research, who shared their experiences of what worked for them and what did not, and whose testimonies have endorsed the ecological theory that underpins my own arguments. Chapters Two and Four, in particular, laid out the process and the effect of using particular lenses in a study of human distress, arguing that a knowledge tradition that focuses upon discrete events and phenomena, on the figure not the ground, underplays and undervalues attention to the dynamic contextual relationships that result from the interaction between the person and the environment. The complexity of the mental health service delivery environment, described in Chapter Three, determined much of the shape of, and passage through, the events that the participants so clearly described and analysed within Chapters Eight and Nine. Their words teach us that we ignore the contextual influences and determinants at our peril.

The use of an ecological perspective, manifested within this thesis through the use of several frameworks and models, has been demonstrated as a relevant and useful tool in the assessment of the complex dynamic between structure, relationship, identity and change prior to, during and after the occurrence of a critical incident. For the participants and the focus groups in this study, the identity and location of the workplace and those who, as consumers, families or workers are bound together in relationship and situations that change over time, are key factors in determining the quality of a critical incident experience. The case study of debriefing, a debate that clearly by Mayor's comments is still raging, illustrates that an understanding of the impact of experience and the construction of appropriate responses is part of a far wider paradigm shift in the Western world's understanding of humanity. An ecological perspective, in the definition provided within this thesis, offers a far more comprehensive and

inclusive means of understanding, of constructing response, and of measuring what worked and what did not.

In our bi-cultural, and increasingly multi-cultural society in Aotearoa New Zealand, at a point where mental health services and professional training are at long last beginning to reflect a truer picture of the worldviews that exist in this part of the Pacific, it is imperative that responses to trauma, extreme stress, crisis and human misery are addressed through a contemporary understanding that attempts to include, rather than redefine, its dimensions. The incorporation of *Te Whare Tapa Wha* in Chapter Five attests to the potential for cultural synergies. Anything else (the imposition of a template of response, for instance) runs the risk of further perpetuating the dynamics of colonisation that, as suggested in Chapter Five, may in fact have eroded structural and systemic resilience.

A fundamental thread of this thesis argument has therefore been to suggest that responses to the occurrence of critical incidents, and the best practice means of evaluating effectiveness of staff support systems, both lie in a contextually-embedded understanding of the interrelationships between person, time and space, represented within this thesis by the construction of the table in Chapter Ten, within which both staff support systems and their evaluation need to be lodged. The implications for this, and recommendations for future research and practice, are now considered.

Reviewing the process, recommending the future

In concluding the thesis argument, it is an appropriate process of action-reflection to consider both the journey taken, and the direction towards which similar endeavours should proceed.

On a personal note, the thesis journey has been fun. There is a lot of 'me' bound up in its construction, in the style of writing, in the worldviews and in the manner in which the arguments from differing perspectives, and the views of the participants, are bound together into a cohesive flow. Its wider integrity can only be determined by opening the chapters to the scrutiny of others. If nothing else, I hope for constructive criticism and debate. The qualitative opportunities of the inquiry provided the correct and inclusive approach by which to explore the fundamentally transtheoretical and applied nature of the discussions, to establish meaning and to promote interpretation of experience. It has personally enabled me to grow in knowledge and intellectual maturity as a result of the dynamic dialogue that has occurred between what are often constructed as discrete sets of knowledge. A major triumph as been that the

challenge of exploring the experience of extreme stress and trauma has not in itself been traumatic.

The experience has taught me, inevitably, that next time round I would do things slightly differently. Aside from 'thesis envy' of full-time researchers who may have got through the process in half the time, there remain several untapped perspectives that signal opportunity for future inquiries. There is an infinite variety of evolving settings within mental health that offer further scope for critical incident research. My own background in forensic social work, for instance, makes me curious about the experiences of those in secure settings, to whom, despite hurdling the appropriate gate-keeping, I did not get to talk. My strong suspicion is that the nature of the institution, of the consumer need and of the management structures in these environments would contribute a different set of dynamics to my discussion. I would have liked the profession of psychology to have been represented amongst the interviewees. This is especially pertinent because so much of the knowledge base surrounding trauma, stress, debriefing and its evaluation emanates from psychology. The issues and experience of those in the vertical, managerial positions offers opportunity for further exploration. Too often, in a service delivery system deeply entrenched in a re-creation of old class and privilege debates, it is assumed that those with perceived power and relative status have also to practice the old school stiff upper lip. An understanding of endemic stress and secondary traumatisation allows us to consider the needs of all parts of a system, and the attention of future research could worthily fall upon the needs of management systems.

On a level of culture, too, whilst I am comfortable with the navigation through the ethical issues of cross-cultural research practice, I know I only began to touch upon the experience of critical incidents as experienced through the hearts and minds of those who belong to another culture. This was brought home to me in a teaching session that I conducted with health social workers concerning critical incident support, during the early stages of the analysis of data. A Pacific Island social worker, whilst appearing to endorse the ecological perspective out of which I was teaching, introduced their own notion of a critical incident. Despite working in a fraught community setting, they commented that it was an assault upon their cultural traditions, their *mana*, which would signal the need for a form of collective debriefing. Like the Maori mental health worker in the thesis research, they felt that their culture provided much of the sustenance needed to weather many of the consumer-related incidents that occurred, but that it was the threats to cultural identity and process that threatened a fundamental security. This is a challenge that I need

to throw out to other researchers, so that a dynamic exchange across cultural traditions can continue.

Future research could conceivably utilise focus groups in additional ways. As I have indicated earlier, I fought shy of having a focus group of those workers who had identified as having experienced critical incidents and traumatic events. Whether or not my initial fears of potential retraumatisation would have been justified, I do not know, but I believe it is worth negotiating these risks as a mental health focus group could have served as a forum for change (Race et al, 1994). The richest quality of feedback, I learnt, was from peers in the field, with a contextual awareness both of the trauma and stress knowledge base, and of the mental health environment. Another potential avenue for a focus group would be to construct one along the lines of a table-top exercise such as advocated below. I have confidence that workers in the field have the ability to articulate and design the shape of critical incident support systems that best describe their own environment. Perhaps this is the next step in the design of appropriately geared programmes of support and evaluation.

As a corollary to this argument about the potential for retraumatisation, I would urge ethics committees to pay more attention to this process. Neither the university committee nor the various organisational processes of gatekeeping paid these risks much attention at all, which as a practitioner-researcher, I believe would be an essential safeguard for individual participants, for focus groups and for researchers themselves.

Where to from here? I engaged in this thesis because I believe that the subject matter is crucial to the maintenance of healthy workplaces and the best possible care for those living with mental health issues. As a mental health worker, these issues need to be taken out of a thesis and into the environments that are best suited to make sense of the arguments. As an educator, I see that there is a responsibility both on me personally, and systemically through the opportunities in my employment, to engage in the preparation of teaching, design of support systems and programmes, and in the further development of meaningful and sensitive evaluation methods. In particular, the trauma auditing of existing educational programmes and their re-design in the light of the stated needs of the participants in this study, is a logical and attainable step, and one that is explored below. In the diverse and sometimes fractured environment of mental health provision in this country, this engagement needs to be taken to all levels, from the small agencies in small towns, to the corridors of the Ministry of Health where issues of staff recruitment and retention are considered. National attention to the impact of both job content and job context,

in the same manner as sentinel events are recorded where consumers themselves are affected, appears to be a necessity, in order to highlight the relationship between the experience of critical incidents and traumatic events and the retention of staff.

In terms of subject matter for research, the investigation of the role of job context on the outcome of incidents and the acceptability of support appears warranted. Just as my own attention has slowly shifted from an exclusive focus upon incident support in the days of my own practice, to an environmentally-embedded appreciation of the need for a *programme* that both supports and monitors staff resilience, so has my awareness that it is often the fundamental characteristics and processes within the workplace that determine outcome. This emphasis on job context as opposed to content is a message that needs to be taken back to the organisations themselves.

The quality of mental health service delivery is an activity fronted by, dependent upon and inspired by, the people involved in it. The recognition that this is indeed an environment of risk is but a first step in ensuring that it grows in its ability to care for both consumers and staff. This thesis argues that an ecological review of what has worked for those affected by critical incidents, informed by an holistic reading of the research literature, presents the optimum knowledge base from which to design a full support system for mental health workers, the responsibility for which lies in active partnership with all components of the field.

Development of a trauma-informed audit

The establishment of a model to monitor and support staff through the passage of a critical incident necessitates the incorporation of a body of knowledge into all ecological levels: education, recruitment, orientation and induction, into the ongoing processes of support such as supervision, and into the incident-specific programmes that may be called in-service training, demobilisation, defusing, debriefing and so on.

The voices of the participants were clear that more could have been done to prepare them for the nature of mental health work and the likelihood that they would be exposed to harmful and potentially traumatic events. This preparation (often termed stress inoculation within the critical incident literature) starts at first training, at the ontological and micro level, and extending into the contextual dimensions at meso and exo level. From a health promotion perspective, this preparation need not exclusively focus upon (for example) trauma symptoms, but should also serve to highlight awareness of

coping strategies, the connections between personal histories and current stressors, and should move (as the individual themselves moves) into awareness and comprehension of the organisational environment, the nature of the work and the supports available. This awareness of stress and trauma characteristics can be heightened through the use of an audit mechanism that can be employed within existing processes of supervision and inservice training. A model of this, previously constructed for supervisors within District Health Board settings, is attached in Appendix Eleven. Similarly, any constructed, positive intervention such as a defusing or debriefing can have its content audited for its attention to stress and trauma, and its honouring of macro level issues of culture, gender and belief.

Honouring the shared responsibility for the support of staff, an additional mechanism of trauma and stress auditing and preparation can be designed for organisational-level planning. The concept of the *table-top exercise* is probably more familiar to emergency services and the military, but can extend its use into any environment in which incidents may occur. The worth of a table-top exercise was brought home to me whilst listening to the co-ordinator of the critical incident response team during the Port Arthur shootings in Tasmania (Richman, 1997). Richman attributed the success of the operational and support coordination at the remote site to a previous exercise in which a similar incident (albeit a bus crash rather than a shooting) had produced similar logistical and psychological demands.

Simply put, by conducting an exercise around the 'what ifs' of a likely scenario, and applying a stress and trauma audit to the analysis, systemic and structural issues of resourcing, systems preparedness and skills can be explored. Natural and informal sources of support, and potential strengths and weaknesses of current service provision, can be identified, assessing the configurations required for support in small agencies, large multi-site organisations, or within multi-disciplinary teams. Support for those immediately affected, and for those touched by secondary traumatisation and operational responsibilities of management, for example, can be explored here. Into these discussions comes the opportunity for the psycho-education described by Everly (1999) as a component of CISM, and an opportunity to begin to define the somewhat blurred distinction between trauma and stress that so marks the debriefing debate.

In these two interlocked ways, the concepts of trauma audits and table top exercises illustrate the potential for the development of a learning organisation focused upon the needs of the staff when faced with critical incidents and

traumatic events. Other creative mechanisms can be devised that will serve the same purpose of shifting the focus of intervention from the individual to the environment, and from the event to the journey of recovery. A key piece of future research could focus upon the abilities of existing debriefing processes to address psychological and social needs following an incident. To this end, some resolution to the shape of evaluation needs to be reached, an issue addressed in the following section.

The shape of evaluation

The shape of an embedded programme of critical incident support, outlined above, suggests that from an ecological basis, several different and diversely targeted processes are required that span anticipatory as well as reactive responses to incidents. The case study of the debriefing debate in Chapter Six suggested that significant shortfalls exist in the application of an evidence based approach to evaluation. Whilst attention is required to fall upon the specific needs of those with identifiable posttraumatic symptoms, a major omission has been the avoidance of issues of complexity and the development of tools appropriate to holistically-conceived programmes. The narratives of the participants in this research lead clearly towards a conclusion that the contextual characteristics of their training, personal, cultural and professional backgrounds, work locations and roles, the bigger picture issues of organisational functioning and the socio-political status of work within mental health, all contribute both to the experience of critical incidents and to the processes of recovery, and must therefore become significant factors in the evaluation of any support system.

An evaluation tool will only receive answers about the questions it asks. The use of a lens to scrutinise the psychological impact and treatment of a single intervention will result in data that is devoid of contextual and temporal considerations, and which whilst containing the kernels of some good analysis (the potential for retraumatisation by emotional arousal being a major example), its lack of a broad focus (and indeed, the absence of a broad programme in the first place) is likely to skew the overall relevance and effectiveness of any evaluation.

Holistic models of evaluation are in existence and have been well-received in presentations within mental health (Chapter 6). The major principles emerging from this study and from the narratives of the participants suggest that there is considerable merit in the development of evaluation measures that are compatible with the shape of ecologically-based support programmes.

Commensurate with the theoretical argument of this thesis, holistic evaluation tools provide opportunity for a variety of traditions of evaluation to emerge from their corners and engage in some meaningful dialogue. Quantitative measures of psychological wellbeing and posttraumatic symptomatology can co-exist with user feedback such as survey tools assessing a graduate's familiarity with signs and symptoms of stress and trauma, for instance, or qualitative feedback regarding subjective coping after receiving follow-up support. Frameworks for evaluation can be suggested by some of the models utilised within this thesis, such as *Te Whare Tapa Wha*, the ecological perspective, and the principles suggested by comprehension of processes of health delivery (the attention to pre-, peri- and post-incident initiatives) and trauma recovery (Herman, 1992a).

There is a major issue of power and control to be addressed in this debate. A reading of the literature about stress and trauma reveals that the major professional and academic researchers and practitioners in the field are psychiatrist and psychologists. Much of the educational input within Aotearoa New Zealand has originated from those with this background. Similarly, critiques of debriefing emanate almost exclusively from these fields. In some jurisdictions in which CISD or psychological debriefing is implemented, policy decisions limiting its facilitation to psychology have been made. The theoretical argument of this thesis has been that the paradigm shifts in which current Western thinking is engaged are of fundamental importance to both the evaluation and construction of effective staff support systems for critical incident and traumatic events. Embracing complexity, an action that underpins and is argued by this research, is both an intellectual and acutely pragmatic endeavour, and one that is as much about socio-political agendas and human rights as it is about stress reactions and psychological wellbeing. The challenge is for practitioners and policy makers to incorporate notions of complexity into their strategic and operational planning, in a manner that the ecological framework in Table Ten suggests provides attention to both personal and political dimensions of wellbeing.

Mental health workplaces can provide inspirational opportunities for personal healing, and often act as the cauldron in which core processes of social change are forged: it is my profound hope that the lives of both mental health workers and consumers can be affirmed and strengthened through this exploration of the experience of the complexities of critical incidents and traumatic events.

Bibliography

Abergavenny, R.D. (2000). Psychiatric patients enjoy better life in community. *British Medical Journal*, 320(6 May), 1228.

ACISA (2000). The 1999 ACISA Glenelg Declaration: Guidelines for good practice for emergency responder groups in relation to early intervention after trauma and critical incidents. *ACISA Forum*, 4(4), 7-12.

Adamson, C.E. (1982). *Absconding from Care*, MA Thesis, Department of Social Administration and Social Work, University of Nottingham, Nottingham.

Adamson, C.E. (2000). The role of supervision in the management of critical incidents and traumatic events. *From Rhetoric to Reality*, (conference proceedings), Centre for Social Work, Auckland College of Education, 7-8 July, 2000, pp33-44.

Adamson, C.E. (2005). An Ecological Understanding of Trauma Practice. In *Social Work Theories in Action*, M.Nash, Munford, R. & O'Donoghue, K. (Eds). London: Jessica Kingsley.

Adamson, C.E., Ruwhiu, L.A. & Walsh-Tapiata, W. (2003). The Trauma Paradigm and the generational impact of colonisation. *European Psychotherapy*, 4(Special Edition), 283.

Addis, N.M. (2002). *Attrition in the New Zealand Police*. Unpublished MA, Massey University, Palmerston North.

Adjukovic, D. & Adjukovic, M. (2003). Social contexts of traumatization and healing, *European Psychotherapy*, Special Edition, 2003.

Agger, L. & Jenson, S.B. (1990). Testimony as ritual and evidence in psychotherapy for political refugees. *Journal of Traumatic Stress*, 3(1), 115-130.

Agnew, R., Dawson, M. & Elliott, C. (1998). Dealing with the Aftermath: why debriefing is critical. *Social Work Now: the Practice Journal of The Children, Young Persons and Their Families Service*, 10(August), 6-11.

Al-Issa, I. (Ed.). (1995). *Handbook of Culture and Mental Illness: An International Perspective*. Madison, Connecticut: International Universities Press.

Alexander, D. & Wells, A. (1991). Reactions of police officers to body handling after a major disaster: a before and after comparison. *British Journal of Psychiatry*, 159, 547-555.

Allcorn, S., Baum, H.S., Diamond, M.A. & Stein, H.F. (1996). *The Human Cost of a Management Failure: Organisational Downsizing at General Hospital.* Westport, Connecticut: Quorum Books.

American Psychiatric Association (APA) (1952). *Diagnostic and Statistical Manual of Mental Disorders.* (1st edition). Washington DC.: American Psychiatric Association.

American Psychiatric Association (APA) (1968). *Diagnostic and Statistical Manual of Mental Disorders.* (2nd edition). Washington DC.: American Psychiatric Association.

American Psychiatric Association (APA) (1980). *Diagnostic and Statistical Manual of Mental Disorders.* (3rd edition). Washington DC.: American Psychiatric Association.

American Psychiatric Association (APA) (1994). *Diagnostic and Statistical Manual of Mental Disorders.* (4th edition). Washington DC.: American Psychiatric Association.

American Psychiatric Association (APA) (2000). *Diagnostic and Statistical Manual of Mental Disorders.* (4th edition, text revision). Washington DC.: American Psychiatric Association.

Andrews, G. (1999). Efficacy, effectiveness and efficiency in mental health service delivery. *Australian and New Zealand Journal of Psychiatry*, 33, 316-322.

Anfuso, D. (1994). Deflecting workplace violence. *Personnel Journal*, 73(10), 66-78.

Anning, B. & Hornung, F. (2000). Comment on Harrop et al from Kumbari/Ngurpai Lag HEC, University of Southern Queensland. *ACISA Forum*, 4(4), 27-29.

Ansley, B. (1995). From Tot to Terror: the sad, strange life of Stephen Staynor - alias Barry Ryder. *The Listener*, December 23, 20-22.

Antonovsky, A. & Sagy, S. (1987). *Unravelling the mystery of health: how people manage stress and stay well.* San Francisco, Jossey-Bass.

Aotearoa New Zealand Association of Social Workers (ANZASW) (1998). *Policy Statement on Supervision*. Education and Training Standing Committee.

Artiss, K. (1963). Human behaviour under stress from combat and social psychiatry. *Military Medicine*, 128, 1011-1019.

Asbury, J. (1995). Overview of focus group research. *Qualitative Health Research*, 5(4), 414-420.

Atkins, P.A. (2002). A paradigm shift in the medical literature. *British Medical Journal*, 325(21 December), 1450-1451.

Avery, A., King, S., Bretherton, R. & Ørner, R. (1999). Deconstructing psychological debriefing and the emergence of calls for evidence-based practice. *Traumatic StressPoints*, 13(2), http://www.www.istss.org/Pubs/TS/Spring99/spring99frame.htm.

Avery, A. & Ørner, R. (1998). More on debriefing: Report of psychological debriefing abandoned: the end of an era? *Australasian Traumatic Stress Points*, July 1998, 4-6.

Bachrach, L. L. (1996). The state of the State Mental Hospital. *Psychiatric Services*, 47, 1071-1078.

Balsa, A.I. & McGuire, T.G. (2003). Prejudice, clinical uncertainty and stereotyping as sources of health disparities. *Journal of Health Economics*, 22(1), 89-116.

Barber, J.G. (1995). Social Work with Addictions. Basingstoke: Macmillan.

Barrett, M.S. & Berman, J.S. (2001). Is psychotherapy more effective when therapists disclose information about themselves? *Journal of Consulting and Clinical Psychology*, 69, 597-603.

Bassett, G. (2001, June). Repositioning fall-out. *Off Campus*, 6, 8.

Bastiaans, J. (1974). The KZ-syndrome: a thirty-year study of the effects on victims of Nazi concentration camps. *Revue de Medecine et Chirurgie*, 78, 573-580.

Bateson, G. (1972). *Steps to an Ecology of Mind.* New York: Ballantine.

BBC News (1998). One in ten health workers attacked (10.8.98). *BBC News Online.* http://news.bbc.co.uk, accessed 15.3.01.

BBC News (2001). One in five psychiatrists assaulted (5.3.01). *BBC News Online.* http://news.bbc.co.uk, accessed 15.3.01.

Beale, D. (2002). Organisational issues related to debriefing. In Professional Practice Board Working Party (Ed.), *Psychological Debriefing* (pp. 31-41). Leicester: British Psychological Society.

Becker, D. (1995). The deficiency of the concept of posttraumatic stress disorder when dealing with victims of human rights violations. In R.J.Kleber, Figley, C.R. & Gersons, B.P.R. (Eds), *Beyond Trauma: Cultural and Societal Dynamics* (pp. 99-110). New York: Plenum Press.

Beckett, C. (2003). The Language of Siege: Military Metaphors in the Spoken Language of Social Workers. *British Journal of Social Work*, 33, 625-639.

Beddoe, E., Appleton, C. & Maher, B. (1998). Social workers' experience of violence. *Social Work Review*, X, 1, 4-11.

Bell, J. (1985). Traumatic event debriefing: Service delivery designs and the role of social work. *Social Work*, 40(1), 36-43.

Bell, S. (1996). Defining Mental Disorder. In W. Brookbanks (Ed), *Psychiatry and the Law* (pp. 71-92). Wellington: Brooker's.

Belsky, J. (1980). Child maltreatment: an ecological integration. *American Psychologist*, 35(4), 320-335.

Benigni, R. (1998). *Life is Beautiful*, [film].

Bennett, N. (2003). Early intervention for traumatic events: mental health initiatives in the Australian Defence Force. *Australasian StressPoints*, Summer 2003, 6-7.

Benson, K. & Hartz, A.J. (2000). A comparison of observational studies and randomized, controlled trials. *New England Journal of Medicine*, 342, 1878-1886.

Bentovim, A. (1992). *Trauma Organized Systems*. London: Karnac Books.

Berah, E.F., Jones, H.J. & Valent, P. (1984). The experience of a mental health team involved in the early phase of a disaster. *Australian-NewZealand Journal of Psychiatry*, 18, 354-358.

Berger, L. (1988). The long term psychological consequences of the Holocaust on the survivors and their offspring. In R.L.Braham (Ed.), *The Psychological Perspectives of the Holocaust and of its Aftermath* (pp. 145-168). New York: Columbia University Press.

Berger, P.L. & Luckmann, T. (1971). *The Social Construction of Reality*. Harmondsworth: Penguin.

Bergman, S.J. (1991). *Men's Psychological Development: A Relational Perspective.* Wellesley, Massachusetts: The Stone Center.

Bibby, P. (1994). *Personal Safety for Social Workers*. Aldershot: Arena.

Bishop, R. (1996). *Whakawhanaungatanga: Collaborative Research Stories.* Palmerston North: Dunmore Press.

Bisson, J., Jenkins, P.L., Alexander, J. & Bannister, C. (1997). Randomised controlled trial of psychological debriefing for victims of acute burn trauma. *British Journal of Psychiatry*, 171, 78-81.

Bisson, J. & Deahl, M. (1994). Psychological debriefing and prevention of post-traumatic stress - more research is needed. *British Journal of Psychiatry*, 165, 717-720.

Blampied, N. (2000). The Research versus Teaching Debate... a fresh approach. *AUS Bulletin* (47, October).

Bloom, S.L. (1996, November 9-13). *Bridging the black hole of trauma; Victims, artists, and society*. Paper presented at the Trauma and Controversy conference, San Francisco, California.

Bloom, S.L. (1997). *Creating Sanctuary: toward the evolution of sane societies.* New York: Routledge.

Bloom, S.L. (1998). Origins and Development of the ISTSS. *Traumatic StressPoints,*12(2), http://www.istss.org/Pubs/TS/Spring98/spring98frame.htm.

Bloom, S.L. & Reichert, M. (1998). *Bearing Witness: Violence and Collective Responsibility.* Binghamton, NY: Haworth Press.

Boniface, L. (2004). The Angry Society. *The Dominion Post*, pp. E1-2, 24.7.04.

Boscarino, J.A. (1995). Post-traumatic stress and associated disorders among Vietnam veterans: the significance of combat exposure and social support. *Journal of Traumatic Stress*, 8(2, April), 317-336.

Boscarino, J.A. (1996). Posttraumatic stress disorder, exposure to combat, and lower plasma cortisol among Vietnam veterans: findings and clinical implications. *Journal of Consulting and Clinical Psychology*, 64(1), 191-201.

Boscarino, J.A. (1997). Diseases among men 20 years after exposure to severe stress: implications for clinical research and medical care. *Psychosomatic Medicine*, 59(6), 605-614.

Boscarino, J.A. & Chang, J. (1999). Higher abnormal leukocyte and lymphocyte counts 20 years after exposure to severe stress: research and clinical implications. *Psychosomatic Medicine*, 61(May-June), 376-386.

Boudreaux, E. & McCabe, B. (2000). Emergency psychiatry: Critical incident stress management: 1. Interventions and effectiveness. *Psychiatric Services*, 51, 1095-1097.

Bowlby, J. (1980). *Attachment and Loss: Loss, sadness and depression* (vol 3). New York: Basic Books.

Bowman, M.L. (1999). Individual differences in posttraumatic distress: problems with the DSM-IV model. *Canadian Journal of Psychiatry*, 44, 21-33.

Boyer, E.L. (1990). *Scholarship Reconsidered: Priorities of the Professoriate.* Princeton, NJ.: Carnegie Foundation.

Bracken, P. & Thomas, P. (2001). Postpsychiatry: a new direction for mental health. *British Medical Journal*, 322, 724-727.

Bracken, P. & Thomas, P. (2003). Time to move beyond the mind-body split. *British Medical Journal*, 325(21-28 December), 1433-1434.

Brayne, M. B., S. (2003). *Trauma, emotions and good journalism* (Conference presentation). Berlin: 8th European Conference on Traumatic Stress.

Breakwell, G.M. (1989). *Facing physical violence.* London: Routledge.

Breggin, P. (1991). *Toxic Psychiatry: why therapy, empathy and love must replace the drugs, electroshock and biochemical theories of the "new psychiatry".* New York: St Martins Press.

Bremner, J.D., Southwick, S.M., Johnson, D.R., Yehuda, R. & Charney, D.S. (1993). Childhood physical abuse and combat-related posttraumatic stress disorder in Vietnam veterans. *American Journal of Psychiatry,* 150, 235-239.

Bremner, J.D., Krystal, J.H., Southwick, S.M. & Charney, D.S. (1995). Functional neuroanatomical correlates of the effects of stress on memory. *Journal of Traumatic Stress,* 8, 527-553.

Bremner, J.D. (2002). *Does stress damage the brain? Understanding trauma based disorders from a neurological perspective.* New York: Norton.

Breslau, N. (2002). Epidemiological studies of trauma, posttraumatic stress disorder, and other psychiatric disorders. *Canadian Journal of Psychiatry,* 2002(47), 923-929.

Breslau, N., Chilcoat, H.D., Kessler, R.C. & Davis, G.C. (1999). Previous Exposure Trauma and PTSD Effects of Subsequent Trauma: Results From the Detroit Area Survey of Trauma. *American Journal of Psychiatry,* 156, 902-907.

Breslau, N., Davis, G.C., Andreski, P. & Peterson, E. (1991). Traumatic events and post-traumatic stress disorder in an urban population of young adults. *Archives of General Psychiatry,* 48(3), 216-222.

Breslau, N. & Davis, G.C. (1992). Posttraumatic stress disorder in an urban population of young adults: Risk factors for chronicity. *American Journal of Psychiatry,* 149(5), 671-675.

Brett, E.A. (1996). The Classification of Posttraumatic Stress Disorder. In B.A. van der Kolk, McFarlane, A.C. & Weisaeth, L. (Eds.), *Traumatic Stress: The effects of overwhelming experience on mind, body and society* (pp. 117-129). New York: The Guilford Press.

Brewin, C. (2001). A cognitive neuroscience account of post-traumatic stress disorder and its treatment. *Behaviour research and therapy,* 39, 373-393.

Brewin, C.R., Andrews, B., Rose, S. & Kirk, M. (1999). Acute Stress Disorder and Posttraumatic Stress Disorder in Victims of Violent Crime. *American Journal of Psychiatry,* 156(March), 360-366.

Bridgman, G., Dyall, L., Bidois, A., Gurney, H,. Hawira, J., Tangitu, P., Huata, W., Webster, S. & Heron, M. (2000). *The Assessment of Wellness - An Outcomes Tool Drawn from the Participant Perspectives in Maori and Mainstream Mental Health.* Paper presented at the Mental Health

Outcomes Research in Aotearoa: Mental Health Research and Development Strategy, Wellington.

Brin, D. (1994). The Dogma of Otherness. In D.Brin (Ed.), *Otherness* (pp. 93-105). London: Orbit.

Brinded, P. M. J., Simpson, A.I.F., Laidlaw, T.M., Fairley, N. & Malcolm, F. (2001). Prevalence of psychiatric disorders in New Zealand prisons. *Australian & New Zealand Journal of Psychiatry*, 35(2), 166-174.

British Medical Association (1992). *Medicine Betrayed - The participation of doctors in human rights abuses.* London: Zed Books.

Brodsky, C. (1982). Work stress in correctional institutions. *Journal of Prison and Jail Health*, 2, 75-101.

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, 32, 513-531.

Bronfenbrenner, U. (1979). *The Ecology of Human Development.* Cambridge, Massachusetts: Harvard University Press.

Brookes, B. & Thomson, J. (Eds). (2001). *Unfortunate Folk: Essays on Mental Health Treatment 1863-1992.* Dunedin: University of Otago Press.

Brown, A. & Bourne, I. (1996). *The Social Work Supervisor.* Buckingham: Open University Press.

Brown, C. (1999). Liability of an employer for damages for a breach of duty involving nervous shock or similar mental injury to an employee. *ACISA Forum*, 4, 4-6.

Brown, G.W. & Harris, T. (1978). *Social Origins of Depression: A Study of Psychiatric Disorder in Women.* London: Tavistock.

Brown, N. (2000). *I am with Soul*, in the Nigel Brown retrospective 2002, Warwick Henderson Gallery, http://www.warwickhenderson.co.nz, accessed 22.2.05.

Brunton, W.A. (1985). Deinstitutionalisation: A romance for all seasons. Paper presented at the *The future of mental health services in New Zealand: deinstitutionalisation* conference, Auckland.

Brunton, W.A. (1987). The New Zealand Lunatic Asylum: Conception and Misconception. Paper presented at the Proceedings of the *First New Zealand Conference on the History of New Zealand and Australian Medicine*, Hamilton.

Brunton, W.A. (1996). Colonies for the mind: the historical context of services for forensic psychiatry in New Zealand. In W.Brookbanks (Ed.), *Psychiatry and the Law* (pp. 3-58). Wellington: Brooker's.

Bryant, R. (1994). Ethical considerations of managing post-trauma responses. *Bulletin of the Australian Psychological Society*, June/July, 3-35.

Bryant, R.A., Guthrie, R.M. & Moulds, M.L. (2001). Hypnotizability in Acute Stress Disorder. *American Journal of Psychiatry*, 158(April), 600-604.

Buchanon, D.R. (1994). Reflections on the relationship between theory and practice. *Health Education Research*, 9(3), 273-283.

Buchanon, G. (1994). *Trauma within the New Zealand Police: Project in Civil Defence.* Massey University Palmerston North.

Buckley, T.C. & Kaloupek, D.G. (2001). A meta-analytic examination of basal cardiovascular activity in posttraumatic stress disorder. *Psychosomatic Medicine*, 63, 585-594.

Bureau of Justice (1997). Special Report: National Crime Victimization Survey, 1992-96. *United States Bureau of Justice.* http://www.ojp.usdoj.gov/bjs, accessed 28.8.04.

Burgess, A.W. & Holstrom, L. (1974). Rape trauma syndrome. *American Journal of Psychiatry*, 131, 981-986.

Burkeman, O. (2001). Veteran killed woman in wartime flashback. *The Guardian*, http://www.guardian.co.uk/Archive, accessed 13.3.01.

Burns, D., Barrett, D., Daley, V., Duignan, P. & Saville-Smith, K. (1994). *Towards a Post-Institutional Response to Mental Health: Consensus statement from the Beyond Care and Control Workshop.* Auckland: Health Research Council.

Burton, O.E. (1935). *The Silent Division: New Zealanders at the Front 1914-1919.* Wellington: Angus & Robertson.

Caird, B. (2001). *Getting a sense of Community Support Work: A review of literature on paradigms to support people who experience mental illness.* Wellington: Ministry of Health.

Caldwell, M.F. (1992). Incidence of PTSD among staff victims of patient violence. *Hospital and Community Psychiatry*, 43(8), 838-839.

Calhoun, L.G. (2003, 22-25 May 2003). *Tempered by the fire: Posttraumatic personal growth.* Paper presented at the European Conference on Traumatic Stress, Berlin.

Calhoun, L.G. & Tedeschi, R.G. (1998). Beyond recovery from trauma: Implications for clinical practice and research. *Journal of Social Issues*, 54, 357-371.

Calhoun, L G. & Tedeschi, R.G. (1999). *Facilitating posttraumatic growth: A clinician's guide.* Mahwah, NJ: Lawrence Erlbaum Associates.

Calhoun, L.G. & Tedeschi, R.G. (2000). Early posttraumatic interventions: Facilitating possibilities for growth. In J.M.Violanti, Paton, D. & Dunning, C. (Ed.), *Posttraumatic stress intervention: Challenges, issues & perspectives* (pp. 135-152). Springfield, Il.: Charles C. Thomas.

Campbell, J.H. (1992). *A comparative analysis of the effects of post shooting trauma on special agents of the Federal Bureau of Investigation.* Unpublished dissertation, Michigan State University.

Cannon, W.B. (1932). *The Wisdom of the Body.* New York: Norton.

Capewell, E. (1998). *Panel discussion on research and CISM*: ACISA conference, 1998, Auckland.

Capewell, E. (2000). The Debriefing Debate: a serious case of confused terminology. *British Medical Journal*, letter in 2.11.2000.

Caplan, G. (1964). *Principles of Preventive Psychiatry.* New York: Basic Books.

Caplan, G. (1974). *Support Systems and Community Mental Health.* New York: Behavioral Publications.

Capra, F. (1996). *The Web of Life: a new synthesis of mind and matter.* London: Harper Collins.

Carey, M.A. & Smith, M.W. (1994). Capturing the group effect in focus groups: a special concern in analysis. *Qualitative Health Research*, 4(1), 123-127.

Carlier, I.V.E., Lamberts, R.D. & Gersons, B.P.R. (1997). Risk factors for posttraumatic stress symptomatology in police officers. *Journal of Nervous and Mental Disease*, 185(8), 498-506.

Carlier, I.V.E., Lamberts, R.D., Fouwels, A.J.D. & Gersons, B.P.R. (1996). PTSD in relation to dissociation in traumatized police officers. *American Journal of Psychiatry*, 153(10), 1325-1328.

Carlier, I.V.E., Lamberts, R.D., van Uchelen, A.J. & Gersons, B.P.R. (1998). Disaster-related post-traumatic stress in police officers: a field study of the impact of debriefing. *Stress Medicine*, 14(3, July), 143-148.

Carlier, I.V.E., Voerman, B.E. & Gersons, B.P.R. (2000). Intrusive traumatic recollections and comorbid posttraumatic stress disorder in depressed patients. *Psychosomatic Medicine*, 62, 26-32.

Carr, V.J., Lewin, T.J., Webster, R.A. & Kenardy, J. (1997). A synthesis of the findings from the Quake Impact Study: a two-year investigation of the psychosocial sequalae of the 1989 Newcastle earthquake. *International Journal of Social Psychiatry and Psychiatric Epidemiology*, 32, 123-136.

Carroll, L. (undated). *Through the Looking Glass and what Alice found there.* London: Odhams Press.

Cederblad, M. & Dahlin, L. (1995). Intelligence and temperament as protective factors for mental health: a cross-sectional and prospective epidemiology study. *European Archives of Psychiatry and Clinical Neuroscience*, 245, 11-19.

Chakraborty, A. (1991). Culture, colonialism, and psychiatry. *Lancet*, 337, 1204-1207.

Chalmers, A. (1998). *Workload and Stress in New Zealand Universities in 1998: a follow-up to the 1994 study*. Wellington: New Zealand Council for Educational Research/ Association of University Staff of New Zealand.

Chalmers, A.F. (1976). *What is this thing called science?* Milton Keynes: Open University Press.

Charlton, P.F.C. & Thompson, J.A. (1996). Ways of coping with psychological distress after trauma. *British Journal of Clinical Psychology*, 35, 517-530.

Charney, D.S., Detch, A.Y., Krystal, J.H., Southwick, S.M. & Davis, C.G. (1993). Psychobiologic mechanisms of Posttraumatic Stress Disorder. *Archives of General Psychiatry*, 50, 294-305.

Cheyne, C., O'Brien, M. & Belgrave, M. (1997). *Social Policy in Aotearoa New Zealand: A Critical Introduction*. Auckland: Oxford University Press.

Children, Young Persons and their Families Agency (1999). *Critical Incident Stress Management Policy and Guidelines*. CYPFA, Wellington.

Chu, J. (1998). *Rebuilding shattered lives: the responsible treatment of post-traumatic and dissociative disorders*. New York: John Wiley.

Cicchetti, D. & Lynch, M. (1993). Toward an ecological/transactional model of community violence and child maltreatment: Consequences for child development. In D.Reiss, Richters, J.E. & Radke-Yarrow, M. (Eds.), *Children and violence* (pp. 96-118). New York: Guilford Press.

Cienfuegos, J. & Monelli, C. (1983): The testimony of political oppression as a therapeutic instrument. *American Journal of Orthopsychiatry*, 53, 43-51

Cimino, M. (Dir.) (1978). *The Deerhunter* (film).

Clarke, J. (2000). Stressed worker has $1m pay. *New Zealand Herald*, www.nzherald.co.nz, accessed 5.7.2000.

Clarke, R. (1991). *'Not mad, but very ill': the treatment of New Zealand's shell-shocked soldiers 1914 to 1939*. Unpublished MA thesis, University of Auckland, Auckland.

Clemans, S.E. (2004). Life changing: the experience of rape-crisis work. *Affilia - Journal of Women and Social Work*, 19(2), 146-159.

Cloitre, M. (1997). Comorbidity of DSM-IV disorders among women experiencing traumatic events. *NCP Clinical Quarterly*, 7(3).

Cohen, S. (1980). *Folk Devils and Moral Panics: the Creation of the Mods and Rockers.* Oxford: M.Robertson.

Cohen, S. & Wills, T.A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin*, 98, 3310-3357.

Coleridge, S.T. (1970). *The Rime of the Ancient Mariner.* New York: Dover Publications.

Collins, E. (1999, March). The South African Conference: interview with Professor Sandy McFarlane. *Australasian Traumatic Stress Points*, 2-4.

Committee on Indigenous Health. (1999). *The Geneva Declaration on the Health and Survival of Indigenous Peoples (WHO/HSD/00.1).* Geneva: World Health Organisation.

Compton, B. & Galaway, B. (1989). *Social Work Processes.* (4th ed.). Belmont, California: Wadsworth.

Concato, J., Shah, N. & Horwitz, R.I. (2000). Randomized controlled trials, observational studies, and the hierarchy of research designs. *New England Journal of Medicine*, 342, 1887-1892.

Connolly, M. (2002). Routes of knowledge toward differing paradigms in social work research. *Social Work Review*, 14(3), 27-29.

Cooper, B. (2001). Constructivism in social work: towards a participative practice viability. *British Journal of Social Work*, 31, 721-737.

Cooper, L. (1998). I'm scared of being a wimp! Supervision: a view from beginning practitioners. *Practice*, 10, 4, 27-36.

Corby, B. (2002). Child Abuse and Protection. In B.Goldson, Lavalette, M. & McKechnnie J. (Eds), *Children, Welfare and the State* (pp. 136-151). London: Sage Publications.

Corcoran, J. & Casebolt, A. (2004). Risk and resilience: Ecological framework for assessment and goal formation. *Child and Adolescent Social Work Journal*, 21,3,211-235.

Cormier, L.S. & Hackney, H. (1987). *The professional counselor: A process guide to helping.* Englewood Cliffs, New Jersey: Prentice-Hall.

Cornell, W. & Kirwan, S. (1997). *Cost Effectiveness of a Comprehensive CISM Program*, Presentation at the Fourth World Congress on Stress, Trauma and Coping in the Emergency Services Professions. Baltimore, April 1997.

Corrigan, P. & Leonard, P. (1978). *Social Work Practice under Capitalism: A Marxist Approach.* London: Macmillan.

Covington, S.S. & Surrey, J. (2000). *The Relational Model of Women's Psychological Development: Implications for Substance Abuse.* Wellesley, Massachusetts: The Stone Center.

Cox, S. (Ed.). (1987). *Public and Private Worlds: women in contemporary New Zealand.* Wellington: Allen & Unwin/Port Nicholson Press.

Coyne, J.C., Ellard, J.H. & Smith, D.A.F. (1990). Social support, interdependence, and the dilemmas of helping. In I.G. Sarason, Sarason, B.R. & Pierce, G.R. (Eds.), *Social Support: an interactional view* (pp. 129-149). New York: John Wiley & Sons.

Craig, A.B. (1999). Mental health nursing and cultural diversity. *Australian and New Zealand Journal of Mental Health Nursing*, 8, 93-99.

Crampton, J.D. (1999). *Violence in the workplace: a survey for the presence of post-incident programs at inpatient psychiatric hospitals.* Unpublished Psy.D.

Creamer, M. (1996). The prevention of post traumatic stress. In Cotter, P. & H. Jackson (Eds) (1996). *Early Intervention and Prevention in Mental Health,* Bowen Hills, Queensland: Australian Academic Press.

Creamer, M. (1997). *Report on the findings of the National Centre for PTSD - Consensus forum on debriefing,* Trauma, Grief and Growth Conference, Sydney.

Crittenden, P.M. (1985). Social networks, quality of child rearing and child development. *Child Development*, 56, 1299-1313.

Croll, L.W. (2000). *Workplace violence in the healthcare industry: effects of coping and social support.* Unpublished PhD, University of Tulsa, Tulsa.

Crompton, R. & Jones, G. (1988). Researching white-collar organisations: why sociologists should not stop doing case studies. In A. Bryman (Ed.), *Doing Research in Organisations* (pp. 68-81). London: Routledge.

CSW Principles and Values Working Party (1998). *Community Support Work Model Principles and Values: a description of the model, its development and the underlying principles and values.* Auckland: CSW P&V Working Party.

Curtis, C. (2004). *Evaluations: Community Support Worker Training Grant Administration and Intermediate Level Training.* Auckland. Mental Health Workforce Development Programme, Health Research Council.

Curtis, L.C. & Hodge, M. (1994). Old Standards, New Dilemmas: Ethics and Boundaries in Community Support Services. *Psychosocial Rehabilitation*, 18(2), 13-33.

Damasio, A.R. (1999). *The feeling of what happens: body and emotion in the making of consciousness.* New York: Harcourt Brace.

Dancu, C.V., Riggs, D.S., Hearst-Ikeda, D., Shoyer, B.G. & Foa, E.B. (1996). Dissociative experiences and posttraumatic stress disorder among female victims of criminal assault and rape. *Journal of Traumatic Stress*, 9, 253-267.

Danieli, Y. (1985). The treatment and prevention of long-term effects and intergenerational transmission of victimization: A lesson from Holocaust survivors. In C.R.Figley (Ed.), *Trauma and its Wake: The Study and Treatment of Post-Traumatic Stress Disorder.* New York: Brunner/Mazel.

Danieli, Y. (1997). International handbook of multigenerational legacies of trauma. *PTSD Quarterly*, 8(1), 1-6.

Danieli, Y. (Ed.). (1998). *International Handbook of Multigenerational Legacies of Trauma.* New York: Plenum Press.

Darling, C.A., Hill, E.W. & McWey, L.M. (2004). Understanding stress and quality of life for clergy and clergy spouses. *Stress and Health*, 20(5), 261-277.

Davidson, C. & Tolich, M. (1999). *Social Science Research in New Zealand.* Auckland: Longman.

Davidson, J.R.T. & Fairbank, J.A. (1993). The epidemiology of posttraumatic stress disorder. In J.R.Davidson & E.B.Foa (Eds), *Posttraumatic stress disorder: DSM-IV and beyond.* Washington DC: American Psychiatric Press.

Davidson, J.R.T. & Foa, E.B. (1991). Diagnostic issues in posttraumatic stress disorder: Considerations for the DSM-IV. *Journal of Abnormal Psychology*, 100(3), 346-355.

Davidson, J.R.T., Hughes, D. & Blaser, D.G. (1991). Post-traumatic stress disorder in the community: an epidemiological study. *Psychological Medicine*, 21, 713-721.

Davidson, J.R.T., Stein, D.J., Shalev, A.Y. & Yehuda, R. (2004). Posttraumatic Stress Disorder: Acquisition, Recognition, Course and Treatment. *Journal of Neuropsychiatry and Clinical Neurosciences*, 16(May), 135-147.

Davies, D.R. (2001). Within and Without (The Story of the Welsh): the impact of cultural factors on mental health in the present day in Wales. In D.R.Bhugra & LIttlewood, R. (Eds.), *Colonialism and Psychiatry* (pp. 185-231). Oxford: Oxford University Press.

Davies, H. & Nutley, S. (2000). Healthcare: evidence to the fore. In H.T.O. Davies, Nutley, S.M.& Smith, P.C. (Eds), *What works? Evidence-based policy and practice in public services.* Bristol: The Policy Press.

Davis, H. (1999). The Psychiatrization of Post-Traumatic Distress: Issues for Social Workers. *British Journal of Social Work*, 29, 755-777.

Davis, S. (2003). *Toiora Whanau: Supporting whanau to achieve wellness.* unpublished teaching material, Palmerston North, Massey University.

de Girolamo, G. & McFarlane, A.C. (1996). The Epidemiology of PTSD: A Comprehensive Review of the International Literature. In A.J.Marsella, Friedman, M.J., Gerrity, E.T. & Scurfield, R.M. (Eds), *Ethnocultural Aspects of Posttraumatic Stress Disorder* (pp. 33-85). Washington DC: American Psychological Association.

de Mause, L. (1997). The psychogenic theory of history. *Journal of Psychohistory*, 25(2), 112-183.

de Silva, P. & Marks, M. (1999). Intrusive Thinking in Post Traumatic Stress Disorder. In W. Yule (1999), *Post Traumatic Stress Disorder: Concepts and Theory*, Wiley, Chichester.

de Soir, E. (2004). *From peer driven early intervention to therapeutic action with military and emergency services personnel* [powerpoint presentation from keynote address, 'The Right Response' ACISA conference, Carlton Hotel, 3-5 October 2003]. Brussels: Department of Behavioural Sciences, Royal Military Academy, Brussels.

deVries, M.W. (1996). Trauma in Cultural Perspective. In B. A. van der Kolk, McFarlane, A.C. & Weisaeth, L. (Eds.), *Traumatic Stress: The effects of overwhelming experience on mind, body and society* (pp. 398-413). New York: The Guilford Press.

Deahl, M.P., Gilham, A.B., Thomas, J., Searle, M.M. & Srinivasan, M. (1994). Psychological sequelae following the Gulf War; factors associated with subsequent morbidity and the effectiveness of psychological debriefing. *British Journal of Psychiatry*, 265, 60-65.

Deahl, M.P. & Bisson, J.I. (1995). Dealing with Disasters: Does psychological debriefing work? *Journal of Accident and Emergency Medicine*, 12, 255-258.

Denzin, N.K. (1989). Strategies of Multiple Triangulation; a theoretical introduction to sociological methods. In N.K. Denzin (Ed.), *The Research Act.* Englewood Cliffs, NJ: Prentice Hall.

Denzin, N.K. & Lincoln, Y.S. (Eds). (1994). *Handbook of Qualitative Research.* Thousand Oaks, California: Sage.

Department of Child, Youth and Family Services (2004). *First Principles Baseline Review.* Wellington: Department of Child, Youth and Family.

Department of Health (2001). *Treatment choice in psychological therapies and counselling.* London: Crown.

Doka, K. (1998). *Disenfranchized Grief: Recognizing and Treating Hidden Sorrow.* Jossey-Bass, San Francisco.

Dominelli, L. (1988). *Anti-Racist Social Work.* London: Macmillan.

Douglas, M. (undated). *Staff costs in the Queensland Public Sector,* http://www.geocities.com/youngmick/eap/md/md.html via ACISA website, accessed 8.8.02.

Draguns, J.G. (1996). Ethnocultural considerations in the treatment of PTSD: Therapy and service delivery. In A.J.Marsella, Friedman, M.J., Gerrity, E.T. & Scurfield, R.M. (Eds), *Ethnocultural Aspects of Posttraumatic Stress Disorder* (pp. 459-482). Washington DC: American Psychological Press.

Driver, T.F. (1991). *The magic of ritual: Our need for liberating rites that transform our lives and our communities.* San Fransisco: Harper San Fransisco.

Duckworth, L. (2002). British plans to lock up mentally ill 'fundamentally flawed'. *New Zealand Herald online,* http://www.nzherald.co.nz, accessed 27.6.02.

Duran, E., Duran, B., Braveheart-Jordan, M. & Yellowhorse-Davis, S. (1998). Healing the American Indian Soul Wound. In Y.Danieli (Ed.), *International Handbook of Multigenerational Legacies of Trauma.* New York: Plenum Press.

Durie, M. (1994). *Whaiora: Maori Health Development.* Auckland: Oxford University Press.

Durie, M. (1996). *A Framework for Purchasing Traditional Healing Services: A Report for the Ministry of Health.* Palmerston North: Massey University: Department of Maori Studies.

Durie, M. (2001). *Mauri Ora: The Dynamics of Maori Health.* Auckland: Oxford University Press.

Durie, M. (2003). The Health of Indigenous Peoples. *British Medical Journal,* 326(8 March), 510-511.

Durkheim, E. (1951). *Suicide.* Glencoe, Illinois: Free Press.

Dutter, B. (1997, 8.3.97). Child Abuse Scandal is Uncovered. *Daily Telegraph* (Electronic).

Dutton, M.A. & Rubenstein, F.L. (1995). Working with people with PTSD: research implications. In C.R. Figley (Ed.), *Compassion Fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized.* New York: Brunner/Mazel.

Dyregrov, A. (1989). Caring for helpers in disaster situations: psychological debriefing. *Disaster Management*, 2, 25-30.

Dyregrov, A. (1997). The process in psychological debriefings. *Journal of Traumatic Stress*, 10(4), 589-604.

Dyregrov, A. & Mitchell, J.T. (1992). Work with traumatized children - psychological effects of coping strategies. *Journal of Traumatic Stress*, 5, 5-17.

Edelman, S.E. (1978). Managing the violent patient in a community mental health center. *Hospital and Community Psychiatry*, 29(7), 460-462.

Edelson, J.L. & Tolman, R.M. (1992). *Interventions for men who batter: an ecological approach.* London: Sage.

Egeland, B. & Susman-Stillman, A. (1996). Dissociation as a mediator of child abuse across generations. *Child Abuse and Neglect*, 20(11), 1123-1132.

Eisenberg, N. & Fabes, R.A. (1994). Mothers' reactions to children's negative emotions: Relations to children's temperament and anger behavior. *Merrill-Palmer Quarterly*, 40, 138-156.

Eitinger, L. (1961). Pathology of the concentration camp syndrome. *Archives of General Psychiatry*, 5, 371-379.

Eliot, T.S. (1970). *Collected Poems 1901-1962.* London: Faber & Faber.

Elklit, A. & Brink, O. (2004). Acute Stress Disorder as a predictor of post-traumatic stress disorder in physical assault victims. *Journal of Interpersonal Violence*, 19(6), 709-726.

Elliott, C. & Agnew, R. (1999). *The development and implementation of Critical Incident Stress Management within the Department of Child, Youth and Family Services* (Internal report). Wellington, Department of Child, Youth and Family Services.

Engel, G. (1980). The clinical application of the biopsychosocial model. *American Journal of Psychiatry*, 37(5), 535-544.

Epstein, I. (1996). In search of a research-based model for clinical practice: Or, why can't a social worker be more like a researcher? *Social Work Research*, 20(2), 97-100.

Epston, D. & White, M. (1990). *Narrative Means to Therapeutic Ends.* New York: Norton.

Erikson, K.T. (1994). *A New Species of Trouble: Explorations in Disaster, Trauma and Community.* New York: W.W.Norton.

Ernst, E. & Pittler, M.H. (2001). Assessment of therapeutic safety in systematic reviews: literature review. *British Medical Journal*, 323(8 September), 546.

Esterson, A. (1998). Jeffrey Masson and Freud's seduction theory: A new fable on old myths. *History of the Human Sciences*, 11, 1-21.

Esterson, A. (2001). The mythologizing of psychoanalytic history: Deception and self-deception in Freud's accounts of the seduction theory episode. *History of Psychiatry*, 12, 329-352.

Eth, S. (1992). Ethical challenges in the treatment of traumatised refugees. *Journal of Traumatic Stress*, 5, 1.

Everly, G.S. (1999). A primer on critical incident stress management: what's really in a name? *International Journal of Emergency Mental Health*, 1(2), 77-79.

Everly, G.S., Flannery, R.B. & Mitchell, J.T. (2000). Critical Incident Stress Management (CISM): a review of the literature. *Aggression and Violent Behavior*, 5(1), 23-40.

Everly, G.S. & Mitchell, J.T. (1998). CISD revisited: a primer on Critical Incident Stress Management (CISM). *Trauma Lines*(Fall), 1-3.

Fahlberg, L.L. & Fahlberg, L.A. (1997). Wellness re-examined: A cross-cultural perspective. *American Journal of Health Studies*, 13(1), 8-16.

Falloon, I.R.H. & Faddon, G. (1993). *Integrated Mental Health Care.* Cambridge: Cambridge University Press.

Farley M., & Barkan, H. (1998), Prostitution, violence, and posttraumatic stress disorder. *Women and Health* 27(3), 37-49.

Farmer, B. & Thomas, M. (1997). Paedophile social worker jailed for 18 years. *The Times*, p3, 8.3.97.

Favaro, A., Zaetta, C., Colombo, G. & Santonastaso, P. (2004). Surviving the Vajont disaster - psychiatric consequences 36 years later. *Journal of Nervous and Mental Disease*, 192(3), 227-231.

Ferriman, A. (2000). The stigma of schizophrenia. *British Medical Journal*, 320(19 February), 522.

Figley, C.R. (1989). *Helping traumatized families.* San Francisco: Jossey-Bass.

Figley, C.R. (1990). *Treating Stress in Families.* New York: Brunner/Mazel.

Figley, C.R. (Ed.) (1995). *Compassion Fatigue: Coping with Secondary Traumatic Stress disorder in those who treat the traumatized.* New York: Brunner/Mazel.

Figley, C.R. & Kleber, R.J. (1995). Beyond the "Victim": Secondary Traumatic Stress. In R. Kleber, Figley, C.R. & Gersons, B.P.R. (Eds), *Beyond Trauma: Cultural and Societal Dynamics.* New York: Plenum Press.

Finch, J. (1984a). Community Care: Developing Non-sexist Alternatives. *Critical Social Policy*, 9, 6-18.

Finch, J. (1984b). 'It's great to have someone to talk to': the ethics and politics of interviewing women. In C.B.H. Roberts (Ed.), *Social Researching: Politics, Problems, Practice.* London: Routledge and Kegan Paul.

Finch, J. (1986). *Research and Policy: the uses of Qualitative Methods in Social and Educational Research.* London: The Falmer Press.

Finlayson, B., Dixon, J., Meadows, S. & Blair, G. (2002). Mind the gap: the extent of the nursing shortage. *British Medical Journal*, 325, 538-541.

Flannery, R.B.J., Fulton, P., Tausch, J. & Deloffi, A. (1991). A program to help staff cope with the psychological sequalae of assaults by patients. *Hospital and Community Psychiatry*, 42, 935-938.

Flannery, R.B.J., Hanson, M.A., Penk, W.E., Flannery, G.J. & Gallagher, C. (1995). The Assaulted Staff Action Program (ASAP): An approach to coping with the aftermath of violence in the workplace. In L.R. J. Hurrell, Souter, S.L. & Keita, G.P. (Eds), *Job Stress Interventions* (pp. 199-212). Washington DC: American Psychological Association.

Fletcher, J. (1999). *Disappearing Acts: Gender, Power, and Relational Practice at Work.* Boston: MIT Press.

Foa, E.B., Keane, T.M. & Friedman, M.J. (2000). *Effective treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies.* New York: Guilford Press.

Foa, E.B. & Riggs, D.S. (1993). Posttraumatic stress disorder and rape. In J.M. Oldham, Riba, M.B. & Tasman, A. (Eds), *American Psychiatric Press Review of Psychiatry* (Vol. 12, pp. 273-303). Washington DC: American Psychiatric Press.

Foa, E.B., Steketee, G. & Rothbaum, B.O. (1989). Behavioral/cognitive conceptualizations of post-traumatic stress disorder. *Behavior Therapy*, 20, 155-176.

Fook, J. (Ed.). (1996). *The Reflective Researcher: Social workers' theories of practice research.* St Leonards, NSW: Allen & Unwin.

Ford, J.D. (1999). *Disorders of extreme stress following warzone military trauma: associated features of Post-traumatic Stress Disorder (PTSD) or comorbid but distinct syndromes?* http://www.trauma-pages.com/ford99.htm.

Ford, J.D. & Kidd, P.K. (1998). Early childhood trauma and disorders of extreme stress as predictors of treatment outcome with chronic posttraumatic stress disorder. *Journal of Traumatic Stress*, 11(4), 743-761.

Foucault, M. (1965). *Madness and Civilisation: A History of Insanity in the Age of Reason.* New York: Vintage.

Foucault, M. (1977). *Discipline and Punish.* London: Allen Lane.

Fouché, C. (2005). An Ecological Understanding of HIV Practice in South Africa. In *Social Work Theories in Action*, M.Nash, Munford, R. & O'Donoghue, K. (Eds). London: Jessica Kingsley.

Frankl, V.E. (1964). *Man's Search for Meaning: an introduction to logotherapy* (Ilse Lasch, Trans.). (3rd edition). London: Hodder & Stoughton.

Fraser, M.W. (2004). Risk and Resilience in Childhood: An Ecological Perspective, 2nd edition. Washington, DC: NASW Press.

Freedman, J. & Coombs, G. (1996). *Narrative Therapy: The Social Construction of Preferred Realities.* New York: Newton.

Freedman, T.G. (2004). Voices of 9/11 first responders: Patterns of collective resilience. *Clinical Social Work Journal*, 32(4), 377-393.

Freire, P. (1972). *Pedagogy of the Oppressed* (Myra Bergman Ramos, Trans.). Harmondworth: Penguin Books.

French, G. (2001). *Issues of causality*. http://www.forensicptsd.com/issues/html, accessed 22.2.01.

Freud, S. (1896/1962). The aetiology of hysteria. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. III,). London: Hogarth.

Freud, S. (1919/1954). *Introduction to Psychoanalysis and the War Neuroses.* (Strachey, Trans.). (Standard 17th ed.). London: Hogarth Press.

Freud, S. (1920/1961). *Beyond the Pleasure Principle* (Strachey, J., Trans.). New York: W.W.Norton.

Freud, S. (1935). *The Ego and the Id.* London: Hogarth Press.

Freyd, J.J. (1996). *Betrayal trauma: The Logic of Forgetting Childhood Abuse.* Cambridge, Massachusetts: Harvard University Press.

Friedman, M.J. & Marsella, A.J. (1996). Posttraumatic stress disorder: an overview of the concept. In A.J.Marsella, Friedman, M.J., Gerrity, E.T. & Scurfield, R.M. (Eds), *Ethnocultural Aspects of Posttraumatic Stress Disorder: Issues, Research, and Clinical Applications* (pp. 11-32). Washington DC: American Psychological Association.

Friedman, M.J. & Schnurr, P.P. (1995). The relationship between trauma, post-traumatic stress disorder, and physical health. In M.J.Friedman, Charney, D.S. & Detch, A.Y. (Eds.), *Neurobiological and clinical consequences of stress: from normal adaptation to post-traumatic stress disorder* (pp. 507-524). Philadelphia: Lippincott-Raven.

Friedman, R.J., Framer, M.B. & Shearer, D.R. (1998). Early response to posttraumatic stress. *EAP Digest*, 8, 45-49.

Fullerton, C. S., Ursano, R.J., Epstein, R.S., Crowley, B., Vance, K., Kao, T.-Z., Dougall, A. & Baum, A. (2001). Gender differences in posttraumatic stress disorder after motor vehicle accidents. *American Journal of Psychiatry*, 158(September), 1486-1491.

Galovski, T. & Lyons, J.A. (2004). Psychological sequelae of combat violence: a review of the impact of PTSD on the veteran's family and possible interventions. *Aggression and Violent Behavior*, 9(5), 477-501.

Garbarino, J. & Sherman, D. (1980). High-risk neighbourhoods and high-risk families: the human ecology of child maltreatment. *Child Development*, 51, 188-198.

Gardiner, W. (1992). *The story of the Maori Battalion.* Wellington: Reed Books.

Garrison, C.Z., Weinrich, M.W., Hardin, S.B., Weinrich, S. & Wang, L. (1993). Post-traumatic stress disorder in adolescents after a hurricane. *American Journal of Epidemiology*, 138, 522-530.

Geering, L. (1994). *Tomorrow's God.* Wellington: Bridget Williams Books.

Gersons, B.P.R. & Carlier, I.V.E. (1992). Posttraumatic stress disorder; the history of a recent concept. *British Journal of Psychiatry*, 161, 742-748.

Gersons, B.P.R., Carlier, I.V.E. & Vrijlandt, I. (1997). *Some urgent questions regarding the practice of debriefing on the basis of research findings in Amsterdam.* Paper presented at the Fifth European Conference, Maastricht.

Gibbs, A., Fraser, D. & Scott, J. (1988). *Unshackling the hospitals: Report of the Hospital and Related Services Taskforce.* Wellington: Government Printing Office.

Gibbs, A. (1997). Focus Groups. *Social Research Update* 17. Department of Sociology, University of Surrey. http://www.soc.surrey.ac.uk/sru/SUU19.html, accessed 23.8.04.

Gibson, J.W. (1994). *Warrior Dreams: Paramilitary Culture in Post-Vietnam America.* New York: Hill & Wang.

Gibson, R. (1986). *Critical Theory and Education.* London: Hodder & Stoughton.

Gilgun, J.F. (1999). CASPARS: new tools for assessing client risks and strengths. *Families in Society*, 80 (6), 629-641.

Gillard, M. & Paton, D. (1999). Disaster Stress Following a Hurricane: the role of religious differences in the Fijian Islands. *Australasian Journal of Disaster and Trauma Studies*, 2, electronic source.

Gilliland, B.E. & James, R.K. (1997). *Crisis Intervention Strategies.* (3rd ed.). Pacific Grove, California: Brooks/Cole.

Gist, R., Lubin, B. & Redburn, B.G. (1998). Psychological, ecological, and community perspectives on disaster response. *Journal of Personal and Interpersonal Loss*, 3, 25-51.

Gist, R. & Woodall, S.J. (1998). Social science versus social movements: the origins and natural history of debriefing. *Australasian Journal of Disaster and Trauma Studies*, 1, ejournal.

Glaser, B. & Strauss, A. (1967). *The Discovery of Grounded Theory*. Chicago: Aldine.

Goffman, E. (1961). *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates.* Chicago: Aldine.

Goffman, E. (1963). *Stigma: Notes on the Management of a Spoiled Identity*. Englewood Cliffs, NJ: Prentice Hall.

Gold, S.N. & Faust, J. (2002). The Future of Trauma Practice: Visions and Aspirations. *Journal of Trauma Practice*, 1,1, 1-15.

Goode, E. (2000, 8.8.00). How Culture Molds Habits of Thought. *New York Times.*

Gordon, R. (1997). *Debriefing teaches things that counselling doesn't.* Paper presented at the Trauma, Grief and Growth: finding a path to healing, Sydney, 7-10 May.

Gordon, R. (1997). Theory and practice of early intervention in trauma. *Psychotherapy in Australia*, 3(2), 44-50.

Gordon, R. (1998). *Meeting with Rob Gordon*: National Advisory Group, Auckland Metro CYPFA.

Goswami, A. (1993). *The Self-Aware Universe: how consciousness creates the material world.* London: Simon & Schuster.

Gould, N.D. & Ryback, V.R. (1999). Misconceptions about date rape. *Boston Globe*, 12.3.99, pp. A31.

Graham-Bermann, S.A. (1998). The Impact of Woman Abuse on Children's Social Development: Research and Theoretical Perspectives. In G.W.Holden, Geffner, R. & Jouriles, E.N. (Eds.), *Children Exposed to Marital Violence: Theory, Research and Applied Issues.* Washington: American Psychological Association.

Graham-Bermann, S. A. & Levendovsky, A.A. (1998). Traumatic Stress Symptoms in Children of Battered Women. *Journal of Interpersonal Violence*, 13(1), 111-128.

Graue, E. & Walsh, D. (1998). *Studying children in context: Theories, methods and ethics.* Thousand Oaks, California, Sage.

Green, B. (1997). *Does toxic exposure lead to PTSD? Conceptual issues and research findings.* Paper presented at the Trauma, Grief and Growth, University of Sydney, Australia, May 7-10.

Green, B.L. (1993). Identifying survivors at risk. In Wilson, J. & B. Raphael (Eds) (1993). *International Handbook of Traumatic Stress Syndromes.* New York: Plenum Press, pp135-144.

Green, B.L. (1995). Introduction to special issue on traumatic memory. *Journal of Traumatic Stress*, 8(4), 501-504.

Green, S. A. & Bloch, S. (2001). Working in a flawed mental health care system: an ethical challenge. *American Journal of Psychiatry*, 158(September), 1378-1383.

Greenhalgh, T. (1997). Getting your bearings (what is this paper about?). In T. Greenhalgh (Ed.), *How to read a paper: the basics of evidence based medicine* (pp. 34-51). London: BMJ Publishing Group.

Griffiths, J. & Watts, R. (1992). *The Kempsey and Grafton bus crashes: the aftermath.* Lismore, NSW: Instructional Design Solutions, University of New England.

Grinker, R.R. & Spiegel, J.P. (1945). *Men Under Stress.* Philadelphia: Blakiston.

Grossi, G., Soares, J.J., Angesleva, J. & Perski, A. (1999). Psychosocial correlates of long-term sick-leave among patients with musculoskeletal pain. *Pain*, 80(3), 607-619.

Grossman, D. (1996). *On killing: the psychological cost of learning to kill in war and society.* Boston: Little, Brown.

Gruenewald, T.K., Taylor, S.E., Klein, L.C. & Seeman, T.E. (1999). Gender disparities in acute stress research. Proceedings of the Society of Behavioral Medicine's 20th Annual Meeting: *Annals of Behavioral Medicine*, 21(supplementary).

Guba, E.G. & Lincoln, Y.S. (1994). Competing paradigms in Qualitative Research. In N.K. Lincoln & Denzin, Y.S. (Eds), *Handbook of Qualitative Research* (pp. 105-117). Thousand Oaks, California: Sage.

Gusman, F.D., Stewart, J., Young, B.H., Riney, S.J., Abueg, F.R. & Blake, D.D. (1996). A multicultural developmental approach for treating trauma. In A.J. Marsella, Friedman, M.J., Gerrity, E.T. & Scurfield, R.M. (Eds.), *Ethnocultural Aspects of Posttraumatic Stress Disorder* (pp. 439-457). Washington DC: American Psychological Press.

Hafemeister, T.L. (1993). Juror Stress. *Violence and Victims*, 8, 177-186.

Haines, H. & Abbott, M. (1985). Deinstitutionalisation and Social Policy: 1: Historical Trends. *Community Mental Health in New Zealand*, 1(2), 44-56.

Hamling, J. (1996). *Tipping the scales in the debriefing debate.* http://members.ozemail.com.au/~jsjp, accessed 1998.

Hanson, F.R. (Ed) (1949). Combat psychiatry: experiences in the North African and Mediterranean theaters of operation, American ground forces, World War II. *The Bulletin of the U.S.Army Medical Department*, 9 Suppl, VII-IX.

Harber, K.D. &Pennebaker, J.W. (1992). Overcoming traumatic memories. In S.A.Christianson (Ed.), *The Handbook of Emotion and Memory: Research and Theory* (pp. 359-387). Hillsdale, New Jersey: Lawrence Erlbaum.

Harkness, L.L. (1993). Transgenerational transmission of war-related trauma. In J. P. Wilson &. Raphael, B. (Eds.), *International Handbook of Traumatic Stress Syndromes.* New York: Plenum.

Hart, C. & Warren, P. (1997). *Critical Incident Stress Debriefing: A Strategy for Organisational Change.* Paper presented at the Trauma, Grief and Growth: finding a path to healing, Sydney, Australia.

Hatcher, S., Mouly, V.S., Rasquihna, D., Miles, W., Burdett, J., Hamer, H. & Robinson, G. (2005). *Improving recruitment to the mental health workforce in New Zealand.* Auckland, Health Research Council.

Hawkins, P. & Shohet, R. (1989). *Supervision in the Helping Professions.* Milton Keynes: Open University Press.

Hayward, J. (Ed.). (1950). *John Donne: A selection of his poetry.* Harmondsworth: Penguin.

Health Education Authority (1999). *Media Mentality*. London: Health Education Authority.

Health Funding Authority (1999). *Mental Health Service Specifications*. Christchurch: Health Funding Authority.

Health Research Council (1994). *Beyond Care and Control?* Auckland: Health Research Council.

Health Workforce Advisory Committee (2002). *The New Zealand health workforce: A stocktake of issues and capacity 2001*. Wellington: Health Workforce Advisory Committee.

Hearst, P. (1981). *Every secret thing*. New York: Doubleday.

Heller, J. (1962). *Catch-22*. London: Cape.

Heinemann, L. (1987). *Paco's Story*. London: Faber & Faber.

Hendin, H. & Haas, A.P. (1984). *Wounds of War: The Psychological Aftermath of Combat in Vietnam*. New York: Basic Books.

Henggeler, S. (1999). Multisystemic therapy: An overview of clinical procedures, outcomes, and policy implications. *Child Psychology and Psychiatry Review*, 4(1), 2-10.

Henry, D.L. (2001). Resilient children: what they tell us about coping with maltreatment. *Social Work in Health Care*, 34 (3-4), 283-298.

Herlihy, J., Scragg, P. & Turner, S. (2002). Discrepancies in autobiographical memories: implications for the assessment of asylum seekers: repeated interviews study. *British Medical Journal*, 324, 324-327.

Herman, J.L. (1992a). *Trauma and Recovery*. New York: Basic Books.

Herman, J.L. (1992b). Complex PTSD: a syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, 3(1), 377-391.

Herndon, J.S. (2002). *Paradigm Lost: The Iatrogenic Effects of CISD* (Conference Presentation). Auckland: ASTSS Ninth Annual Conference.

Herskovits, E.H., Gerring, J.P., Davatzikos, C. & Nick Bryan, R. (2002). Is the spatial distribution of brain lesions associated with closed-head injury in children predictive of the subsequent development of posttraumatic stress disorder? *Radiology*, 224, 345-351.

Higham, P.E. (2001). Developing an interactive approach in social work research: the example of a research study on head injury. *British Journal of Social Work*, 31(2), 197-212.

Hiroeh, U., Appleby, L., Mortenson, P.B. & Dunn, G. (2001). Death by homicide, suicide, and other unnatural causes in people with mental illness: a population-based study. *The Lancet*, 358, 2110-2112.

Hitchcock, A. (Dir.) (1945). *Spellbound* (film).

Hodgkinson, P. & Stewart, M. (1991). *Coping with Catastrophe.* London: Routledge.

Holmes, T. & Rahe, R. (1967). The social adjustment rating scale. *Journal of Psychosomatic Research,* 11, 219-225.

Holstein, J.A. & Gubrium, J.F. (1994). Phenomenology, Ethnomethodology and Interpretive Practice. In N.K. Lincoln & Denzin, Y.S. (Ed.), *Handbook of Qualitative Research* (pp. 262-272). Thousand Oaks, California: Sage.

Hood, L. (2001). *A City possessed: the Christchurch Civic Creche case: Child abuse, gender politics and the law.* Dunedin: Longacre Press.

Horowitz, M.J. (1986). *Stress Response Syndromes.* Northvale, NJ: Jason Aronson.

Horowitz, M.J. (1993). Stress-response syndromes: A review of posttraumatic stress and adjustment disorders. In J.P.Wilson & B.Raphael (Eds.), *The international handbook of traumatic stress syndromes* (pp. 49-60). New York: Plenum.

Hough, G. (1996). Using ethnographic methods to research the work world of social workers in child protection. In J. Fook (Ed.), *The Reflective Researcher: social workers' theories of practice research* (pp. 43-54). St Leonards, NSW: Allen & Unwin.

Huddleston, L. M. (2002). *The impact of traumatic and organizational stressors on New Zealand police recruits: a longitudinal investigation of psychological health and posttraumatic growth outcomes.* Unpublished PhD, Massey University, Palmerston North.

Hughes, H.M. (1996). Research with Children in Shelters: Implications for Clinical Services. *Children Today*, 15(2), 21-25.

Human Rights Watch (2003). www.hrw.org.

Ife, J. (2001). *Human Rights and Social Work: towards rights-based practice.* Cambridge: Cambridge University Press.

Ikin, J.F., Sim, M.R., Creamer, M.C., Forbes, A.B., McKenzie, D.P., Kelsall, H.L., Glass, D.C., McFarlane, A.C., Abramson, M.J., Ittak, P., Dwyer, T., Blizzard, L., Delaney, K.R., Horsely, K.W.A., Harrex, W.K. & Schwarz, H. (2004). War-related psychological stressors and risk of

psychological disorders in Australian veterans of the 1991 Gulf War. *British Journal of Psychiatry*, 185 (August), 116-126.

Ioannidas, J.P.A., Haidich, A.B. & Lau, J. (2001). Any casualties in the clash of randomised and observational evidence? *British Medical Journal*, 322(14 April), 879-880.

Irwin, K. (1994). Maori research methods and processes: an exploration. *Sites*, 28 (Autumn), 25-43.

Izutsu, T., Tsutsumi, A., Asukai, N., Kurita, H. & Kawamura, N. (2004). Relationship between a traumatic life event and an alteration in stress response. *Stress and Health*, 20(2), 65-73.

Jack, G. (2000). Ecological influences on parenting and child development. *British Journal of Social Work*, 30, 6, 703-720.

Jacobsen, L.K., Southwick, S.M.& Kosten, T.R. (2001). Substance use disorders in patients with posttraumatic stress disorder: a review of the literature. *American Journal of Psychiatry*, 158(August), 1184-1190.

Jaffe, P.G., Wolfe, D.A. & Wilson, S.K. (1990). *Children of Battered Women*. Newbury Park: Sage.

Janet, P. (1889). *L'Automatisme Psychologique*. Paris: Alcan.

Janoff-Bulman, R. (1992). *Shattered Assumptions: Towards a New Psychology of Trauma*. New York: Free Press.

Janosik, E.H. (1984). *Crisis Counseling; A contemporary approach*. Monterey, California: Wadsworth Health Sciences Division.

Johnson, S. (1988). Guidelines for social workers in coping with violent clients. *British Journal of Social Work*, 18, 377-390.

Jones, E., Hodgins-Vermaas, C., McCartney, H., Everitt, B., Beech, C., Poynter, D., Palmer, I., Hyams, K. & Wessely, S. (2002). Post-combat syndromes from the Boer War to the Gulf War: a cluster analysis of their nature and attribution. *British Medical Journal*, 324(9 February), 321-324.

Jones, K. & Fowles, A.J. (1984). *Ideas on institutions: analysing the literature on long-term care and custody*. London: Routledge & Kegan Paul.

Jongedijk, R.A., Carlier, I.V.E., Schreuder, B.J.N. & Gersons, B.P.R. (1995). Is there a place for the Complex Post-traumatic Stress Disorder? *Tijdschrift voor Psychiatrie*, 37(1), 287-302.

Jorm, A.F. (2000). Mental health literacy: Public knowledge and beliefs about mental disorders. *British Journal of Psychiatry*, 177(5), 396-401.

Joseph, R. (1992). *The Right Brain and the Unconscious: Discovering the Stranger Within.* New York: Plenum.

Joseph, S., Williams, R. & Yule, W. (1993). Changes in outlook following disaster: The preliminary development of a measure to assess positive and negative responses. *Journal of Traumatic Stress*, 6, 271-279.

Joseph, S. (2004). Client-centred therapy, post-traumatic stress disorder and post-traumatic growth: Theoretical perspectives and practical implications (1). *Psychology and Psychotherapy: Theory, Research and Practice*, 77, 101-119.

Juhnke, G.A. (1997). After school violence: an adapted critical incident stress debriefing model for student survivors and their parents. *Elementary School Guidance & Counselling*, 31(February), 163-170.

Jureidini, J. (2004). Does dissociation offer a useful explanation for psychopathology? *Psychopathology*, 37(6), 259-265.

Kadis, J. (undated). *Workforce Planning: how to recruit and retain mental health workers*, [website]. Community Living Exchange Collaboration [2004, 28.8.04].

Kadushin, A. (1992). *Supervision in Social Work.* (3rd ed.). New York: Columbia University Press.

Kagee, A. (2004). Present concerns of survivors of human rights violations in South Africa. *Social Science & Medicine*, 59(3), 625-635.

Kalliath, P. & Kalliath, T. (2002). The crisis of a sudden illness: how Social Workers can make a difference. *Social Work Review*, 14(1), 43-46.

Kardiner, A. (1941). *The Traumatic Neuroses of War.* New York: Hoeber.

Kardiner, A. & Spiegel, H. (1947). *War Stress and Neurotic Illness.* New York: Paul B. Hoeber.

Kassam-Adams, N. (1995). *The risks of treating sexual trauma: stress and secondary trauma in psychotherapists.* Unpublished doctoral dissertation, University of Virginia.

Kavanagh, D. (1987). *Thatcherism and British Politics: the end of consensus?* Oxford: Oxford University Press.

Kawamura, N., Kim, Y. & Asukai, N. (2001). Suppression of cellular immunity in men with a past history of posttraumatic stress disorder. *American Journal of Psychiatry*, 158(March), 484-486.

Kazdin, A. & Weisz, J. (1998). Identifying and developing empirically supported child and adolescent treatments. *Journal of Consulting and Clinical Psychology*, 66, 19-36.

Keel, P. (1998). Psychological and psychiatric aspects of fibromyalgia syndrome (FMS). *Rheumatology*, 57(Suppl 2), 97-100.

Keenan, B. & van der Kolk, B. (2000). *Keenan Interview* [audio tape]. Melbourne: Third World Conference of the International Society for Traumatic Stress Studies.

Kellerman, N. P. F. (2000). *Transmission of Holocaust Trauma*, [website]. National Israeli Center for Psychosocial Support of Survivors of the Holocaust and the Second Generation. Available: http://members.tripod.com/~Peterfelix/home/trans.htm [2004, 24.8.04].

Kelly, K. (1999a). *Preventing job related posttraumatic stress disorder among remote health practitioners* (occasional paper no.2). Alice Springs: Council of Remote Area Nurses of Australia.

Kelly, K. (1999b, September). Responding to Job Related Trauma in Remote Areas. *Australasian Traumatic Stress Points*, September 1999, 4-6.

Kempe, C.H., Silverman, F.N., Steel, B.F., Droegemuller, W. & Silver, H.K. (1962). The battered child syndrome. *Journal of the American Medical Association*, 181, 17-24.

Kenardy, J. (2000). The current status of psychological debriefing. *British Medical Journal*, 321(28 October), 1032-1033.

Kenardy, J.A., Webster, R.A., Lewin, T.J., Carr, V.J., Hazell, P.L. & Carter, G.L. (1996a). Stress debriefing and patterns of recovery following a natural disaster. *Journal of Traumatic Stress*, 9(1), 37-49.

Kenardy, J.A. & Carr, V. (1996b). Imbalance in the debriefing debate: What we don't know far outweighs what we do. *Bulletin of the Australian Psychological Society*, 18(2), 4-6.

Kessler, B.L. & Bieschke, K.J. (1999). A retrospective analysis of shame, dissociation, and adult victimization in survivors of childhood sexual abuse. *Journal of Counseling Psychology*, 46(3), 335-341.

Kessler, R.C., Sonnega, A. Bromet, E. et al. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry*, 52(12), 1048-1060.

Kiecolt-Glaser, J.K., Glaser, R., Gravenstein, S., Malarkey, W.B. & Sheridan, J. (1996). Chronic stress alters the immune response to influenza virus vaccine in older adults (93), [medline, from http://www.healing-arts.org/mehl-madrona/mmstress-immunity.htm]. *Proceedings of the National Academy of Science* (USA) [19.7.00].

Kiecolt-Glaser, J.K., McGuire, L., Robles, T. & Glaser, R. (2002). Emotions, Morbidity and Mortality: new perspectives from Psychoneuroimmunology. *Annual Review of Psychology*, 53, 83-107.

Kincheloe, J.L. & McLaren, P.L. (1994). Rethinking Critical Theory and Qualitative Research. In N.K.Denzin & Lincoln, Y.S. (Eds.), *Handbook of Qualitative Research* (pp. 138-157). Thousand Oaks, California: Sage.

King, A. (2002). Checkpoint interview, *National Radio* [2002, 3.5.02].

King, D.W., King, L.A., Foy, D.W. & Gudanowski, D.M. (1996). Pre-war factors in combat-related posttraumatic stress disorder: structural equation modeling with a national sample of female and male Vietnam veterans. *Journal of Consulting and Clinical Psychology*, 64, 520-531.

Kingi, T. & Durie, M. (2000). *Hua Oranga: A Maori Measure of Mental Health Outcome.* Paper presented at the Mental Health Outcomes Research in Aotearoa: Mental Health Research and Development Strategy, Wellington, September 2000.

Kingi, T. & Durie, M. (2001). *Hua Oranga: A Maori Measure of Mental Health Outcome.* Palmerston North. Massey University, School of Maori Studies, Te Pumanawa Hauora.

Kira, I.A. (2001). Taxonomy of Trauma and Trauma Assessment. *Traumatology*, 7, www.fsu.edu/trauma/v7.

Kirmayer, L.J. (1996). Confusion of the senses: Implications of ethnocultural variations in somatoform and dissociative disorders for PTSD. In A.J. Marsella, Friedman, M.J., Gerrity, E.T. & Scurfield, R.M. (Eds.), *Ethnocultural Aspects of Posttraumatic Stress Disorder* (pp. 131-163). Washington DC: American Psychological Press.

Kiro, C. (2000). Maori Research and the Social Services: Te Puawaitanga o te Tohu. Social Work Review, 12(*Te Komako* 4), 26-32.

Kisiel, C.L. & Lyons, J.S. (2001). Dissociation as a mediator of psychopathology among sexually abused children and adolescents. *American Journal of Psychiatry*, 158(July), 1034-1039.

Kitzinger, J. (1995). Qualitative Research: introducing focus groups. *British Medical Journal*, 311, 299-302.

Kleber, R.J., Figley, C.R. & Gersons, B.P.R. (Eds). (1995). *Beyond Trauma: Cultural and Societal Dynamics.* New York: Plenum Press.

Kleinman, A. & Good, B. (Eds). (1985). *Culture and Depression.* Los Angeles: University of California Press.

Kolb, L.C. (1987). Neurophysiological hypothesis explaining posttraumatic stress disorder. *American Journal of Psychiatry*, 144, 989-995.

Krantz, D.S. & McCeney, M.K. (2002). Effects of psychological and social factors on organic disease: a critical assessment of research on coronary heart disease. *Annual Review of Psychology*, 53, 341-369.

Krieger, S. (1983). *The Mirror Dance: Identity in a woman's community.* Philadelphia: Temple University Press.

Krieger, S. (1991). *Social Science and the Self: Personal Essays on an Art Form.* New Brunswick, NJ: Rutgers University Press.

Krishnan, R. (2004). Evidence-Based Medicine in Psychiatry - A new perspective: an expert interview with Ranga Krishnan. *Medscape Psychiatry and Mental Health*, 9.

Krystal, H. (1978). Trauma and affects. *Psychoanalytic Study of the Child*, 33, 81-116.

Krystal, H. (1988). *Integration and self-healing: Affect, trauma, alexithymia.* Hillsdale, NJ: Analytic Press.

Kubany, E.S. (1998). Cognitive Therapy for Trauma Related Guilt, in V. Follette, Ruzek, J. & Abueg, F. (Eds)*Cognitive Behavioural Therapies for Trauma*, Guildford Press, New York.

Kuhn, T. (1970). *The Structure of Scientific Revolutions.* (2nd ed.). Chicago: University of Chicago Press.

Kulka, R.A., Schlenger, W.E., Fairbank, J.A., Hough, R.L., Jordan, B.K. & Marmar, C.R. (1990). *Trauma and the Vietnam War Generation: Report of the Findings from the National Vietnam Veterans' Readjustment Study.* New York: Brunner Mazel.

Kutchins, H. & Kirk, S. (1999). *Making us crazy: DSM, the psychiatric Bible and the creation of mental disorders.* London: Constable.

Langan, M. & Day, L. (Eds). (1992). *Women, Oppression & Social Work.* London: Routledge.

Larkin, M. (1999). Can post-traumatic stress disorder be put on hold? *The Lancet*, as reported via Traumatic Stress list (September 18).

Larsen, R.J., Diener, E. & Cropanzano, R.A. (1987). Cognitive operations associated with individual differences in affect intensity. *Journal of Personality and Social Psychology*, 53, 767-774.

Laws, T. & Hawkins, C. (1995). Critical incident stress: a normal response to an abnormal situation. *Australian Nursing Journal*, 2(7), 32-32.

Layton, B. & Krikorian, R. (2002). Memory mechanisms in posttraumatic stress disorder. *Journal of Neuropsychiatry and Clinical Neuroscience*, 14(August), 254-261.

LeDoux, J.E. (1994). Emotion, memory, and the brain. *Scientific American*, 270, 50-57.

Lee, J.A. (1985). *Civilian into Soldier*. Auckland: Oxford University Press.

Lees-Haley, P. (1986). Pseudo post-traumatic stress disorder. *Trial Diplomacy*, Winter, 17-20.

Leff, J. & Trieman, N. (2000). Quality of Life improves for long-stay psychiatric patients discharged to community care. *British Journal of Psychiatry*, 176, 217-223.

Lembcke, J. (1998). *The Spitting Image: Myth, Memory and the Legacy of Vietnam*. New York: New York University Press.

Lewis, M.J. (2001). From Colonial Dependence to Independent Centre: Australian Psychiatry, 1788-1980. In D.Bhugra & Littlewood, B. (Eds), *Colonialism and Psychiatry* (pp. 105-130). Oxford: Oxford University Press.

Lieberman, A.F. (2004). Traumatic stress and quality of attachment: Reality and internalization in disorders of infant mental health. *Infant Mental Health Journal*, 25(4), 336-351.

Lifton, R.J. (1988). Understanding the Traumatized Self: Imagery, Symbolization, and Transformation. In J.P. Wilson, Harel, Z. & Kahana, B. (Eds), *Human Adaptation to Extreme Stress: From the Holocaust to Vietnam* (pp. 7-31). New York: Plenum Press.

Lindemann, E. (1944). Symptomatology and management of acute grief. *American Journal of Psychiatry*, 101, 141-148.

Lindemann, E. (Ed.). (1995a). *Crisis Intervention*. Northvale, New Jersey: Jason Aronson Inc.

Lindemann, E. (1995b). Reactions to one's fatal illness. In E. Lindemann (Ed.), *Crisis Intervention* (pp. 231-245). Northvale, New Jersey: Jason Aronson Inc.

Lindy, J. (1985). The trauma membrane and other clinical concepts derived from psychotherapeutic work with survivors of natural disasters. *Psychiatric Annals*, 15, 153-160.

Link, B.G., Phelan, J.C., Bresnahan, M., Stueve, A. & Pescosolido, B.A. (1999). Public conceptions of mental illness: labels, causes, dangerousness, and social distance. *American Journal of Public Health*, 89(9), 1328-1333.

Littlewood, R. (2001). Colonialism and Psychiatry. In D.L.Bhugra & Littlewood, R. (Eds), *Colonialism and Psychiatry* (pp. 1-14). Oxford: Oxford University Press.

Litz, B.T., Gray, M.J., Bryant, R.A. & Adler, A.B. (2002). Early intervention for trauma: current status and future directions. *Clinical Psychology: science and practice*, 9(2), 112-134.

Lockwood, S. (2004). "Evidence of me" in evidence based medicine? *British Medical Journal*, 329, 30 October, 1033-35.

Lovell, D. (2000). Re: The current status of psychological debriefing. *British Medical Journal*, 321(http://bmj.com/cgi/eletters).

Luparell, S. (2004). Faculty encounters with uncivil nursing students: An overview. *Journal of Professional Nursing*, 20(1), 59-67.

Macdonald, G. (1999). Social Work and its Evaluation: A Methodological Dilemma? In F. Williams, Popay, J. & Oakley, A. (Eds.), *Welfare Research: A Critical Review* (pp. 89-103). London: UCL Press.

Macdonald, N. (2003). Staff hurt by violent patients. *The Dominion Post*, pp. A6, 5.12.2003.

MacGibbon, L. (2003). *Power, knowledge and reflexivity: Learning 'from experience' in a women's refuge*. D.Phil thesis, Christchurch, University of Canterbury.

Mackay, C.J., Cousins, R., Kelly, P.J., Lee, S. & McCaig, R.H. (2004). 'Management Standards' and work-related stress in the UK: Policy background and science. *Work and Stress*, 18(2), 91-112.

Main, M. & Goldwyn, R. (1984). Predicting rejecting of her infant from mother's representation of her own experience: Implications for the abused-abusing intergenerational cycle. *Child Abuse and Neglect*, 8, 203-217.

Main, M. & Hesse, E. (1990). Parents' unresolved traumatic experiences are related to infant disorganised attachment status: Is frightened and/or frightening parental behaviour the linking mechanism? In M.T. Greenberg, Cicchetti, D. & Cummings, E. M. (Eds.), *Attachment in the Preschool Years: Theory, Research and Intervention*. Chicago: University of Chicago Press.

Mandell, M.P. (2000). A revised look at management in network structures. *Social Work Review*, 12(3), 6-12.

March, J.S. (1993). What constitutes a stressor? The "Criterion A" issue. In J.R.T.Davidson & Foa, E.B. (Eds). *Posttraumatic stress disorder: DSM-IV and beyond* (pp36-54). Washington, DC: American Psychiatric Press.

Marmar, C.D. (1998, March). Trauma and Dissociation. *Australasian Stress Points*, 4-6.

Marsella, A.J., Friedman, M.J., Gerrity, E.T. & Scurfield, R.M. (1996). *Ethnocultural Aspects of Posttraumatic Stress Disorder*. Washington DC: American Psychological Association.

Marshall, I. & Zohar, D. (1997). *Who's afraid of Schrödinger's Cat?* New York: William Morrow.

Marshall, R. A. (Ed.). (1975). *After a War*. Auckland: Longman.

Martin, J.L., Morris, K. & Romans, S.E. (1998). Participation in retrospective child sexual abuse research: beneficial or harmful? What women think six years later. In L. Williams & Banyard, V. (Eds), *Trauma and Memory* (pp. 149-159). Newbury Park, CA: Sage.

Maslach, C. (1987). Burnout Research in the Social Services: A Critique. In D.F.Gillespie (Ed.), *Burnout among Social Workers*. New York: Haworth Press.

Maslow, A.H. (1998). *Toward a psychology of being*. New York: John Wiley & Sons.

Mason, K.H. (1988). *Report of the committee of inquiry into procedures used in certain psychiatric hospitals in relation to admission, discharge or release on leave of certain classes of patients (Psychiatric Report 1988)*. Wellington: Ministry of Health.

Mason, K.H., Johnston, J. & Crowe, J. (1996). *Inquiry under section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services: report of the Ministerial Inquiry to the Minister of Health (Ministerial Inquiry)*. Wellington: Ministry of Health.

Masson, J.M. (1985). *The Assault on Truth: Freud's Suppression of the Seduction Theory*. New York: Penguin Books.

Masson, J.M. (2002). *Freud, Ferenczi & the Abandonment of Trauma*. Presentation at 9th annual ASTSS conference on Traumatic Stress.

Masten, A.S. & Best, K.M. (1990). Resilience and development: contributions from the study of children who overcame adversity. *Developmental Psychopathology*, 1990(2).

Mater, N. (1999). *Mehmed's Testimonies from the Conflict Region*. Paper presented at the Psychotraumatology, Clinical Practice and Human Rights, Istanbul, Turkey, June 1999.

Matsakis, A. (1994). *Post-Traumatic Stress Disorder: A Complete Treatment Guide*. Oakland, California: New Harbinger Publications.

Matthiesen, S.B. & Einarsen, S. (2004). Psychiatric distress and symptoms of PTSD among victims of bullying at work. *British Journal of Guidance & Counselling*, 32(3), 335-356.

Maturana, H. & Varela, F. (1980). *Autopoiesis and Cognition*. Dordrecht, Holland: D. Reidel.

Maturana, H. & Varela, F. (1987). *The Tree of Knowledge*. Boston: Shambhala.

Maunder, R.G. & Hunter, J.J. (2001). Attachment and psychosomatic medicine: Developmental contributions to stress and disease. *Psychosomatic Medicine*, 63, 556-567.

Mauthner, N. & Doucet, A. (1998). Reflections on a voice-centred relational method: Analysing maternal and domestic voices, in J.Ribbens & Edwards, R. (Eds), *Feminist dilemmas in qualitative research: Public knowledge and private lives.* Thousand Oaks, California, Sage.

Mayor, S. (2005). Psychological therapy is better than debriefing for PTSD. *British Medical Journal*, 330:689 (26 March).

McBeth, H. (1996). *Health Outcomes: Biological, social and economic perspectives.* New York: Oxford University Press.

McCammon, S.L. & Allison, E.J.Jr. (1995). Debriefing and treating emergency workers. In C.R.Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treated the traumatized* (pp. 115-130). New York: Brunner/Mazel.

McCann, I.L. & Pearlman, L.A. (1990a). *Psychological trauma and the adult survivor: Theory, therapy and transformation.* New York: Brunner/Mazel.

McCann, I.L. & Pearlman, L.A. (1990b). Vicarious Traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3(1), 131-149.

McCord, S. & Associates. (undated). http://stewartmccord.com, accessed 6.1.05.

McCullin, D. (1994). *Sleeping with Ghosts: a life's work in photography.* London: Jonathon Cape.

McFarlane, A.C. (1988). The longitudunal course of posttraumatic morbidity: the range of outcomes and their predictors. *Journal of Nervous Mental Disorders*, 176(1), 30-39.

McFarlane, A.C. (1990). An Australian disaster: the 1983 bushfires. *International Journal of Mental Health*, 19, 36-47.

McFarlane, A.C. (1992a). Avoidance and intrusion in posttraumatic stress disorder. *Journal of Nervous and Mental Disease*, 180, 258-262.

McFarlane, A.C. (1992b). Multiple diagnoses in posttraumatic stress disorder in the victims of a natural disaster. *Journal of Nervous and Mental Disorders*, 180, 498-504.

McFarlane, A.C. (1993). PTSD: Synthesis of research and clinical studies: the Australian Bushfire Disaster. In J. R. Wilson, B. (Ed.), *International Handbook of Traumatic Stress Syndromes.* New York: Plenum Press.

McFarlane, A.C. (1995). The Severity of the Trauma: Issues about its role in posttraumatic stress disorder. In R. Kleber, Figley, C.R. & Gersons, B.P.R. (Eds.), *Beyond Trauma: Cultural and Societal Dynamics* (pp. 31-54). New York: Plenum Press.

McFarlane, A.C. (2000). *The Compounding Psychological Effects of Trauma.* Paper presented at The Rehab Challenge: Working Together Beyond 2000, Sheraton Hotel, Auckland, 12.10.00.

McFarlane, A.C. (2000). On the social denial of trauma and the problem of knowing the past. In A.Y. Shalev, Yehuda, R. et al (Eds.), *International Handbook of human response to trauma* (pp. 11-26). New York: Kluwer Academic/Plenum Publishers.

McFarlane, A.C. & de Girolamo, G. (1996). The nature of traumatic stressors and the epidemiology of posttraumatic reactions. In B.A. van der Kolk, McFarlane, A.C. & Weisaeth, L. (Eds), *Traumatic Stress: The effects of overwhelming experience on mind, body and society* (pp. 1219-1154). New York: The Guilford Press.

McFarlane, A.C. & van der Kolk, B.A. (1996a). Conclusions and Future Directions. In B.A. van der Kolk, McFarlane, A.C. & Weisaeth, L. (Eds), *Traumatic Stress: The effects of overwhelming experience on mind, body and society.* New York: The Guilford Press.

McFarlane, A.C. & van der Kolk, B.A. (1996b). Trauma and its challenge to society. In B.A. van der Kolk, McFarlane, A.C. & Weisaeth, L. (Eds), *Traumatic Stress: The effects of overwhelming experience on mind, body and society* (pp. 24-46). New York: The Guilford Press.

McFarlane, A.C. & Yehuda, R. (1996). Resilience, vulnerability and the course of posttraumatic reactions. In B.A. van der Kolk, McFarlane, A.C. & Weisaeth, L. (Eds.), *Traumatic Stress: The effects of overwhelming experience on mind, body and society* (pp. 155-181). New York: The Guilford Press.

McHugh, S. (2001). *Critical Incident Stress Debriefing and Management: a review of the research and current practice*: Consultant report, private practitioner.

McKee, M. (2004). Not everything that counts can be counted; not everything that can be counted counts. *British Medical Journal*, 328:153.

McKinlay, J., Plumridge, L. & Daley, V. (1999). Methodology for studying health and society. In P.Davis & Dew, K. (Eds.), *Health and Society in Aotearoa/New Zealand* (pp. 35-49). Melbourne: Oxford University Press.

McLellan, D. (1995). *Ideology.* Milton Keynes: Open University Press.

McMillen, J.C. (1999). Better for it: how people benefit from adversity. *Social Work*, 44(5), 455-467.

McMillen, J.C. & Fisher, R.H. (1998). The Perceived Benefit Scales: measuring perceived positive life changes after negative events. *Social Work Research*, 22(3), 173-187.

McNally, R.J. (2004). Conceptual problems with the DSM-IV criteria for posttraumatic stress disorder. In G.M.Rosen (Ed). *Posttraumatic Stress Disorder: Issues and Controversies.* New York: John Wiley & Sons.

Mechanic, M.B. (2004). Beyond PTSD: Mental health consequences of violence against women - a response to Briere and Jordan. *Journal of Interpersonal Violence*, 19, 11, 1283-1289.

Meichenbaum, D. (1985). *Stress inoculation Training.* New York, Pergamon.

Meichenbaum, D. (1994). *A clinical handbook/practical therapist manual for assessing and treating adults with posttraumatic stress disorder.* Waterloo, Ontario: Institute Press.

Mental Health Commission (1997). *Blueprint for Mental Health Services in New Zealand: Working Document.* Wellington: Mental Health Commission.

Mental Health Commission (1998). *Blueprint for Mental Health Services in New Zealand: How things need to be.* Wellington: Mental Health Commission.

Mental Health Commission (1998). *Report of the Key Messages to the Mental Health Commission from the Hui held in February-April 1998.* Wellington: Mental Health Commission.

Mental Health Commission (2001). *Recovery Competencies for New Zealand Mental Health Workers.* Wellington: Mental Health Commission.

Meyer, C.H. (1995). The Ecosystems Perspective: Implications for Practice. In C.H.Meyer & Mattaini, M.A. (Eds), *The Foundations of Social Work Practice* (pp. 16-27). Washington DC: NASW Press.

Mezzina, R. (2000). *Deinstitutionalisation and Community: a possible restitution.* Building Bridges Conference, Auckland, 29-31 March.

Milgram, S. (1974). *Obedience to Authority.* New York: Harper Colophon.

Miller, J. (2003). Critical Incident Debriefing and Social Work: Expanding the Frame. Journal of *Social Service Research*, 30(2), 7-25.

Miller, K.I., Stiff. J.B. & Ellis, B.H. (1988). Communication and empathy as precursors to burnout among human service workers? *Communication Monographs*, 55: 250 - 265

Miller, N.R. (1998). *Client and caregiver opinion of the service provided by Tairawhiti Healthcare Community Mental Health Keyworkers.* Unpublished research report (unpublished) for MSW (Applied), Massey University, Palmerston North.

Ministry of Health (1997). *Mental Health in New Zealand from a Public Health Perspective.* Wellington, Ministry of Health.

Ministry of Health (2000). *Guidelines to the Mental Health Amendment Act 1999*. Wellington: Ministry of Health.

Minuchin, S., Lee, W-Y, & Simon, G.M. (1996). *Mastering family therapy: journeys of growth and transformation*. New York: John Wiley & Sons.

Miskiman, D. (1990). *The Impact of Critical Incident Stress upon Emergency Response Personnel*: presentation to the Psychologists' Association of Alberta conference, May 1990.

Mitchell, J.T. (1983). When disaster strikes: The critical incident stress debriefing process. *Journal of Emergency Medial Services*, 8, 36-39.

Mitchell, J.T. (1992). Protecting your people from critical incident stress. *Fire Chief*, 36(5), 61-67.

Mitchell, J.T. (1995a). Essentials of Critical Incident Stress Management. In G.S. Everly (Ed.), *Innovations in Disaster and Trauma Psychology, Volume One: Applications in emergency services and disaster response* (pp. 68-89). Ellicott City, Md: Chevron.

Mitchell, J.T. (1995b). *Keynote Address* : CRICIS '95, Auckland.

Mitchell, J.T. & Bray, G. (1990). *Emergency services stress*. Englewood Cliffs, NJ: Prentice-Hall.

Mitchell, J.T. & Dyregrov, A. (1993a). Traumatic stress in disaster workers and emergency personnel: Prevention and intervention. In J.P. Wilson & Raphael, B. (Eds), *International Handbook of Traumatic Stress Syndromes* (pp. 905-914). New York: Plenum Press.

Mitchell, J.T. & Everly, G.S. (1993b). *Critical Incident Stress Debriefing*. Baltimore: Chevron Publishing Co.

Mitchell, J.T. & Everly, G.S. (1995c). Critical Incident Stress Debriefing (CISD) and the prevention of work related traumatic stress among high risk occupational groups. In G.S. Everly & Lating, J.M. (Eds), *Psychotraumatology: Key papers and core concepts in post-traumatic stress* (pp. 267-280). New York: Plenum Press.

Mitchell, J.T. & Everly, G.S. (1996). *Critical Stress Debriefing: an operations manual for the prevention of traumatic stress among emergency services and disaster workers.* (2nd edition, revised ed.). Ellicott City: Chevron Publishing.

Mitchell, J.T. & Everly, G.S. (1997). The scientific evidence for critical incident stress management. *Journal of Emergency Medical Services*, 22(1), 86-93.

Mitchell, J.T. & Everly, G.S. (1998). Critical Incident Stress Management: A new era in crisis intervention. *Traumatic StressPoints*, 1998(Fall), 6-11.

Mitchell, J.T. & Everly, G.S. (2000). Critical Incident Stress Management and Critical Incident Stress Debriefings: Evolutions, effects and outcomes. In J. Wilson & Raphael, B. (Eds), *Psychological Debriefing: Theory, Practice and Evidence.* Cambridge: Cambridge University Press.

Morgan, C.A., Hazlett, G., Wang, S., Richardson, E.G., Schnurr, P. & Southwick, S.M. (2001). Symptoms of dissociation in humans experiencing acute, uncontrollable stress: a prospective investigation. *American Journal of Psychiatry*, 158(August), 1239-1247.

Morgan, D.L. (1988). *Focus groups as qualitative research.* London: Sage.

Morgan, D.L. & Spanish, M.T. (1984). Focus Groups: A new tool for qualitative research. *Qualitative Sociology*, 7(3), 253-270.

Morgan, J. (2002). *Social Support: A reflection on humanity.* New York: Baywood Publishing.

Morrison, T. (1993). *Staff Supervision in social care: An action learning approach.* Harlow, Essex: Longman.

Morrison, T. (1998). *Inter-agency collaboration and change: effects of interagency on management of risk and prognosis for change in dangerous family situations.* Paper presented at the ISPCAN, Auckland, NZ.

Morse, J.M. (1994). Designing funded Qualitative Research. In N.K. Lincoln & Denzin, Y.S. (Ed.), *Handbook of Qualitative Research* (pp. 220-235). Thousand Oaks, California: Sage.

Mosher, L.R. & Burti, L. (1994). *Community Mental Health: Summary of the treatment principles of the Montgomery County Department of Addictions, Victim and Mental Health Services.* New York: W.W.Norton & Co.

M'panji, J. (2001). *Interview with Kim Hill*, National Radio : National Radio.

Mullen, P. (1992). *Psychopathy.* Auckland: Progress in Forensic Psychiatry conference.

Mullen, P.E. (1996). The dangerousness of the mentally ill and the clinical assessment of risk. In W. Brookbanks (Ed.), *Psychiatry and the Law* (pp. 93-116). Wellington: Brooker's.

Muller, R.T., Hunter, J.E. & Stollak, G. (1995). The intergenerational transmission of corporal punishment: A comparison of social learning and temperament models. *Child Abuse and Neglect*, 19(11), 1323-1335.

Mulvey, E. (1994). Assessing the link between mental illness and violence. *Australian and New Zealand Journal of Psychiatry*, 31, 3-11.

Munford, R. (2003). And then there was social work. *New Zealand Sociology*, 18(1), 46-54.

Murray, G. & Snyder, J.C. (1991). When staff are assaulted. *Journal of Psychosocial Nursing*, 29, 24-29.

Nadeau, J.W. (2002). Family construction of meaning. In R.A.Neimeyer (Ed.), *Meaning Reconstruction and the Expression of Loss.* Washington DC: American Psychological Association.

Nakazawa, K., Quirk, M.C., Chitwood, R.A., Watanabe, M., Yeckel, M.F., Sun, L.D., Kato, A., Carr, C.A., Johnston, D., Wilson, M.A. & Tonegawa, S. (2002). Requirement for hippocampal CA3 NMDA receptors in associative memory recall, [html]. *Science.* http://www.sciencemag.org/scienceexpress/recent.shtml [3.6.2002].

Nash, M. (1993). The use of self in experiential learning for cross-cultural awareness: an exercise linking the personal with the professional. *Journal of Social Work Practice*, 7(1), 55-61.

National Institute of Mental Health (2001). *Research in response to terrorist acts against America*: Addendum to PA-91-04, 'Rapid Assessment Post-Impact of Disaster (RAPID) Research Grant Program'. Washington DC: National Institute of Mental Health.

Neisser, U. (1992). The development of consciousness and the acquisition of skill. In F.Kessel, Cole, P.M. & Johnson, D. (Ed.), *Self and consciousness: Multiple perspectives* (pp. 1-18). Hillsdale, New Jersey: Erlbaum.

Nemiah, J.C. & Sifneos, P.E. (1970) Affect and fantasy in patients with psychosomatic disorders. In O.W.Hill (ed). *Modern Trends in Psychosomatic Medicine.* Vol. 2. London: Butterworth.

Neumann, D.A. & Gamble, S.J. (1995). Issues in the professional development of psychotherapists: Countertransference and vicarious traumatisation in the new trauma therapist. *Psychotherapy*, 32, 341-347.

New Zealand's Children & Young Persons Service (undated). *Dealing with Aggressive and Abusive Behaviours: creating a safety culture for New Zealand's Children & Young Persons Service (project guidelines).* Christchurch: Risk Management Project, NZCYPS.

Newsroom (2002). *Student Nurses Complain of Bullying*, [internet]. newsmail@newsroom.co.nz, accessed 8.4.02.

Nijenhuis, E. (1999). *Language Development and the Evolution of Stress Modulation.* Paper presented at the Psychotraumatology, Clinical Practice and Human Rights, Istanbul, Turkey, 7.6.99.

Nijenhuis, E.R.S., Spinhiven, P., Van Dyck, R., & Van der Hart, O. & Vanderlinden, J. (1998). Degree of somatoform and psychological dissociation in dissociative disorders is correlated with reported trauma. *Journal of Traumatic Stress*, 11, 711-730.

NIMH Journal Editors (1998). *Consortium on Development and Psychopathology: Editorial Statement.* Traumatic Stress@LIST.APA.ORG: Traumatic stress list.

Noble, I. (2001). *Talking brings hope in Uganda.* BBC News Online, http://news.bbc.co.uk, accessed 11.10.01.

Norman, J. (2000). Constructive narrative in arresting the development of post-traumatic stress disorder. *Clinical Social Work Journal*, 28(3), 303-319.

North, C.S., Nixon, S.J., Shariat, S., Mallonee, S., McMillen, J.C., Spitznagel, E.L. & Smith, E.M. (1999). Psychiatric Disorders Among Survivors of the Oklahoma Bombing. *Journal of the American Medical Association*, 282(August 25), 755-762.

Noy, S. (2002). *Salmon's principle.* Traumatic Stress list.

Oakley, A. (1981). Interviewing Women: a contradiction in terms. In H.Roberts (Ed.), *Doing Feminist Research* . London: Routledge.

Oakley, A. (1993). *Essays on Women, Medicine and Health.* Edinburgh: Edinburgh University Press.

O'Brien, M. (1999). Changing economy, changing state, changing social work: the case of New Zealand. *International Perspectives on Social Work*, 1(1), 87-99.

O'Connor, S. (1994). 'Famine', from '*Universal Mother*' [track from 'Universal Mother' CD]. London: Ensign Records.

Oliver, J.E. (1993). Intergenerational transmission of child abuse: Rates, research and clinical implications. *American Journal of Psychiatry*, 150(9), 1315-1324.

Oliver, M. (1990). *Politics of Disablement.* London: Macmillan Education.

Oliver, M. (1992). Changing the social relations of research production? *Disability, Handicap and Society*, 7(2), 101-114.

Olsson, C.A., Bond, L., Burns, J.M., Vella-Brodrick, D.A. & Sawyer, S.M. (2003). Adolescent resilience: a concept analysis. *Journal of Adolescence*, 26(1), 1-11.

Opie, A. (1999). Knowledge-based teamwork. In P.Davis & Dew, K. (Eds.), *Health and Society in Aotearoa/New Zealand* (pp. 181-198). Melbourne: Oxford University Press.

Ormerod, J. (2002). Current research into the effectiveness of debriefing. In British Psychological Society Professional Practice Board Working Party (Ed.), *Psychological Debriefing* (pp. 8-17). Leicester: British Psychological Society.

Ørner, R. (1995). Intervention strategies for emergency response groups: a new conceptual framework. In S.E. Hobfall & de Vries, M.W. (Eds), *Extreme Stress and Communities: Impact and Intervention* (pp. 499-521). Netherlands: Kluwere Academic publishers.

Ott, K. & Henry, P. (1997). *Critical Incident Stress Management at Goulburn Correctional Centre.* Goulburn, NSW: NSW Department of Corrective Services.

Ozer, E.J. & Weiss, D.S. (2004). Who develops posttraumatic stress disorder? *Current Directions in Psychological Science*, 13(4), 169-172.

Paez, D., Basabe, N. & Gonzalez, J.L. (1997). Social processes and collective memory: A cross-cultural approach to remembering political events. In J.W.Pennebaker, Paez, D. & Rime, B. (Eds.), *Collective memory of political events* (pp. 147-174). Mahwah, NJ: Lawrence Erlbaum.

Page, G. (Ed.). (1983). *Shadows from Wire: Poems and photographs of Australians in the Great War.* Ringwood, Victoria: Penguin.

Papanikolaou, P.N., Churchill, R., Wahlbeck, K. & Ioannidis, J.P.A. (2004). Safety reporting in randomized trials of mental health interventions. *American Journal of Psychiatry*, 161, 1692-1697.

Paradiso, S., Johnson, D.L., Andreasen, N.C., O'Leary, D.S., Watkins, G.L., Ponto, L.L.B. & Hichwa, R.D. (1999). Cerebral blood flow changes associated with attribution of emotional valence to pleasant, unpleasant, and neutral visual stimuli in a PET study of normal subjects. *American Journal of Psychiatry*, 156(October), 1618-1629.

Parkinson, F. (1993). *Post-trauma stress.* London: Sheldon.

Parsons, S. & Armstrong, A. (2000). Psychiatric Power and Authority: A scientific and moral defence. In P. Barker & Stevenson, C. (Eds), *The Construction of Power and Authority in Psychiatry* (pp. 203-333). Oxford: Butterworth-Heinemann.

Parton, N. (1998). Risk, Liberalism and Child Welfare: the need to rediscover uncertainty and ambiguity. *British Journal of Social Work*, 28, 5-27.

Paton, D., Violanti, J.M. & Dunning, C. (2000). Posttrauma stress intervention: Pursuing the alternatives. In D.Paton, Violanti, J.M. & Dunning, C. (Eds.), *Posttraumatic stress intervention: Challenges, issues, and perspectives* (pp. 205-210). Springfield, Il: Charles C.Thomas.

Paton, D., Violanti, J.M. & Smith, L.M. (2002). Individual, group and organisational perspectives on resilience and growth. In D.Paton, Violanti, J.M. & Smith, L.M. (Eds.), *Promoting capabilities to manage posttraumatic stress: perspectives on resilience* (pp. 1-12). Springfield, Il.: Charles C.Thomas.

Patton, M.Q. (1990). *Qualitative Evaluation and Research Methods.* (2nd edition). Newbury Park: Sage.

Payne, M. (1997). *Modern Social Work Theory.* (2nd ed.). London: Macmillan Press.

Pearlman, L.A. & Saakvitne, K.W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatisation in psychotherapy with incest survivors.* New York: Norton.

Pearlman, L.A. & Saakvitne, K. W. (1996). *Transforming the Pain: A workbook on Vicarious Traumatization.* New York: Norton.

Pelcovitz, D., van der Kolk, B.A., Roth, S., Mandel, F., Kaplan, S. & Resick, P. (1997). Development of a criteria set and a structured interview for disorders of extreme stress (SIDES). *Journal of Traumatic Stress,* 10(1), 3-16.

Pennebaker, J.W. (1989). Confession, inhibition, and disease. *Advances in Experimental Psychology,* 22, 211-244.

Pennebaker, J.W. (1990). *Opening up: The healing power of confiding in others.* New York: Morrow.

Pennebaker, J.W. (1993). Putting stress into words: Health, linguistic, and therapeutic implications. *Behav. Res. Ther.,* 31(6), 539-548.

Pennebaker, J.W. (1995). *Emotion, Disclosure and Health.* Washington D.C.: American Psychological Association.

Pennebaker, J.W. & Beall, S.K. (1986). Confronting a traumatic event: Toward an understanding of inhibition and disease. *Journal of Abnormal Psychology,* 95, 274-281.

Pennebaker, J.W. & Susman, J.R. (1988). Disclosure of traumas and psychosomatic processes. *Social Science and Medicine,* 26(3), 327-332.

Perry, B.D. (1995). Childhood Trauma, the Neurobiology of Adaptation, and the 'Use-Dependent' Development of the Brain: How States Become Traits. *Infant Mental Health Journal,* 16(4).

Perry, B.D. (1997). Incubated in Terror: Neurodevelopmental factors in the 'Cycle of Violence'. In J. Osofsky (Ed.), Children, Youth and Violence (pp. 124-148). New York: Guilford Press.

Perry, B.D. & Pate, J.E. (1994). Neurodevelopment and the psychobiological roots of post-traumatic stress disorder. In L. F. Koziol & Stout, C.E. (Eds.), *The Neuropsychology of Mental Disorders: A Practical Guide.* Springfield: Charles C. Thomas.

Phelan, J., Link, B., Stueve, A. & Pescosolido, B. (2000). Public conceptions of mental illness in 1950 to 1996: has sophistication increased? Has stigma declined? *Journal of Health and Social Behaviour*, 41, 188-207.

Phillips, J. (1996). *A Man's Country? The Image of the Pakeha Male - A History*. (Revised edition). Auckland: Penguin.

Pickett, M., Brennan, A.M.W., Greenberg, H.S., Licht, L. & Worrell, J.D. (1994). Use of debriefing techniques to prevent compassion fatigue in research teams. *Nursing Research*, 43, 250-252.

Pihama, L. (1993). *Critical Theory, Tungia Te Ururua, Kia Tupu Whakaritorito Te Tupu o Te Harakeke: A Critical Analysis of Parents as First Teachers.* Auckland: Education Department, University of Auckland.

Pilger, J. (1986). *Heroes.* London: Pan Books.

Pitman, R.K., Sparr, L.F., Saunders, L.S. & McFarlane, A.C. (1996). Legal Issues in Posttraumatic Stress Disorder. In B.A. van der Kolk, McFarlane, A.C. & Weisaeth, L. (Ed.), *Traumatic Stress: The effects of overwhelming experience on mind, body and society* (pp. 378-397). New York: The Guilford Press.

Polakow-Suransky, S. (2003, accessed 12.12.03). *Sins of our Fathers.* Brown Alumni magazine online.

Pope, K.S. & Garcia-Peltoniemi, R.E. (1991). Responding to victims of torture: Clinical issues, professional responsibilities, and useful resources. *Professional Psychology: Research and Practice*, 22(4), 269-276.

Powell, A. & Davies, H.T.O. (2000). Qualitative research may be more appropriate. *British Medical Journal*, 322 (http://bmj.com/cgi/content/full/322/7291/928).

Powell, R.A. & Single, H.M.(1996). *Focus Groups. International Journal of Quality in Health Care*, 8, 5, 499-504.

Prasad, R. (1988). *Towards a theoretical framework in foster care: A framework for the management of and research into transitions in foster care.* King George, Virginia: American Foster Care Resources.

Priebe, S. & Turner, T. (2003). Reinstitutionalisation in mental health care. *British Medical Journal*, 326, 175-176.

Priebe, S., Badesconyi, A., Fioritti, A., Hansson, L., Killian, R., Torres-Gonzales, F., Turner, T. & Wiersma, D. (2005). Reinstitutionalisation in mental health care: comparison of data on service provision from six European countries. *British Medical Journal*, 300, 123-126.

Probst, T.M. & Brubaker, T.L. (2001). The effects of job insecurity on employee safety outcomes: cross-sectional and longitudinal explorations. *Journal of Occupational Health Psychology*, 6(2), 139-159.

Professional Practice Board Working Party.(2002). *Psychological Debriefing*. Leicester: British Psychological Society.

Pugmire, S. (1978). *The role of various specialists in the psychiatric hospital* : Internal memo from inservice training, Lake Alice Hospital, Wanganui Hospital Board.

Punch, M. (1994). Politics and Ethics in Qualitative Research. In N.K. Lincoln & Denzin, Y.S. (Ed.), *Handbook of Qualitative Research* (pp. 83-97). Thousand Oaks, California: Sage.

Purves, D.G. & Erwin, P.G. (2004). Post-traumatic stress and self-disclosure. *Journal of Psychology*, 138(1), 23-33.

Putnam, F.W. (1991). Dissociative phenomena. In A. Tasman & Goldfinger, S.M. (Eds.), *Review of Psychiatry* (Vol. 10, pp. 145-160). Washington, DC: American Psychiatric Press.

Putnam, F.W. (1997). *Dissociation in children and adolescents: A developmental perspective.* New York: Guilford.

Putnam, F.W. (2003). Ten-year research update review: Child Sexual Abuse. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42(3), 269-278.

Pynoos, R.S., Steinberg, A.M. & Goenjian, A. (1996). Traumatic Stress in Childhood and Adolescence: Recent developments and current controversies. In B.A. van der Kolk, McFarlane, A.C. & Weisaeth, L. (Ed.), *Traumatic Stress: The effects of overwhelming experience on mind, body and society* (pp. 331-358). New York: The Guilford Press.

Race, K.E., Hotch, D.F. & Parker, T. (1994). Rehabilitation program evaluation: use of focus groups to empower clients, *Evaluation Review*, 18, 6, 730-40.

Raftery, J. (1997a). Doing better than the media: ethical issues in trauma research. *Australasian Journal of Disaster and Trauma Studies*, 1997(2).

Raftery, J. (1997b). *From Neurasthenia to PTSD War and Traumatic Stress.* (Vol. 22). Palmerston North: Department of Psychology, Massey University.

Raphael, B. (1986). *When Disaster Strikes: a handbook for caring professions.* New York: Basic Books.

Raphael, B., Meldrum, L. & McFarlane, A. (1995). Does debriefing after psychological trauma work? *British Medical Journal*, 310, 1479-1480.

Raphael, B., Swan, P. & Martinek, N. (1998). Intergenerational aspects of trauma for Australian Aboriginal People. In Y.Danieli (Ed.), *International Handbook of Multigenerational Legacies of Trauma.* New York: Plenum Press.

Raphael, B. & Wilson, J.P. (2000). *Psychological Debriefing - theory, practice and evidence.* Cambridge: Cambridge University Press.

Raphael, B., Wilson, J., Meldrum, L. & McFarlane, A.C. (1996). Acute Preventive Interventions. In B.A. van der Kolk, McFarlane, A.C. & Weisaeth, L. (Eds), *Traumatic Stress: The effects of overwhelming experience on mind, body and society* (pp. 463-479). New York: The Guilford Press.

Rapp, C.A. (1993). Theory, principle and methods of the strengths model of case management. In M.Harris & Bergman, H. (Eds), *Case Management: theory and practice.* Washington DC: American Psychiatric Association.

Rapp, C.A. (1998). *The Strengths Model: case management with people suffering from severe and persistent mental illness.* New York: Oxford University Press.

Rapp, C.A. & Hanson, J. (1988). Towards a model social work curriculum for practice with the chronically mentally ill. *Community Mental Health Journal*, 24(4, Winter), 270-282.

Rauch, S.L., van der Kolk, B.A., Fisler, R.E., Alpert, N.M., Orr, S.P. Savage, C.R., Fischman, A.J., Jenike, M.A. & Pitman, R.K. (1996). A symptom provocation study of posttraumatic stress disorder using positron emission tomography and script-drive imagery. *Archives of General Psychiatry*, 53, 380-387.

Read, J., Perry, B.D., Moskowitz, A. & Connolly, J. (2001). The contribution of early traumatic events to schizophrenia in some patients: a traumagenic neurodevelopmental model. *Psychiatry: Interpersonal and biological processes*, 64, 319-345.

Read, J., Mosher, L. & Bentall, R. (Eds). (2004). *Models of Madness: psychological, social and biological approaches to schizophrenia.* London: Brunner-Routledge.

Ream, J.H. (1999). *A comprehensive critical incident stress management (CISM): programming a correctional system: it's more than dealing with workplace violence.* http://www.aaets.org/arts/art88.htm, accessed 25.9.2000.

Reid, F. & Hoffmann, D. (2000). *Long Night's Journey into Day [film].*

Remarque, E.M. (1929). *All Quiet on the Western Front. London*: Putnam & Co.

Resnick, H.S., Kilpatrick, D.G., Best, C.L. et al. (1992). Vulnerability stress factors in development of posttraumatic stress disorder. *Journal of Nervous & Mental Disorder* 180, 424-430.

Rey, L.D. (1996). What social workers need to know about client violence. *Families in Society*, 77(1), 33-39.

Reynolds, C. & Leininger, M. (1993). *Cultural care diversity and universality theory*. California: Sage.

Reynolds, V. (1998). *Therapeutic Work with Torture Survivors*. Address to Professional Issues Forum, Auckland Institute of Technology (Department of Psychotherapy and Applied Psychology). 19.11.98.

Richman, M. (1997). *The Port Arthur Incident: from a Critical Incident Stress Management Perspective*. Paper presented at the Trauma, Grief and Growth: finding a path to healing, Sydney, Australia.

Rine, B.A., Warsh, R. & Maluccio, A.N. (Eds). (1993). *Together again: family reunification in foster care*. Washington DC: Child Welfare League of America.

Rix, R. (2000). Trauma, science and the law: a brief history of trauma research and the social response. *Journal of Aggression, Maltreatment & Trauma*, 3(2), 1-47.

Robinson, R. (1989). Psychological debriefing: a review of psychological debriefings conducted by Melbourne critical incident stress debriefing team. *Ambulance World*, 23-31.

Robinson, R., Mitchell, J. & Murdoch, P. (1995a). The debate of psychological debriefings. *Australasian Journal of Emergency Care*, 17, 5-10.

Robinson, R. (1995b). *Trauma and critical incident stress management* (presenter's lecture notes).

Robinson, R. (1997). The Victorian Ambulance Crisis Counselling Unit - ten years on. *ACISA forum*, February 1997, 11-14.

Robinson, R. & Mitchell, J. (1993). Evaluation of psychological debriefing. *Journal of Traumatic Stress*, 6(3), 367-382.

Rogers, C. (1961). *On Becoming a Person: A Therapist's View of Psychotherapy*. London: Constable.

Rose, S. & Bisson, J. (1998). Brief early psychological interventions after trauma: a systematic review of the literature. *Journal of Traumatic Stress*, 11, 697-710.

Rose, S., Brewin, C., Andrews, B. & Kirk, M. (1999). A randomised controlled trial of individual psychological debriefing for victims of violent crime. *Psychological Medicine*, 29, 793-799.

Rose, D., Ford, R., Lindey, P., Gawith, L. and the KCW Mental Health Monitoring Users' Group. (1998). In Our Experience: *User-focused monitoring of mental health services in Kensington & Chelsea & Westminster Health Authority* . London: The Sainsbury Centre for Mental Health.

Rose, S. & Tehrani, N. (2002). History, methods and development of psychological debriefing. In British Psychological Society Professional Practice Board Working Party (Ed.), *Psychological Debriefing* (pp. 2-7). Leicester: British Psychological Society.

Rosenheck, R. A. (1986). Impact of post-traumatic stress disorder of World War II on the next generation. *Journal of Nervous and Mental Disease*, 174(6), 319-327.

Roth, S., Newman, E., Pelcovitz, D., van der Kolk, B. & Mandel, F.S. (1997). Complex PTSD in victims exposed to sexual and physical abuse: results from the DSM-IV field trial for Posttraumatic Stress Disorder. *Journal of Traumatic Stress*, 10, 539-555.

Rothschild, B. (2000). *The Body Remembers: the Psychophysiology of Trauma and Trauma Treatment.* New York: W.W.Norton.

Rothschild, B. (2002). *The mind and body of vicarious traumatization*: emailed article from author, 25.6.02.

Rotman, J. (2000). *Dayroom, Forensic Unit, Lake Alice Psychiatric Hospital, 2000.* Adam Art Gallery, www.vuw.ac.nz/adamartgal/. Accessed 21.5.05

Rowland-Klein, D. & Dunlop, R. (1998). The transmission of trauma across generations: identification with parental trauma in children of Holocaust survivors. *Australian and New Zealand Journal of Psychiatry*, 31, 358-369.

Roy-Byrne, P., Smith, W.R., Goldberg, J., Afari, N. & Buchwald, D. (2004). Post-traumatic stress disorder among patients with chronic pain and chronic fatigue. *Psychological Medicine*, 34(2, February), 363-368.

Rubin, A. & Babbie, E. (1997). *Research Methods for Social Work.* (3rd ed.). Pacific Grove, California: Brooks/Cole.

Rubonis, A. & Bickman, L. (1991). Psychological impairment in the wake of disaster: The disaster-psychopathology relationship. *Psychological Bulletin*, 109, 384-399.

Rutter, M. (1990). Psychosocial resilience and protective mechanisms. In A.S. Masten, Rolf, J., Cicchetti, D., Neuchterlein, K. & Weintraub, S. (Eds), *Risk and protective factors in the development of psychopathology* (pp. 181-214). New York: Cambridge University Press.

Ruzek, J. (1993). Professionals coping with vicarious trauma. *NCP Clinical Newsletter*, 3(2, Spring).

Rydstedt, L.W., Devereux, J. & Furnham, A.F. (2004). Are lay theories of work stress related to distress? A longitudunal study in the British workforce. *Work and Stress*, 18,3, 245-254.

Rynearson, E.K. (2001).*Retelling Violent Death.* Brunner Routledge, Philadelphia.

Saakvitne, K.W., Tennen, H. & Affleck, G. (1998). Exploring thriving in the context of clinical trauma theory: constructivist self development theory. *Journal of Social Issues*, 54(2), 279-300.

Sachdev, P. (2001). The impact of colonialism on the mental health of the New Zealand Maori: A historical and contemporary perspective. In D.Bhugra & Littlewood, R. (Eds.), *Colonialism and Psychiatry* (pp. 15-45). Oxford: Oxford University Press.

Sackett, D.L., Rosenberth, W.M., Jray, J., Haynes, R.B. & Richardson, W.S. (1996). Evidence based practice: what it is and what it isn't. *British Medical Journal*, 312(7023), 71-72.

Sainsbury Centre for Mental Health (2001). *The Capable Practitioner*. London: SCMH.

Saleebey, D. (2000). Power in the people: strengths and hope. *Advances in Social Work*, 1 (2), 127-136, Fall.

Salmon, T.W. (1918). *Care and Treatment of the Mental Diseases of War Neuroses (Shellshock) in the British Army*. New York: Report of the War Office Committee.

Salmon, T.W. (1919). The war neuroses and their lesson. *New York Journal of Medicine*, 59, 993-994.

Salmon, T.W. & Fenton, N. (1929). The Medical Department of the United States Army in the World War, Vol X, *Neuropsychiatry in the American Expeditionary Forces*, (Vol. 10). Washington DC.: U.S. Government Printing Office.

Salmond, P. (2002). Using language for empowerment and hope. *Social Work Now*, 22(August), 20-26.

Salovey, P. & Sluyter, D.J. (Eds). (1997). *Emotional Development and Emotional Intelligence: Educational Implications*. New York: BasicBooks.

Sanders, J., Munford, R. & Richards-Ward, L. (1999). *Barnados: Working Successfully with Families: Stage Three*. Palmerston North: The Child, Family and Research Centre.

Sapolsky, R.M. (1994). *Why Zebras don't get Ulcers: a guide to Stress, Stress-Related Diseases, and Coping*. New York: W.H.Freeman & Co.

Sarantakos, S. (1993). *Social Research*. South Melbourne: Macmillan Education Australia.

Sartorius, N. (2002). Iatrogenic stigma of mental illness. *British Medical Journal*, 324(22 June), 1470-1471.

Scheff, T.J. (1996). Labelling mental illness. In T. Heller, Reynolds, J., Gomm, R., Muston, R. & Pattison, S. (Eds), *Mental Health Matters: A reader* (pp. 64-69). Houndmills, Basingstoke: Macmillan.

Schon, D. (1991). *Educating the Reflective Practitioner.* Oxford: Jossey Bass.

Schooler, J.W. (1994). Seeking the Core: The issues and evidence surrounding recovered accounts of sexual trauma. *Consciousness and Cognition*, 3, 452-469.

Schwandt, T.A. (1994). Constructionist Interpretivist Approaches to Human Inquiry. In N.K. Denzin & Lincoln, Y.S. (Eds), *Handbook of Qualitative Research* (pp. 118-137). Thousand Oaks, California: Sage.

Schwartz, J.E., Pickering, T.G. & Landsbergis, P.A. (1996). Work-related stress and blood pressure: current theoretical models and considerations from a behavioral medicine perspective. *Journal of Occupational Health Psychology*, 1(3, July), 287-310.

Scott, M.J. & Stradling, S.G. (1994). Post-traumatic stress disorder without the trauma. *British Journal of Clinical Psychology*, 33(1), 71-74.

Scott, M.J. & Stradling, S.G. (1997). Client compliance with exposure treatments for posttraumatic stress disorder. *Journal of Traumatic Stress*, 10, 523-526.

Seligman, M. (1992). *Helplessness: On Development, Depression and Death.* New York: Freeman.

Seligman, M. (1995). The effectiveness of psychotherapy; The Consumer Reports study. *American Psychologist*, 50, 965-974.

Selye, H. (1982). History and present status of the stress concept. In L. Goldberger & Breznitz, S. (Eds), *Handbook of Stress: Theoretical and clinical aspects* (pp. 7-17). New York: The Free Press.

Sentinel Events Project Working Party (2001). *Toward Clinical Excellence: Learning from Experience (Working Party report).* Wellington: Ministry of Health.

Seymour, M. & Moore, S. (2000). *Effective Crisis Management: Worldwide Principles and Practice.* London: Cassell.

Sgroi, S. (1989). Stages of Recovery for Adult Survivors of Child Sexual Abuse. In S. Sgroi (Ed.), *Vulnerable Populations.* Lexington, MA: D.C.Heath.

Shalev, A.Y. (1994). Debriefing following traumatic exposure. In R.J.Ursano, McCaughey, B.G. & Fullerton, C.S. (Eds), *Individual and community responses to trauma and disaster: the structure of human chaos.* Cambridge: Cambridge University Press.

Shalev, A.Y. (1996). Stress versus Traumatic Stress: From acute homeostatic reactions to chronic psychopathology. In B.A. van der Kolk, McFarlane, A.C. & Weisaeth, L. (Eds.), *Traumatic Stress: The effects of overwhelming experience on mind, body and society* (pp. 77-101). New York: The Guilford Press.

Shalev, A.Y., Peri, T., Canetti, L. & Schreiber, S. (1996). Predictors of PTSD in injured trauma survivors: a prospective study. *American Journal of Psychiatry*, 153, 219-225.

Shapiro, F. (1995). *Eye movement desensitization and reprocessing: basic principles, protocols, and procedures*. New York: Guilford Press.

Shatan, C. (2001). Effects of war unfold in literature, art and the humanities throughout history. *Traumatic Stresspoints*, 15(1), http://www.istss.org/Pubs/TS/Winter01/ Winter01frame.htm.

Shay, J. (1994). *Achilles in Vietnam: Combat Trauma and the Undoing of Character*. New York: Simon & Schuster.

Sheehan, M., McCarthy, P., Barker, M. & Henderson, M. (2001). *A model for assessing the impacts and costs of workplace bullying*. Paper presented at the Standing Conference on Organisational Symbolism (SCOS), Trinity College, Dublin, 30 June-4 July 2001.

Showalter, E. (1997). *Hystories: Hysterical Epidemics and Modern Culture*. New York: Columbia University Press.

Silver, S. M. (1986). An inpatient program for post-traumatic stress disorder: Context as treatment. In C.R.Figley (Ed.), *Trauma and Its Wake, Volume 11: Post-Traumatic Stress Disorder; Theory, Research and Treatment*. New York: Brunner/Mazel.

Simpson, A., McKenna, B., Moskowitz, A., Skipworth, J. & Barry-Walsh, J. (2003). *Myth and Reality: the relationship between Mental Illness and Homicide in New Zealand* (research report). Auckland: Health Research Council.

Simpson, M. (1993). Bitter waters: effects on children of the stresses of unrest and oppression. In J.P. Wilson & Raphael, B. (Eds.), *International Handbook of Traumatic Stress Syndromes*. New York: Plenum Press.

Small, R., Lumley, J., Donohue, L., Potter, A. & Walderströ, U. (2000). Randomised controlled trial of midwife-led debriefing to reduce maternal depression after operative childbirth. *British Medical Journal*, 321, 1043-1047.

Smith, E.M. & North, C.S. (1993). Posttraumatic stress disorder in natural disasters and technological accidents. In J.P. Wilson & B. Raphael (Eds), *International Handbook of Traumatic Stress Syndromes* (pp. 405-419). New York: Plenum Press.

Smith, L.M. & Paton, D. (1997). A structural re-assessment of the Impact of Event Scale: the influence of occupational and cultural contexts. In G.Habermann (Ed.), *Looking back, moving forward: 50 years of New Zealand psychology* (pp. 240-251). Wellington: New Zealand Psychological Society.

Smith, L.T. (1991). Te rapunga i te ao marama (the search for the world of light): Maori perspectives on research in education. In J.Morss & Linzey, T. (Eds), *Growing Up - The Politics of Human Learning* (pp. 46-55). Auckland: Longman Paul.

Smith, L.T. (1999). *Decolonizing Methodologies: Research and Indigenous Peoples.* Dunedin: University of Otago Press.

Smith, M., McMahon, L. & Nursten, J. (2003). Social workers' experiences of fear. *British Journal of Social Work*, 33, 659-671.

Smith, R. (2001). Measuring the social impact of research. *British Medical Journal*, 323(8 September), 528.

Smith, R. (2003). Learning from indigenous people. *British Medical Journal*, 327(23 August).

Solomon, S.D. & Davidson, J.R.T. (1997). Trauma: prevalence, impairment, service use, and cost. *Journal of Clinical Psychiatry*, 58(9), 5-11.

Solomon, Z. & Benbenishti, R. (1986). The role of proximity, immediacy and expectancy in front-line treatment of combat stress reactions among Israeli CSR casualties. *American Journal of Psychiatry*, 143(5), 613-617.

Solomon, Z., Waysman, M., Avitzur, E. & Enoch, D. (1991). Psychiatric symptomatology among wives of soldiers following combat stress reaction: The role of the social network and marital relations. *Anxiety Research*, 4, 213-223.

Somervell, P.D., Manson, S.M. & Shore, J.H. (1995). Mental Illness Among American Indians and Alaska Natives. In I. Al-Issa (Ed.), *Handbook of Culture and Mental Illness: An International Perspective.* Madison, Connecticut: International Universities Press.

Southwick, S.M. & Yehuda, R. (1997). Situations of Threat. *NCPTSD Clinical Quarterly*, 7(4), reprinted article.

Spanos, N.P. (1994). Multiple identity enactments and multiple personality disorder: a sociocognitive perspective. *Psychological Bulletin*, 116(1), 143-165.

Spiegel, D., Koopman, C., Cardena, E. & Classen, C. (1996). Dissociative symptoms in the diagnosis of acute stress disorder. In L.K. Michelson & Ray, W.J. (Eds.), *Handbook of Dissociation* (pp. 367-380). New York: Plenum.

Staffwriter (2004, April) *PPTA News*, 25, 1.

Stamm, B.H. (1997). *Work-related Secondary Traumatic Stress*, [Internet]. National Center for PTSD.http://www.ncptsd.org/research/literature/treatment/secondary_PTSD.html, accessed 27.2.01.

Stamm, B.H. (2002). Measuring Compassion Satisfaction as well as Fatigue. In C.Figley (Ed), *Compassion Fatigue* , Brunner Routledge, New York.

Stanley, L. & Wise, S. (1990*). Feminist Praxis: Research, Theory and Epistemology in Feminist Sociology*. London: Routledge.

Stark, R. (2001). Work shy or work sick? *Guardian Unlimited*, http://society.guardian.co.uk/comment.story/0,7884,458080,458000.html, Monday, March 19 2001.

Steadman, H.J., Mulvey, E.P., Monahan, J., Robbins, P.C., Appelbaum, P.S., Grisso. T., Roth, L.H. & Silver, E. (1998). Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. *Archives of General Psychiatry*, 55(5), 393-401.

Stein, M.B., Walker, J.R. & Forde, D.R. (2000). Gender differences in susceptibility to posttraumatic stress disorder. *Behav Res Ther*, 38(6, June), 619-628.

Steinberg, A. (1989). Holocaust survivors and their children: a review of the clinical literature. In P.Marais & Rosenberg, A. (Eds), *Healing their Wounds: Psychotherapy with Holocaust Survivors and their Families* (pp. 23-45). New York: Praeger.

Stevens, L. (1993). Reflexivity: Recognising subjectivity in research. In D.Colquhuon & Kellehear, A. (Eds), *Health Research in Practice* (pp. 152-170). London: Chapman & Hall.

Stevenson, R.L. (1979). *The Strange Case of Dr. Jekyll and Mr. Hyde, and other stories.* Harmondsworth, Middlesex: Penguin.

Stewart, K. (2001). The evolution of Critical Incident Stress Management within secondary schools in Aotearoa New Zealand. *Social Work Review*, 8(2), 37-42.

Stewart, S.H., Mitchell, T.L., Wright, K.D. & Loba, P. (2004). The relations of PTSD symptoms to alcohol use and coping drinking in volunteers who responded to the Swissair Flight 111 airline disaster. *Journal of Anxiety Disorders*, 18(1), 51-68.

Stone, O. (Dir.) (1989). *Born on the Fourth of July* [film].

Straker, G. & the Sanctuaries Counselling Team (1987). *The continuous traumatic stress syndrome - the single therapeutic interview.* Psychology in Society, 8:46-79.

Straton, D. (1999). The trouble with PTSD. *Traumatology*, 5(1), Article 4.

Strenz, T. (1982). The Stockholm Syndrome. In F. Ochberg & Soskis, D. (Eds.), *The victims of terrorism* (Vol. 3, pp. 149-164). Boulder, CO: Westview.

Summerfield, D. (1995). Addressing Human Response to War and Atrocity: Major Challenges in Research and Practices and the Limitations of Western Psychiatric Models. In R.Kleber, Figley, C.R. & Gersons, B.P.R. (Eds.), *Beyond Trauma: Cultural and Societal Dynamics*. New York: Plenum Press.

Summerfield, D. & Hume, F. (1993). War and posttraumatic stress disorder: The question of social context. *Journal of Nervous and Mental Disease*, 181, 522.

Summerskill, B. (2002). *Bullying rife in Britain's 'caring' jobs.* The Observer, http://www.observer.co.uk/uk_news/story/0,6903,714188,714100.html, accessed 12.5.2002.

Sussman, S., Burton, D., Dent, C.W., Stacy, A.W. & Flay, B.R. (1991). Use of focus groups in developing an adolescent tobacco use cessation program: collective norm effects. *Journal of Applied Social Psychology*, 21(21), 1772-1282.

Swartz, L. (2000). *The Impact of Human Rights Violations on Victims, Survivors and Perpetrators - research for the South African Truth and Reconciliation Commission*: unpublished.

Swigonowski, M.E. (1994). The logic of feminist standpoint theory for social work research. *Social Work*, 39(4), 387-393.

Szasz, T. (1961). *The Myth of Mental Illness.* New York: Harper & Row.

Szmukler, G. (1999). Ethics in Community Psychiatry. *Australian and New Zealand Journal of Psychiatry*, 33, 328-338.

Tarrier, N. & Gregg, L. (2004). Suicide risk in civilian PTSD patients - Predictors of suicidal ideation, planning and attempts. *Social Psychiatry and Psychiatric Epidemiology*, 39(8), 655-661.

Taylor, A.J.W. (1996). Disaster and Victim Classification. In D.Paton & Long, N. (Eds), *Psychological Aspects of Disasters: Impact, Coping and Intervention* (pp. 26-39). Palmerston North: Dunmore Press.

Taylor, A.J.W. (1998). Brief Report on a Critical Incident Debriefing Assignment in the Cook Islands. *Australasian Traumatic Stress points*, March 1998, 9-10.

Taylor, A.J.W. (1999). Value Conflict Arising from a Disaster. *Australasian Journal of Disaster and Trauma Studies*, 2, from electronic source.

Taylor, A.J.W. & Frazer, D. (1982). The stress of post-disaster body handling and victim identification. *Journal of Human Stress*, 39, 19-40.

Taylor, S.E., Klein, L.C., Lewis, B.P., & Gruenewald, T. L., Gurung, R.A.R, & Updegraff, J.A. (2000). Biobehavioral Responses to Stress in Females: Tend-and-Befriend, Not Fight-or-Flight. *Psychological Review*, 107(3), 411-429.

Te Puni Kokiri. (1993). *Nga Ia o te Oranga Hinengaro Maori/The Trends in Maori Mental Health.* Wellington: Te Puni Kokiri.

Teariki, C. & Spoonley, P. (1992). *Te whakapakari te mana tangata: the politics and process of research for Maori* . Palmerston North: Massey University.

Tedeschi, R.G. (1999). Violence transformed: Posttraumatic growth in survivors and their societies. *Aggression and Violent Behavior*, 4, 319-341.

Tedeschi, R.G. & Calhoun, L.G. (1995). *Trauma and Transformation: Growing in the Aftermath of Suffering*. Thousand Oaks: Sage.

Tedeschi, R.G. & Calhoun, L.G. (1996). The Posttraumatic Growth Inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress*, 9, 455-471.

Tehrani, N. (2002). Psychological debriefing and commercial providers. In Professional Practice Board Working Party (Ed.), *Psychological Debriefing* (pp. 41-51). Leicester: British Psychological Society.

Tehrani, N. (2004). Bullying: a source of chronic post traumatic stress. *British Journal of Guidance & Counselling*, 32(3), 357-366.

Tehrani, N. & Westlake, R. (1994). Debriefing individuals affected by violence. *Counselling Psychology Quarterly*, 7(3), 251-259.

Teicher, M. H. (2000). Brain abnormalities common in survivors of childhood abuse. *Cerebrum*, 2, 50-67.

Terr, L.C. (1979). Children of Chowchilla: A study of psychic trauma. *Psychoanalytic Study of the Child*, 34, 552-623.

Terr, L.C. (1991). Childhood Traumas: An outline and overview. *American Journal of Psychiatry*, 148, 10-20.

Terr, L.C., Bloch, D.A., Beat, M.A., Hong Shi, M.S. & Metayer, S. (1999). Children's Symptoms in the Wake of Challenger: A Field Study of Distant-Traumatic Effects and an Outline of Related Symptoms. *American Journal of Psychiatry*, 156(October), 1536-1544.

The King's Fund Mental Health Inquiry (2003). *London's Mental Health.* London: The King's Fund.

Thompson, M. & Thompson, T. (1997). *Discrimination against people with experience of mental illness.* Wellington: Mental Health Commission.

Thompson, N., Stradling, S, Murphy, M. & O'Neill, P. (1996). Stress and Organisational Culture. *British Journal of Social Work,* 26(5), 647-665.

Thompson, R.A. (1993). Posttraumatic stress and posttraumatic loss debriefing: brief strategic intervention for survivors of sudden loss. *The School Counselor,* 41, 16-22.

Thorogood, N. (1992). What is the relevance of sociology for health promotion? In R. Bunton & Macdonald, G. (Eds), *Health promotion: Disciplines and diversity* (pp. 42-65). London: Routledge.

Thygesen, P., Hermann, K. & Willanger, R. (1970). Concentration camp survivors in Denmark: Persecution, disease, disability, compensation: A 23 year follow-up. *Danish Medical Bulletin,* 17, 65-108.

Tiet, Q.Q., Bird, H.R, Hoven, C.W., Wu, P., Moore, R. & Davies, M. (2001). Resilience in the face of maternal psychopathology and adverse life events. *Journal of Child and Family Studies,*10 (3), 347-365.

Tiihonen, J., Isohanni, M., Raesaenen, P., Koiranen, M. & Moring, J. (1997). Specific major mental disorders and criminality: a 26-year prospective study of the 1996 Northern Finland Birth Cohort. *American Journal of Psychiatry,* 154(6), 840-845.

Tomas, N. (2004). Trauma associated with land loss in Aotearoa (New Zealand). *Stress Points,* 4, March, 3-6.

Tomb, D.A. (1994). The phenomenology of post-traumatic stress disorder. *Psychiatric Clinic of North America,* 17(2), 237-250.

Tomm, K. (1990). A critique of the DSM. *Dulwich Centre Newsletter,* 3, 5-8.

Trauma Intervention Programs Inc (2001). *Emotional First Aid.* Trauma Intervention Programs: http://www.tipnational.org/emotion.html [22.3.01].

Trevillion, S. (2000). Social Work, Social Networks and Network Knowledge. *British Journal of Social Work,* 30, 505-517.

True, W.R., Rise, J., Eisen, S., Heath, A.C., Goldberg, J., Lyons, M. & Nowak, J. (1993). A twin study of genetic and environmental contributions to liability for posttraumatic stress symptoms. *Archives of General Psychiatry,* 50, 257-264.

van der Kolk, B.A. (1989). The compulsion to repeat the trauma: Re-enactment, revictimisation, and masochism. *Psychiatric clinics of North America: treatment of victims of sexual abuse*, 12, 389-411.

van der Kolk, B.A. (1996a). The Body Keeps the Score: Approaches to the Psychobiology of Posttraumatic Stress Disorder. In B.A. van der Kolk, McFarlane, A.C. & Weisaeth, L. (Eds), *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society* (pp. 214-241). New York: The Guilford Press.

van der Kolk, B.A. (1996b). The complexity of adaptation to trauma: self-regulation, stimulus discrimination, and characterological development. In B.A. van der Kolk, McFarlane, A.C. & Weisaeth, L. (Eds), *Traumatic Stress: The effects of overwhelming experience on mind, body and society* (pp. 182-213). New York: The Guilford Press.

van der Kolk, B.A. (1996c). Trauma and Memory. In B.A.van der Kolk, A.C. McFarlane & L.Weisaeth (Eds), *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body and Society* (pp. 279-302). New York: The Guilford Press.

van der Kolk, B.A. (2001). The Assessment and Treatment of Complex PTSD. In R. Yehuda (Ed.), *Traumatic Stress*. Washington DC: American Psychiatric Press.

van der Kolk, B.A., Burbridge, J.A. & Suzuki, J. (1997). The psychobiology of traumatic memory: Clinical implications of neuroimaging studies. *Annals New York Academy of Sciences*, 821, 99-113.

van der Kolk, B.A. & Fisler, R. (1995). Dissociation and the fragmentary nature of traumatic memories: Overview and exploratory study. *Journal of Traumatic Stress*, 8, 505-525.

van der Kolk, B.A. & Greenberg, M.S. (1987). The psychobiology of the trauma response: Hyperarousal, constriction, and addiction to traumatic reexposure. In B.A. van der Kolk (Ed.), *Psychological trauma*. Washington D.C: American Psychiatric Press.

van der Kolk, B.A. & McFarlane, A.C. (1996). The Black Hole of Trauma. In B.A. van der Kolk, McFarlane, A.C. & Weisaeth, L. (Eds.), *Traumatic Stress: The effects of overwhelming experience on mind, body and society* (pp. 3-23). New York: The Guilford Press.

van der Kolk, B.A., McFarlane, A.C. & van der Hart, O. (1996). A General Approach to Treatment of Posttraumatic Stress Disorder. In B.A. van der Kolk, McFarlane, A.C. & Weisaeth, L. (Ed.), *Traumatic Stress: The effects of overwhelming experience on mind, body and society* (pp. 417-440). New York: The Guilford Press.

van der Kolk, B.A., McFarlane, A.C. & Weisaeth, L. (Eds.). (1996). *Traumatic Stress: The effects of overwhelming experience on mind, body and society*. New York: The Guilford Press.

Tunnecliffe, M. (1995). The Support Process. *Emergency Support*, 1, 1 & 4, November.

Tunnecliffe, M. (1997). *How to facilitate a stress debriefing.* (Revised edition ed.). Western Australia: Bayside Books.

Tunnecliffe, M. (1998a). *Advanced Peer Support Workshop*: Emergency Support Network.

Tunnecliffe, M. (1998b). Are people still saying it doesn't work? *Emergency Support*, 4(2), 1.

Tunnecliffe, M. (1999). Leadership as a Variable in Stress Debriefing Success. *Emergency Support Network*, 5(2, June), 1.

Tunnecliffe, M. (2001). Emotional First-Aid: Suggestions for helping the emotionally distressed person in the aftermath of a crisis. *Emergency Support*, 7, 1, February.

Turia, T. (2000). *Speech to NZ Psychological Society Conference.* Paper presented at the NZ Psychological Society Annual Conference, Palmerston North.

Turner, S.W., McFarlane, A.C. & van der Kolk, B.A. (1996). The Therapeutic Environment and New Explorations in the Treatment of Posttraumatic Stress Disorder. In B.A. van der Kolk, McFarlane, A.C. & Weisaeth, L. (Eds.), *Traumatic Stress: The effects of overwhelming experience on mind, body and society* (pp. 537-558). New York: The Guilford Press.

Ungar, M. (2003). Qualitative contributions to resilience research. *Qualitative Social Work*, 2(1), 85-102.

Ursano, R.J., Grieger, T.A. & McCarroll, J.E. (1996). Prevention of Posttraumatic Stress: Consultation, Training, and Early Treatment. In B.A. van der Kolk, McFarlane, A.C. & Weisaeth, L. (Eds.), *Traumatic Stress: The effects of overwhelming experience on mind, body and society* (pp. 441-462). New York: The Guilford Press.

USA Today (1995). Company programs can prevent violence. *USA Today*, 124, 6-8.

Valent, P. (1999a). *Trauma and Fulfillment Therapy.* Philadelphia: Brunner/Mazel.

Valent, P. (1999b). Traumatology at the turn of the millennium. *Australasian Traumatic Stress Points*, December 1999, 2-4.

Valent, P. (2003). 2003 Farewell Tribute: the address by Dr Paul Valent. *Stress points (ASTSS newsletter)*, Summer 2003, 14-17.

van der Hart, O., van Dijke, A. & van Son, M. (2000). Somatoform dissociation in traumatized World War I combat soldiers: a neglected clinical heritage. *Journal of Trauma and Dissociation*, 1(4), 33-66.

van der Kolk, B.A., Pelcovitz, D., Roth, S., Mandel, F.S., McFarlane, A. & Herman, J.L. (1996). Dissociation, somatization, and affect dysregulation: the complexity of adaptation of trauma. *American Journal of Psychiatry*, 153, 83-93.

van der Kolk, B.A. & van der Hart, O. (1989). Pierre Janet and the breakdown of adaptation in psychological trauma. *American Journal of Psychiatry*, 146, 1530-1540.

van der Kolk, B.A. & van der Hart, O. (1991). The Intrusive Past: the flexibility of memory and the engraving of trauma. *American Imago*, 48(4), 425-454.

van der Kolk, B.A., van der Hart, O. & Marmar, C.A. (1996). Dissociation and Information Processing in Posttraumatic Stress Disorder. In B.A. van der Kolk, McFarlane, A.C. & Weisaeth, L. (Eds.), *Traumatic Stress: The effects of overwhelming experience on mind, body and society* (pp. 303-327). New York: The Guilford Press.

van der Kolk, B.A., Weisaeth, L. & van der Hart, O. (1996). History of Trauma in Psychiatry. In B.A. van der Kolk, McFarlane, A.C. & Weisaeth, L. (Eds), *Traumatic Stress: The effects of overwhelming experience on mind, body and society* (pp. 47-74). New York: The Guilford Press.

van Dijk, J. & Igreja, V. (1999). *Transcultural Aspects of Research on Post-Traumatic Stress Symptoms in Rural Areas in Mozambique.* Paper presented at the ESTSS Psychotraumatology, Clinical Practice and Human Rights conference, Istanbul.

Violanti, J.M. & Aron, F. (1995). Ranking police stressors. *Psychological Reports*, 75, 824-826.

Violanti, J.M., Paton, D. & Dunning, C. (Eds.). (2000). *Posttraumatic stress intervention: Challenges, issues, and perspectives.* Springfield, Il.: Charles C. Thomas.

Vlahov, D., Galea, S., Resnick, H., Ahern, J., Boscarino, J.A., Bucuvalas, M, Gold, J. & Kilpatrick, D. (2002). Increased use of cigarettes, alcohol and marijuana among Manhattan, New York, residents after the September 11th terrorist attacks. *American Journal of Epidemiology*, 155(11), 988-996.

Vogt, D. (2000). *The benefits of focus groups in stress and trauma research.* Traumatic StressPoints, 14(1), http://www.istss.org/Pubs/TS/Winter00.

von Bertalanffy, L. (1967). Ecology and general systems theory. In N.Demerath & Peterson, R.A. (Eds), *Systems change and conflict* (pp. 119-129). New York: Free Press.

von Bertalanffy, L. (1971). *General Systems Theory: Foundations, Development, Application.* London: Allen Lane.

von Känel, R., Miulls, P.J., Fainman, C. & Dimsdale, J.E. (2001). Effects of psychological stress and psychiatric disorders on blood coagulation and fibrinolysis. *Psychosomatic Medicine*, 63, 531-544.

Voss, M., Floderus, B. & Diderichsen, F. (2001). Physical, psychosocial, and organisational factors relative to sickness absence: a study based on Sweden Post. *Occupational and Environmental Medicine*, 58(March), 178-184.

Walker, E.A., Newman, E., Koss, M. & Bernstein, D. (1997). Does the study of victimization revictimize the victims? *General Hospital Psychiatry*, 19, 403-410.

Walker, L. (1979). *The battered woman*. New York: Harper & Row.

Walker, R. (1990). *Ka Whawhai Tonu Matou: Struggle without End*. Auckland: Penguin.

Walrond-Skinner, S. (1976). *Family Therapy: The treatment of natural systems*. London: Routledge & Kegan-Paul.

Warren, H. (1997). The hard end of community care: psychiatric patients and the community. In *Community Issues in New Zealand*, C. Bell (Ed). Palmerston North:Dunmore Press.

Weisaeth, L. & Eitinger, L. (1993). Post traumatic stress phenomena: Common themes across wars, disasters and traumatic events. In Wilson, J. & B.Raphael (Eds) (1993). *International Handbook of Traumatic Stress Syndromes*. New York: Plenum Press, pp69-77.

Weisenberg, M. S., J. Waysman, M., Solomon, Z. & Klingman, A. (1993). Coping of school-age children in the sealed room during SCUD missile bombardment and postwar stress reactions. *Journal of Consulting and Clinical Psychology*, 61, 462-467.

Weldon, F. (1995). *Splitting*. London: Flamingo.

Wells, P. (2001). *Long Loop Home*. Auckland: Vintage.

Wessely, S., Rose, S. & Bisson, J. (Eds). (1999). *A systematic review of brief psychological interventions ("debriefing") for the treatment of immediate trauma-related symptoms and the prevention of post traumatic stress disorder. (Vol. 4)*. Oxford: Update Software.

Western Management Consultants (1996). *The Medical Services Branch CISM evaluation report*. Edmonton, Alberta: Western Management Consultants.

White, M. & Epston, D. (1990). *Narrative Means to Therapeutic Ends*. New York: Norton.

Wiesenthal, S. (1997). *The Sunflower*. New York: Schocken.

Wilkinson, R.G. (1996). *Unhealthy Societies: the afflictions of inequality*. London: Routledge.

Williams, W.H. (1987). *Out of Sight Out of Mind.* Porirua: Porirua Hospital.

Williamson, S. (1999). The experience of trauma: working with refugees from Kosovo. *Australasian Traumatic Stress Points,* July, 5-6.

Wilson, J.P. & Lindy, J.D. (Eds.). (1994). *Countertransference in the treatment of PTSD.* New York: Guilford Press.

Wilson, J.R. & Raphael, B. (1993). *International Handbook of Traumatic Stress Syndromes.* New York: Plenum Press.

Witten-Hannah, C. (2001). Attachment and Trauma. *Social Work Now* (August 2001).

Working group on debriefing in the Netherlands (1999). *Summary of the Dutch conference on debriefing, May 26, 1999.* Doorn: Centre for Expertise and Research, Veterans Institute.

Wolin, S.J. & Wolin, S. (1993). *The Resilient Self.* New York: Villard Books.

World Health Organisation (1948). *Manual of the international statistical classification of diseases, injuries, and causes of death.* Geneva: World Health Organisation.

World Health Organisation (WHO) (1984). *Health Promotion: European Monographs in Health and Health Education, Research No.6.* Copenhagen: WHO.

World Health Organisation (WHO) (1992). *ICD-10: International statistical classification of diseases and related health problems.* (10th revision). Geneva: World Health Organisation.

Wortman, C.B. & Silver, R.C. (1992). Reconsidering assumptions about coping with loss: an overview of current research. In L. Montada, Filipp, S-H. & Lerner, M. (Ed.), *Life crises and experiences of loss in adulthood.* Hillsdale, New Jersey: Erlbaum.

Yapko, M. (1994). *Suggestions of Abuse: True and False Memories of Childhood Sexual Trauma.* New York: Simon & Schuster.

Yassen, J. (1995). Preventing Secondary Traumatic Stress Disorder. In C.Figley (Ed.), *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in those who treat the traumatized* (pp. 178-208). New York: Brunner/ Mazel.

Yehuda, R. (1999). Biological factors associated with susceptibility to posttraumatic stress disorder. *Canadian Journal of Psychiatry,* 44, 34-39.

Yehuda, R. & McFarlane, A.C. (1995). *Conflict between current knowledge about posttraumatic stress disorder and its original conceptual basis.* Trauma Information Pages. Available: http://www.trauma-[ages.com/yehuda95.htm [4.7.03].

Yehuda, R. & McFarlane, A.C. (1997). Introduction. In R.Yehuda & McFarlane, A.C. (Eds). *Psychobiology of posttraumatic stress disorder* (pp. xi-xv). New York: New York Academy of Sciences.

Yehuda, R., Schmeidler, J., Giller, E.L. & Siever, L.J. (1998a). Relationship between PTSD characteristics of Holocaust survivors and their adult offspring. *American Journal of Psychiatry*, 155, 841-843.

Yehuda, R., Schmeidler, J., Wainberg, M., Binder-Brynes, K. & Duvdevani, T. (1998b). Increased vulnerability to posttraumatic stress disorder in adult offspring of Holocaust survivors. *American Journal of Psychiatry*, 155, 1163-1172.

Yehuda, R., Steiner, A., Kahana, B., Binder-Brynes, K., Southwick, S.M., Zemelman, S. & Giller, E.L. (1997). Alexithymia in Holocaust survivors with and without PTSD. *Journal of Traumatic Stress*, 10(1), 93-100.

Young, A. (1995). *The Harmony of Illusions: Inventing Post-traumatic Stress Disorder.* Princeton, New Jersey: Princeton University Press.

Yule, W. (2001). Early intervention strategies with traumatised children, adolescents and families. *Advances in Mind-Body Medicine*, 17, 1-36.

Zaidi, L.Y. & Foy, D.W. (1994). Childhood abuse experiences and combat-related PTSD. *Journal of Traumatic Stress*, 7, 33-42.

Zemeckis, R. (dir) (1994). *Forrest Gump* [film].

Zohar, D. (1990). *The Quantum Self.* London: Bloomsbury.

Zohar, D. (1997). *Rewiring the Corporate Brain: using the new science to rethink how we structure and lead organisations.* San Francisco: Berrett-Koehler.

Zuckerman, M. (1999). *Vulnerability to Psychopathology: a biosocial model.* Washington, DC.: American Psychological Association.

Appendix 1: DSM-IV criteria for Posttraumatic Stress Disorder

DSM-IV: Diagnostic criteria for Posttraumatic Stress Disorder

American Psychiatric Association (1994: 427-429)
(References to children have been removed)

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 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 reexperienced 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, including those that occur on awakening or when intoxicated)
   (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
   (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent 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 that 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 (eg unable to have loving feelings)
   (7) sense of a foreshortened future (eg does not expect to have a career, marriage, children, or a normal lifespan)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
   (1) difficulty falling or staying asleep
   (2) irritability or outbursts of anger
   (3) difficulty concentrating
   (4) hypervigilance
   (5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.

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

[The diagnosis also differentiates between acute, chronic and delayed features of PTSD]

Appendix 2: DSM-IV criteria for Acute Stress Disorder

DSM-IV: Diagnostic criteria for Acute Stress Disorder

American Psychiatric Association (1994:431-432)

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 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. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:

(1) a subjective sense of numbing, detachment, or absence of emotional responsiveness

(2) a reduction in awareness of his or her surroundings (eg "being in a daze")

(3) derealization

(4) depersonalization

(5) dissociative amnesia (ie inability to recall an important aspect of the trauma)

C. The traumatic event is persistently reexperienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.

D. Marked avoidance of stimuli that arouse recollections of the trauma (eg thoughts, feelings, conversations, activities, places, people).

E. Marked symptoms of anxiety or increased arousal (eg difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.

G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.

H. The disturbance is not due to the direct physiological effects of a substance (eg a drug of abuse, a medication) or a general medical condition, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of a pre-existing Axis I or Axis II disorder.

Appendix 3: DESNOS proposed criteria

Disorders of extreme stress not otherwise specified (DESNOS): Proposed Criteria

van der Kolk (1996:203)

A: Alterations in regulating affective arousal
1. chronic affect dysregulation
2. difficulty modulating anger
3. self-destructive and suicidal behaviour
4. difficulty modulating sexual involvement
5. impulsive and risk-taking behaviours

B: Alterations in attention and consciousness
1. amnesia
2. dissociation

C: Somatisation

D: Chronic characterological changes
1. alterations in self-perception: chronic guilt and shame; feelings of self-blame, of ineffectiveness, and of being permanently damaged
2. alterations in perception of perpetrator: adopting distorted beliefs and idealising the perpetrator
3. alterations in relations with others:
    a) an inability to trust or maintain relationships with others
    b) a tendency to be revictimised
    c) a tendency to victimise others

E: Alterations in systems of meaning
1. despair and hopelessness
2. loss of previously sustaining beliefs

Appendix 4: Terms employed to describe secondary stress

Literature in regard to the effects of secondary exposure variously describes its processes as **countertransference**, **secondary** or **vicarious traumatisation**, **compassion fatigue** and **burnout**. Stamm (1997) has produced a review of the terms and definitions, charting the recognition of work-related trauma from the 1980s onwards; the psychotherapeutic notion of countertransference predates this and has origins in psychoanalysis.

Countertransference refers to a distortion of the therapeutic relationship on the part of the therapist. Figley and Kleber (1995) comment that it is used more generally to include all conscious and unconscious feelings or attitudes that a therapist has toward a client. Countertransference tends to focus on the personal and individual responses within therapy and can be applied to contexts other than the traumatic. It is a state condition, tied in to a therapist's response to the person and material of an individual case, as opposed to processes that influence the general beliefs of a therapist (Figley & Kleber, 1995; Stamm, 1997). Whilst initially used to capture the psychological sequalae of working with traumatised individuals (Wilson & Lindy, 1994), it is a term usually construed as something that stems from the actions of the client and this may not always be the case in trauma work. Countertransference has the negative connotation of something that good ethical practice can avoid, whereas secondary traumatic stress may be a natural part of the engagement process. It remains relevant to use in situations where there is a specific response under consideration, such as where exposure to another person's experience triggers a link to a personal memory.

Figley (1989) first used the term '**compassion fatigue**' in relation to PTSD, Joinson (1972, cited in www.codt.org/dictionary). He developed the notion further by distinguishing between primary, secondary and tertiary traumatic stress disorders (in Stamm, 1997). Primary in this context refers to those directly impacted upon by a traumatic event, that is, the victim. Secondary in this context refers to the disorders experienced by the supporters or helpers of these

primary PTSD victims, and the tertiary disorder refers to the supporters helping the supporters (for instance, Richman, 1997). This introduces an ecological aspect to the definition and opens up discussion of workplace contexts and incidents. Taylor employs a similar model (Taylor & Frazer, 1982; Taylor, 1996). Used broadly, however, the term does not relate specifically to trauma reactions and is, despite Figley's original intentions, often allied with the concept of burnout in the literature. Often used within a therapeutic framework, the term assumes that some moderation of pace is in the control of the therapist. In emergency or crisis work there may be no chance at personal moderation or intentional behaviour because of the circumstances of the event, and compassion fatigue as a concept appears to be limited in its application to such systemic and structural issues. For this reason, I do not tend to use the term here, although its generic description is usefully counterbalanced by the term 'compassion satisfaction' (Stamm, 2002).

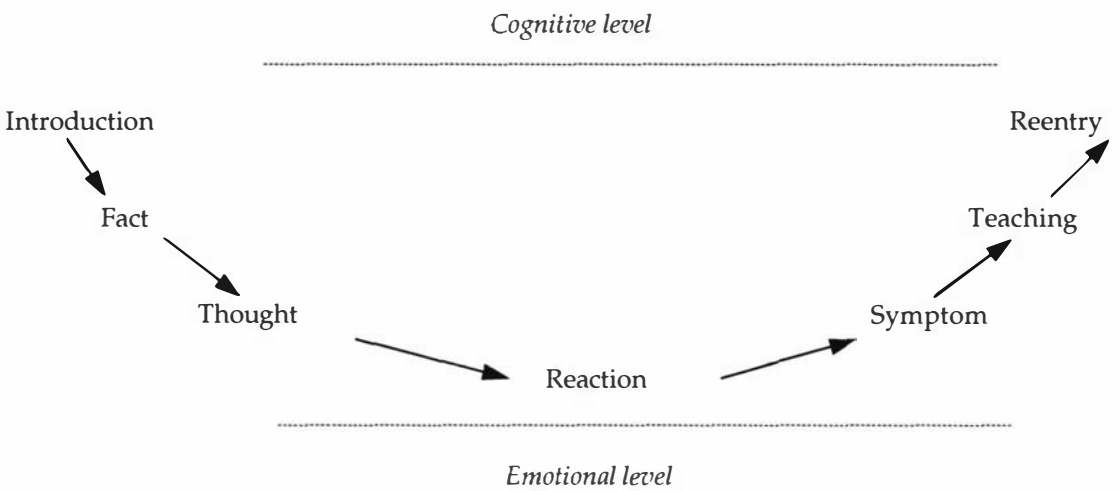
'**Burnout**' is used to describe the response to institutional stresses and high levels of work (for example, Maslach, 1987). Gentry regards burnout as a by-product of primary and secondary traumatic stress and defines it as a chronic condition where perceived demands outweigh perceived resources (Compassion Fatigue Internet list, 9.9.04). Burnout suggests that a person provides so much support that they become exhausted, in the sense of energy depletion. The notion of depletion accounts for the reason why these effects often take time to develop (Figley & Kleber, 1995).

Vicarious traumatisation describes changes in one's identity and worldview, similar to those explored as affecting primary victims of trauma (McCann & Pearlman, 1990; Neumann & Gamble, 1995; Pearlman & Saakvitne, 1995; Pearlman & Saakvitne, 1996; Rothschild, 2002; Ruzek, 1993). The need for counter measures to include the importance of balance, the use of external resources, self-acceptance and connection, and the need to foster one's sense of meaning, interdependence and hope is stressed. McCann and Pearlman (1990) also suggest that working with victims may lead to an enhanced empathy for the suffering of people and a deeper sense of connection to others.

Stamm (1997) concludes that agreement for the term for traumatic reactions resulting from exposure to the experiences of others incurred whilst in a professional or helping role, has yet to emerge into consensus in the literature. In this thesis, I tend to use the term 'secondary' in terms of the traumatic stress reactions or traumatisation that occurs, as it appears to best reflect ecological principles (Berah, Jones & Valent, 1984; Figley and Kleber, 1995; Kassam-Adams, 1995; Pope & Garcia-Peltoniemi, 1991; Yassen,1995).

Appendix 5: Critical Incident Stress Debriefing

Critical Incident Stress Debriefing: the seven stage process



1. Introductory Phase
   Rules of the session are established, purpose of the debriefing, the process it will take, the importance of confidentiality is emphasised.
2. Fact Phase
   Each person has the opportunity to recall what has happened and his/her involvement, describe what was heard, seen, smelt and done during the incident.
3. Thought Phase
   Participants are asked to recall their first thoughts about the incident when they were able to move out of automatic pilot.
4. Reaction Phase
   Participants are encouraged to express how they felt during the incident and how they are feeling now. Also, if this brings up past unresolved feelings.
5. Symptom Phase
   Participants are asked about the symptoms they are experiencing now and perceived unusual experiences at the time of and/or since the incident.
6. Teaching Phase
   Participants are given information regarding the signs and symptoms of stress, the normal reactions they can expect to experience to such an abnormal event.
7. Reentry Phase
   The leaders draw together the above information, answer questions, provide regarding counselling and practical resources for participants, reinforce the normality of the stress reaction and the confidentiality of the session.

Text from CISD training, Auckland, 1995

Appendix 6: Massey University Ethics Committee Application

MASSEY UNIVERSITY

APPLICATION TO HUMAN ETHICS COMMITTEE

APPLICANT:	Carole Adamson
STATUS OF APPLICANT:	Lecturer at Massey University; part-time PhD candidate
SCHOOL:	School of Social Policy and Social Work
PROJECT STATUS:	PhD Research Thesis
FUNDING SOURCES:	MURF award
NAME OF SUPERVISORS:	Dr Robyn Munford Dr Kay Fielden
TITLE OF PROJECT:	Staff support systems for traumatic events in the Mental Health service
ATTACHMENTS:	a) interview schedule b) informed consent form c) information sheet for participants d) interview evaluation form for pilot e) letter to Clinical Leaders

DESCRIPTION OF PROJECT:

a) Justification

This Ethics Committee application pertains to a pilot project only, which is designed to test the appropriateness of interview questions prior to an Ethics application for a full research project. This two part process is deemed essential because of the potential for re-traumatisation of participants and the need to sensitively construct appropriate questions within a semi-structured interview framework. A full Ethics application will be based upon evaluation and refinement of this pilot interview schedule.

The purpose of this research is to explore the range of available coping mechanisms and support systems that are appropriate to a mental health setting when staff are faced with traumatic events and critical incidents.

Intrinsic to the nature of mental health service delivery is the experience of actual and threatened acts of violence such as assault, sudden death and self-harm. In themselves, these incidents have the power to traumatise those involved or witnessing them. The varied roles that mental health professionals adopt, and the environments in which they work, will add to the impact of these events on staff. Furthermore, the nature of the human interaction involved in mental health provides an embedded awareness and experience of stress, the origins of which stem from a matrix of personal, professional and organisational dynamics. The thesis seeks to explore the experience of participants in relation to the interaction of cumulative and acute stress reactions. It is to be focussed towards gaining an understanding of the coping mechanisms (both formal and informal) adopted, and towards the construction of a transtheoretical model of intervention that is suited to the mental health environment.

Understanding of traumatic and acute stress within the workplace has produced a range of organisational responses within the Emergency Services and health and welfare organisations. Internationally and within the Auckland environment the models of intervention (eg Employee Assistance Programmes; Critical Incident Stress Debriefing) have typically emerged out of a knowledge base designed for use within the emergency services (eg fire; ambulance; disaster workers). Much literature owes its existence to studies of military personnel and post-traumatic stress disorder. It has been suggested that the health and welfare environment, characterised by a multi-professional, multi-site service delivery, provides a different environment in which to provide support in the event of traumatic events. This project seeks to explore the characteristics of the mental health service environment and to consider coping mechanisms and support interventions that are cognisant of the known effects of traumatic stress as well as appropriate to the shape of the workplace.

b) Objectives

The project, in its full and pilot stages, is designed as qualitative research geared at exploring the meaning of traumatic events for the participant, and to consider participants' own coping strategies as well as formal interventions offered and utilised.

This pilot project is solely geared to the interviews with mental health personnel who have personally experienced a traumatic event, as it is this group for whom there is the greatest need for sensitivity in the face of the potential for re-traumatisation. It specifically seeks to explore the appropriateness, flow, length and sensitivities inherent within the semi-structured interview questions and schedule. The full project, subject to a future Ethics Committee application, will also seek to interview management and facilitators of responses to traumatic events,

This process not only serves as an aid to establishing the authenticity of questions but assists in the establishment of the validity of the research by consulting with professionals outside of the chosen geographical area of study.

c) Procedure for recruiting participants and obtaining informed consent

It is proposed that a pilot interview schedule be tested with staff from the mental health services in the Waikato and Manawatu-Wanganui areas. These sites have been chosen

i) because of the researcher's close professional links with key service personnel in these health areas, and the researcher's knowledge of the environmental and organisational characteristics of the services,

ii) because these sites are distinct from the chosen area of final research within Auckland.

Researcher links with these service personnel are historical rather than current, so no conflict of interest is envisaged. Participants will be recruited through personal contact and subsequent written requests to key clinical leaders within these mental health services [see attachment (e)]. These clinical leaders will then approach service personnel through their own organisational processes, and request that if interested in participating, staff should then make contact directly with the researcher. Participants will then be formally approached by letter and follow-up telephone call prior to interview.

d) Procedures in which research participants will be involved

Research participants in this pilot study will be asked to participate in a semi-structured interview [see attached schedule of questions] that explores their recollection of a traumatic event that has affected them in their workplace, and the coping mechanisms (personal, professional and organisational; formal and informal) that they have adopted in their recovery process.

Participants will also be requested to provide verbal and written feedback regarding the interview process and content, with a view to refining the research design for the full research project [see attached evaluation form].

e) Procedures for handling information and materials produced

It is proposed that the interviews for this pilot study will be audio-taped, for the purposes of considering

i) the appropriate content of questions in the light of participant response and feedback

ii) the appropriate interview process (introduction of research subject matter, order of questions, interviewer style, setting etc)

iii) sensitivity, potential for re-traumatisation, and personal and organisational options for support.

iv) operational issues such as quality of sound recording, strategies for transcription etc.

No actual transcriptions will result from this pilot process, although should pertinent comments be considered as potential material for contribution to the main study, participants will have their permission sought by the researcher. Retention and use of these comments will be subject to permission being granted. Participants will have the right to have audio-tapes returned to them following review by the researcher; otherwise tapes will be held by the researcher, will be stored in a secure place and erased following completion of the study.

ETHICAL CONCERNS

a) Access to participants

Access to participants will be obtained through agreement with participants and their line management. Interviews will be conducted in the participants' own time: the researcher will be the only other party. Support systems within these organisations will have been ascertained prior to interview.

b) Informed consent

The participants will have been approached through their clinical and/or professional line manager, after prior contact between manager and researcher. Professional and organisational consent runs in parallel with personal informed consent. A verbal and written explanation of the research project, and a copy of the consent form will be provided prior to meeting. The potential for raised stress levels or re-traumatisation will be acknowledged and information regarding the availability for any required personal assistance within the employing organisation will be included. The pilot nature of the research project will be emphasised, as will the request for evaluative feedback of the interview process. A spirit of collaboration will be emphasised, and interviewees will receive acknowledgement of their

contribution to the research design by receipt of a final draft of the interview schedule.

c) Confidentiality
Researcher-participant confidentiality will be highlighted given the personal nature of the required responses. Participants' responses will not be disclosed to a third party or to their employing organisation. No participant will be named at any stage of the study. Privacy and anonymity are therefore fully acknowledged and addressed. Information remains with the researcher and will not be used for purposes other than contributing to the knowledge base of the project. Whilst the prime purpose of this pilot study is as an aid to questionnaire design, participants will be alerted to the potential use of material within the full body of the thesis. Participants at this point will be asked to review the material proposed for use and will be able to request removal of identifying features that may affect the confidentiality and anonymity of their contribution.

It is also acknowledged that confidentiality applies to any client/consumer information disclosed to the researcher during the course of the interviews. Material utilised for the pilot and full interviews will be screened for identifiable client information by both participant and researcher.

d) Potential harm to participants and researcher
The nature of the research question makes this an important area for consideration. Minimisation of harm is of paramount importance. Prior understanding of the support systems within the pertinent organisation will be gained and made available to the participants within the information sheet, and verbally acknowledged in the interview process. The importance of the interviewer/researcher skills in the interview process is acknowledged, alongside the participants' right to withdraw from the process at any time. No feedback will be provided to other parties.

The researcher at all times will be aware of the sensitivity of any material emerging in the interview, and the opportunities located within the interview for either a process of either re-traumatisation or resolution.

Researcher health and safety is also of consideration; personal and professional support systems (counselling supports; focus groups) are in place.

e) Participants' right to decline
Participation in this pilot study is a voluntary and collaborative process. The right to decline, prior to or during the interview, is emphasised in both the written consent form and in the spoken introduction to the interview. Participants will be able to decline participation or use of their material until the final writing phase of the research project.

f) Arrangements for participants to receive information
Prior information will be disseminated as above. Audio tapes will be returned on request to the participants, or will be stored in a secure place until completion of the project. Feedback regarding the interview process and final form of the interview schedule will be provided to participants alongside an acknowledgement of their contribution to the research.

g) Use of the information
Participants will be informed of the full collaborative purpose of this pilot study, ie information is primarily to be used for the researcher to further refine the interview questions, and potentially in the research project findings, subject to participants' consent, review of material and right to decline.

h) Conflicts of interest
There are no anticipated conflicts of interest as any professional relationship between participants and researcher is of a historical nature, and not current.

i) Other ethical concerns
The researcher is aware of the social and personal sensitivity of the research.

CULTURAL CONCERNS

This research is conducted from within a western, kawanatanga paradigm of research and participants in both pilot and full research studies work in 'mainstream' mental health services. However the method, methodology and theoretical perspectives of this research are based within ecological paradigms that require the researcher to take into account the perspectives of cultures other than my own. In addition, the location of workers within organisations is in itself of cultural importance, given the research interest in exploration of the interface between cumulative and acute experiences of stress; staff from cultural groups other than the dominant pakeha group have a unique position in relation to coping mechanisms, and the research will be open to consideration of these dimensions.

LEGAL ISSUES

a) Copyright
There are no issues of copyright in this study.

b) Ownership of data or materials produced
Participants in this pilot study will have final ownership of the audiotapes, which will be either returned to them or erased at a three month point after the interview. Knowledge gained from the interview and evaluation process will contribute to the refinement of the final interview format.

c) Any other legal issues relevant to the research

There are no other legal issues apparent in this proposal. Participants are to be advised that this interview process is geared to the exploration of coping mechanisms after traumatic events and that information of an operational nature, especially that with a potential for future litigation, should not be addressed.

APPLICATION TO OTHER ETHICAL COMMITTEES:

Application to the Ethics Committee of the Health Funding Authority, and again to the Massey University Human Ethics Committee, will be made for the full research project, subsequent to the analysis of this pilot project.

Massey University

Office of the Principal
Massey University
Albany Campus
Private Bag 102 904,
North Shore MSC,
Auckland,
New Zealand
Principal: 64 9 443 9799 ext 9517
Campus Registrar: 64 9 443 9799 ext 9516
Facsimile: 64 9 414 0814

20 June 2000

Carole Adamson
C/O School of Social Policy & Social Work
Massey University
Albany

Dear Carole

HUMAN ETHICS APPROVAL APPLICATION – MUAHEC 00/015
STAFF SUPPORT SYSTEMS IN THE MENTAL HEALTH SERVICE

Thank you for your amended application details, which we recently received and have been placed on our files.

The amendments you have made now meet the requirements of the Massey University, Albany Campus, Human Ethics Committee and the ethics of your application, therefore, are approved.

Yours sincerely

Dr Mike O'Brien
CHAIRPERSON,
MASSEY UNIVERSITY, ALBANY CAMPUS
HUMAN ETHICS COMMITTEE

Appendix 7: Information Sheet for participants

INFORMATION SHEET FOR PARTICIPANTS

STAFF SUPPORT SYSTEMS FOR TRAUMATIC EVENTS

IN MENTAL HEALTH

Researcher: Carole Adamson

I am a lecturer in Social Work at Massey University engaged in doctoral research in this subject. I am supervised by Professor Robyn Munford, Massey University, Palmerston North, and Associate Professor Mike O'Brien, Massey University, Albany.

Contact details: School of Social and Cultural Studies
Massey University Albany
PO Box 102-904
North Shore Mail Centre
Auckland

ph 09-443-9700 ext 9081
fax 09-441-8162
email <C.E.Adamson@massey.ac.nz>

Supervisors' contact phone numbers:
Professor Munford: 09-443-9700 ext 2825
Assoc. Professor O'Brien: 09-441-8161

Research details: This research is the fieldwork for my doctoral thesis.

The purpose of the research is to consider what happens when staff are faced with traumatic events and critical incidents within the course of their work in mental health organisations, and in particular, what helps people cope. The goal of the research is to design the models of intervention best suited to the mental health environment.

Traumatic events are incidents that lie outside of the range of usual experience within mental health employment which have the potential to have a powerful impact on any person's normal coping abilities and thus to cause severe stress reactions.

The study seeks to explore the experience of participants in relation to the interaction of cumulative and acute stress reactions. It is to be focused towards gaining an understanding of

the coping mechanisms (both formal and informal) adopted, and towards the construction of a transtheoretical model of intervention that is suited to the mental health environment.

What participants are asked to do: Participants are to be interviewed by the researcher regarding their own experience of a traumatic event or critical incident in their mental health work environment. The interviews are semi-structured, with a series of general questions aimed at an open exploration of the research question.

It is envisaged as a collaborative research enterprise in which participants will be asked to provide feedback.

A focus group of practitioners and academics from within the traumatic stress and critical incident fields will assist this study with its theoretical and conceptual material: focus group members will not have access to material gained from these individual interviews.

Recording: It is proposed that these interviews will be audio-taped. Full transcripts of the interviews will be made. Tapes, written comments and evaluative feedback will be kept in a secure location, in a locked cabinet in my office. Tapes and transcripts of the interviews will be returned to the participant on request, or erased/destroyed at the end of the study at the time of the final draft.

Participants have a right:

- to decline to participate in an interview at any time prior to or during the interview
- to refuse to answer any particular question
- to ask any questions about the study at any time during participation
- to withdraw material for research use at any time prior to final drafting of the research
- to terminate the tape recording of the interview at any time during the interview
- to provide information on the understanding that the participant's name will not be used unless explicit permission is given to the researcher
- to be given access to a summary of the findings of the study when it is concluded

Sensitivity of the interview material: Any discussion of the impact of a traumatic event or critical incident has the power to re-evoke feelings and memories associated with the experience. Whilst a reconsideration of the experience may offer the chance for further understanding and healing, it is acknowledged that there is a potential for retraumatisation and distress. The researcher has sought information regarding the formal support systems in place within the organisation for whom the participants work: participants are encouraged to be aware of their personal support systems. The researcher has had experience and training in critical incident stress debriefing and is highly aware of the sensitivities inherent in the interview process.

Confidentiality and anonymity: The researcher undertakes to preserve the confidentiality of the participants. No participant will be named at any stage of the study, and all personal details, audio tapes and consent forms will be kept in a secure place. No information will be disclosed to a third party or to the employing organisation. Anonymity is advantaged by the use of more than one site for interview purposes. Material related to client information will be similarly safeguarded and strenuously protected. Participants will have the opportunity to review any recorded or written information prior to its use.

Legal concerns: The purpose of the interview is to gain information and assistance about the subject of coping mechanisms and responses to traumatic events. Participants are advised that any operational matters likely to be subject to legal or organisational investigation are neither necessary nor are to be discussed.

Time involved: It is envisaged that the interview and evaluation process will last no more than two hours.

Appendix 8: Focus Groups

The following describes the purpose of the two focus groups.

The abstract for the therapist focus group was announced in the ATSSS network as:

> "My doctoral research has concerned the issue of support systems for mental health workers involved in critical incidents and traumatic events in the workplace. What has emerged is a sense that the recovery or post incident context environment makes a crucial difference in the ability of a person to work through and make sense of what has happened. What then becomes of key importance is how the impact of trauma - the impact of which is initially involuntary and arguably physiologically-based - can be mediated by the surrounding influences. What, exactly, is the relationship between trauma and context?
>
> I would invite a discussion with the trauma community to discuss some of these issues. In particular, I am keen to hear practitioner views about the emphasis that can be placed on either the physiological reactions (arousal, avoidance etc) or on the emergent principles from other levels, such as workplace environment, communication patterns, support systems and culture.
>
> I am also keen to explore the question: If some traumatisation occurs to a group of people (eg a cultural group or a workplace team) and some (but maybe not all) of them experience posttraumatic symptoms, what is the role of individual versus collective responses (or treatments or interventions)?"

Appendix 9: Interview Questions

Interview Questions

Identify your professional identity and/or employment status
Role and training - eg social work, community support worker, nurse

In what sort of mental health environment do you work?
Inpatient/community/forensic etc
Interactions with other staff members - group, multi-disciplinary, formal and informal contacts, whether they work alone or in a team etc

Job satisfaction
Important factors about being in the job - what motivates people and keeps them going.

Could you define a traumatic event or critical incident? Personal understanding of the sort of events that can challenge coping responses

Did your training (pre-entry, post-entry) or appointment process have much content about traumatic events, safety and personal wellbeing?

How much did your training and selection prepare you for cumulative stress, dangers of burnout etc?

What do you know about the concept of secondary traumatisation or compassion fatigue?

Could you tell me about your own experience of a traumatic event/critical incident?
- what was the work environment like at the time?
- what happened?
- how did you feel?
- what happened afterwards?

What helped you cope? where did you find these resources?
- personal
- family/friends
- colleagues/peers
- organisational systems - management, supervisors, team leaders, EAP, counsellors, CISD team etc

What have you learned from this incident?
- Has it changed your perception of the job in any way?
- Has it changed your perception of other things in life?

Are there other comments that you would like to make?

Appendix 10: Critical Incident Narratives

Narrative One:

I was working [...] on the [...] team, doing what was relatively routine; drop offs and medication for somebody. We went round there and [the consumer] wasn't home, but she'd left a message with her flatmate saying 'no, I really want [the medication] but can you [...] bring it back later, I really need it, that would be great, thanks'.

So that was fine and we went and did our other duties and on our way back to the office quite late at night, we dropped by her flat and I was taking another call from the pager, so I was actually on the phone and [the other nurse] who I was working with went to the flat to drop off the night medication, and came back and said 'the flatmates say, 'she's come home and said not to worry about it' and I just got off the phone at that stage and he said 'well, what will we do?' It just didn't quite add up because she was quite... I don't know, it didn't add up.

There's these funny things about confidentiality, like how much did the flat mates know or not know, the clients, the practising doctor and how much do you say to the flatmates, whatever. Just saying that we would insist on seeing her anyway and we had to insist that we were allowed into their house but try not to tell them why. [...] We weren't sure [about the confidentiality issue] either, but ... something just didn't seem right and she wouldn't answer the door and the flatmates were saying 'at the moment she's asleep, maybe you should go'. This didn't seem right, so we just went in anyway, which is really kind of gruff, going uninvited into a bedroom, you're not meant to, it's sort of a bit over the top. And she was in her bed and she said 'I really don't want to see you, I'm fine, I'm gonna sleep now, thanks, but I'm fine'.

We put the light on and she seemed quite comfortable in bed and I pulled the covers back and she was lying in a pool of arterial blood, it just missed me. I'm really squeamish about blood, I don't know why I pulled the covers back, I don't know why, and I hate blood, it makes me... It was just so awful, she was just soaked in it, soaked in blood and it smelt and it was wet and it was pumping and this was completely unexpected

and we just looked at each other. I was sitting on this side of her bed, pulling the bed covers back and I knew that I had to do something, patch it or, which is what I wanted to do, but I couldn't move.

And I said 'call an ambulance'. He said 'oh, what's the number? Which is it?' At the same time I was thinking, I've got to hold onto this, I don't want to touch it and I stood up and I looked around her room until I found a T-shirt, 'cos I couldn't touch it, I just couldn't. I found a T-shirt and kind of wrapped my hand in it and plugged it. And he was saying 'I'm on the cell phone, do I dial? Just dial 111 or do you have to dial [area code] 111?' [...] it was just the shock of things, so I said 'I think you dial 111'. I don't know what else we're gonna do and she's saying 'I'm all right, just leave me alone'.

It took for ages and we had to tell her flatmates what was happening 'cos you know there was gonna be sirens and stuff, and ... they came running in, saying 'oh she's going into shock, this is happening and that's happening' and using all these sort of... obviously avoiding 'blood'. 'Oh we need to do this, we need to do that, oh let's get, let's take her out of all of these bloody clothes', which seemed quite reasonable. While I was holding her, they started undressing her, she'd actually cut holes in herself that weren't really obvious, I mean realistically, I should have know that more of that blood couldn't have come from just the hole she had cut in her arm. But she had cut holes in herself all up her arm, like 1cm x 1cm x 2cm so it was just awful.

What more do you want? [*and continues without prompting*]

It was all pretty gross. The ambulance came and took her away, flatmates all cracked up, didn't know what to do. I began in super efficient mode and disposed of every last bit of bloody property except for the mattress 'cos they couldn't fit it into any wheelie bins. Leaving the flatmates my name and address [...], if anyone had any problems, they could discuss it with me, [...] - and all that blood in the house...

Q: and then you left the house?

Yeah, to do all the other bits and pieces. We were on afternoon shift so we finished off our work. She went to a hospital and [we] did everything we had to do for anyone that had done any sort of self harm and went back to work, did some notes and finished up the evening and then I was on a day shift the next day and I went to work.

The triage nurse likes to give hand over to everyone and I worked my way through those things that had happened over the weekend. They got to that particular client, I just started, and I thought I was all right and I realised I couldn't continue and [...] I said and, and, and I couldn't keep going, which sort of horrified everyone else 'cos they don't see me being emotional in any way. My voice was kind of shaky and I just couldn't describe it but [my colleague] also was on a day shift that day [so they finished the handover].

... It was a shitty night at work but it kept haunting me. I kept seeing...

Q: it was the visual bit?

Yeah, I mean, even now.

Psychiatric nurse, community

Narrative Two:

... a patient who was in a dissociated state was strangling me and that ended up really quite freaking me out. I don't think we knew she had a knife on her at the time [...]. She'd become quite paranoid and we were aware that she'd thought that one of the chaps over there was one of the people who'd abused her (and he wasn't). And she'd verbally abused him so she was brought over to the clinic and I'd actually got someone else in with me, specifically because of the concern about violence, but when we went into the room together, the door actually catches, you couldn't take it from the outside, so in fact I was locked in the room with her.

She had assumed another ego and ... I don't have very good recollection of the events but basically the blazing eyes and that's what I recall, and [...] I'd obviously done one of my surf life-saving manoeuvres, [...] got her against the wall and then there was this awful situation where [the nurse] was outside knocking all the doors, trying to get in. I was trying to turn around and open the door while keeping [the patient] who kept doing that up against the wall. I'd ended up with red marks around my neck, and what I remember is her here [*gestures in front of their face*], her eyes up against the wall and me trying to open [the door]. So I assume that we got out and that it was all right.

Yeah, you're stuck, yeah, and the silly thing is I'd arranged for someone to be there. And then I think that I ended up being part of transporting her to hospital. That's another one - we were going along the motorway and I was in the back and she kept on trying to reach forward and strangle the driver.

Psychiatrist

Narrative Three:

What it felt like was when my husband, in the really violent times [when he] was drinking, it was just like he'd come home at 5.30, but if he never got home at 5.30, is he going to be violent? is he going to be angry? ... And it's like the unknown, and I can remember, if he came home after the normal time, if we'd eaten we'd get in trouble because we'd eaten without him, if we hadn't eaten I'd get into trouble because I hadn't fed the kids and it was past their dinner time. If we'd eaten and dishes weren't done, we'd get into trouble for that, and it was like no matter what we did nothing was right, but I remember in those days always trying to make it right, I worked hard [...]. I remember one night in particular, I probably did it a thousand times, I don't know, but just knowing we'd tided up, all the dishes were done, everything was done and we were relaxed watching TV, and then I thought the kids need to have their showers ready for bed, so got them all having their showers and in their jamies, and then sitting there thinking, 'Oh, we've done that, we've made it' and then thinking he's probably expecting us all to be in bed, so getting everyone to go to bed, especially my older ones moaning and making them go to bed, and then getting into bed myself thinking, and I could really [breathes a big sigh] 'We've made it!', and then thinking 'What if he comes home?' and decides we shouldn't be in bed and getting them all up again, and I did that about three or four times until my son who's always been a bit like that 'I'm not doing that, I'm watching my programme on TV', and me getting really upset because he always spoilt it. But I know that's crazy behaviour and I know it was crazy now, but that's just how I was feeling at that time. So it was like when we were all back there.

Support worker, residential

Narrative Three (a):

I couldn't think, and I really wanted someone to take charge somehow. And then I went home, they actually asked me if I was alright to go home, and when I got home I got really frightened, I was worse than when I was here. [...] I wasn't sure

if the guy actually knew where I lived or not, I'm not sure if he'd ever been on a van trip to my home.

I couldn't think about it, but I know I was just really frightened when I was at home. My daughter and I live there and I just told her I was really frightened about being there. She is the person that doesn't think anyone is going to burgle our house, no-one is going to steal from you [or] attack you, she'd lived in [place] all her life and she said that most of the people that go around and are violent are ones she knows anyway, so they wouldn't hit her, so that's her attitude really.

But she actually must have picked up my panic or my fear because she said 'Well, what can we do then?' Firstly she said 'Well, do you want to go somewhere and I'll stay here?' and I said 'No because I just feel that he's the type of person that, he may be after me, but if he can't get me he'll take someone else out'. So I went and stayed at my cousin's place out in [another part of town] and was fine, I mean we had dinner and we chatted and watched TV and that and went to bed. And then I couldn't sleep, and I was really frightened then, I was too scared to go to the toilet.

Q: Your mind was imagining things?

Yes, that he'd know where I was, and I was trying to work that out, but he might. And I've actually got three cats and then I got really really frightened for my cats, that if he knows where my home was, he'd go there and he'd find my cats and he would harm my cats. And my cats are pretty old, so you can't just pick them up and take them off somewhere, one's had a stroke and is frightened of her own shadow, and just doesn't like any changes to anything. And so we had to go home and feed the cats and play with them every day, which was really scary, and then go off again.

Q: Sort of like a CAT team? Sorry!! [55]

Yes, and I know my daughter said she would feed them, but I was frightened of her going on her own, and just everything was really scary, everything, I didn't know where he was or where he wasn't and I tried to find out and no-one knew.

Q: So it was out of control in that sense?

Yes, and I felt that nobody cared, I really did, because no-one knew and when I was asking 'where is he living? Where is he?'

[55] My comment here reflects the degree of rapport that the respondent and I had established. 'CAT' teams (Crisis and Assessment Teams) are known for their crisis focus and mobility.

No-one seemed to know and no-one seemed to care, that's how I felt about it. I actually asked, after the first night, I just couldn't stop crying, so I rang and asked if they had arranged for me to have time with Occhealth, I need to do something, I need to talk to someone about it.

My son came [and] stayed with me, I never drove a car, I never went anywhere on my own at all, never stayed home on my own. I've lived on my own for a while, and I'd just drive myself anywhere, everywhere go, do whatever I liked, and that had all gone. Even going to Occhealth I had two of my kids taking me there and waiting for me, but I felt quite secure at Occhealth, but it was taking me and leaving me. The doctor at Occhealth gave me some sleeping pills and I was too frightened to take them, so I didn't take those either.

Q: Too frightened because of what might happen while you were asleep?

Yes, so it was like a catch-22. I really don't know [what else might help] other than meeting with him and that could have been quite disastrous, it still may be, I don't know, but I couldn't think of anything else, even today I can't think of anything.

Support worker, residential

Narrative Three (b):

I suppose I've got a big disappointment, in that to me the Maori way of doing it as well hasn't happened and I'm working [in a Maori environment] and I feel like everyone's forgotten it happened. No one has asked me, 'do I ever think about? Does it ever come up? Am I okay with it?'

They actually told me I could stay off 'til I felt OK, but [...] after about three weeks they said, 'When are you coming back?' and I came back [...] part-time. We [...] have staff meetings, and I suppose I am free to bring it up at anytime, and I think that I haven't because I don't want it to be brushed aside. [...] I don't want someone saying 'Oh that happened months ago!'

[I] was told 'Oh well, he's threatened other people and nothing's happened', and I was saying 'But, you know, for me that doesn't feel good enough'. I really felt [...] that nobody was taking me seriously.

Support worker, residential

Narrative Four:

I was taking a [...] relaxation group, [...] and different people come to the group, it's not closed or anything. But this particular day this man came to join the group. He'd been to the group once before [...]. But on this particular day he decided to come into the group and that was fine, but through the group he exposed himself to me, which was a difficult situation to deal with. It was traumatic because I felt personally offended and furious and angry and quite frightened thinking about how to deal with it. I mean, he was lying down, but my fear was that if I'd confronted it, it could have escalated, and I also had a feeling that somehow I had to keep the group safe as well.

There were seven consumers in the room, all lying down, all very vulnerable [...], particularly with their eyes closed. And it just happened and it was horrible, I really felt very trapped, because I mean my head was doing this multi-layered thing: what am I going to do, my breathing was going and I was feeling frightened and trying to avoid the escalation of the situation. Trying to make sure that my voice stayed steady while I gave myself thinking time, knowing that I couldn't stop reading the script because people would open their eyes for a start and so I felt very much a prisoner. And the way I dealt with it was okay, while I was thinking about how to deal with it, and by that time, a period probably of about five or ten minutes, I don't know, because time changes....

Occupational therapist

Narrative Four (a):

... and a couple of weeks later I happened to bump into this bloke again in his car. I was walking up a drive and he was there and I was alone, and it was a deserted driveway and I was walking past... that was dead dodgy. And I carried on and when I returned to my car he hurled some verbal abuse at me, told me I deserved 'fucking death' was what he said, which was horrible. Yeah, and I told him then that I was going to report him to the police and got in my car and he was further down the driveway with his car, which made me anxious to drive for a couple of days. It made me worry about what would happen, because I live in the same area, so it really worried me about what was going to happen to my husband and children. I felt very scared. I got his number plate and his car colour and stuff, and I gave that to the police, but I don't think anything happened, because I told them to get in touch and they haven't, so he's still out there somewhere. I'm still aware now of looking for the car...

I [...] think about where I am, because I'm a smoker, you see, and because I smoke often when I'm out visiting, I like to just go to a park and smoke, but that's not safe.

Occupational therapist, community

Narrative Four (b):

The manager wasn't there that day so I couldn't speak to her... So I spoke to the manager [elsewhere], came back here, spoke to a couple of colleagues and then I went home that evening and spoke to my husband. Came back the next day, [...] the manager wasn't there again. Because I was in a dilemma about whether to take it to the police or what, [...] I went to the EAP to help seek some clarity on that, and as a result of that discussion, I went to the police [...]. And then that was on Friday, so it kind of dragged on and on [...] and then on Monday I had to go and see the manager and [the offender is] in transit, so he has a key worker but they're not here. I also have no access to any Hazard Sheet, so I have no access to any past history, like verbal violence, or threat... I did make contact the following week with his key worker in the [other region] team, and they said they were going to fax me through information on his Hazard Sheet, but they didn't. The police were going to contact the key worker in the other area, but had difficulty and both the police and the other team said they had difficulty connecting with phone calls, so it was hard to believe who was telling the truth, and so in that sense it felt very loopy.

Occupational therapist, community

Narrative Five:

The incident that probably has been the most difficult for me [...] was a suicide on my caseload, shortly after I started, of a young woman who was on my caseload and she was missing for a period of time before she was found, probably for a week. So I guess it was a prolonged kind of experience in terms of not knowing for a while and then knowing at the end of the week. I was the key worker, there would have probably been about ten to fifteen people on my team at that time. So there was also a doctor assigned to her, but he wasn't here at the time she killed herself, and there was a registrar who had seen her last, [but] was no other one person who was also going through it at the same time. [...] she was reported missing, so there was kind of a week's lead-up, and I think people were really pretty blasé about that and there wasn't a lot of support. And at the end of the time when she was found, she'd hung herself and she was

found in a park, then the more systems-oriented things kicked into place.

Social worker, community

Narrative Five (a):

It's still really vivid - it was at [holiday] time, so there were days off and I was home alone a lot of the time and there was really intense anxiety and feeling really sick, real negative thoughts, in terms of catastrophising what eventually happened and all the sort of traditional 'what have I done wrong?' kinds of thoughts. It was a constant sense of anxiety about the likely outcome and probably feeling scattered and unorganised and feeling sick a lot of the time. It's almost like a pre-critical incident, isn't it? I did a lot of assurance seeking as well, in terms of my partner, which we know never works anyway. And then coming back to work and she still hadn't been found at that point and I actually heard about the incident on the news in the morning, you hear 'a body has been found ...' and I was actually the one who phoned the police to say, 'listen, I think I know who it is'. They fingerprinted [her] and thank goodness a fingerprint matched and then they informed the family, so I actually was the first person to know.

They were able to inform the family within a couple of hours after the [discovery of the body]. I did my best to be in contact with the family and see if there was anything I, or the service, could do in terms of supporting the family. And then I think the funeral was probably three or four days after that and I attended the funeral with a couple of other colleagues, and that feels a bit foggy still... I kept waiting for someone to say 'this is your fault' and that never happened really.

There were some other issues involved though, [...] the Special Incident Review Panel probably didn't happen for two months after the fact, so it was always knowing that that was coming and [...] the lawyer that's assigned to come to the Special Review Panel who's notorious for attacking staff in the Review Panel, and she actually wasn't able to come and she sent someone else who was a real pussycat, so... and I had at least been prepared by people that this may be really horrible. I would have called the family every three weeks for probably a few months after the fact and then the coroner's inquest wasn't for another, oh, probably for another year after, but ... it was a really open and shut case in terms of that, so I gave the police my report. So, that was that and I still, four years later, I drive by the road that she lived on every morning and every single morning, I remember.

Social worker, community

Narrative Five (b):

> It's all a bit foggy, [...] I did the job, and I was probably definitely not 100% there. There was no support at that time. I think I took a sick day the day after they found her, but there was nothing in place to help support the other work that needed to be done. There was certainly no structural stuff in place to deal with trauma at that time, and in many ways you get further traumatised by the operational reviews and you're also the person that's expected to be the person supporting the family through it [...]. And that still happens consistently, that the key worker sort of has to try and support everyone else through it.
>
> Social worker, community

Appendix 11: Model of a stress and trauma audit

STRESS, INCIDENTS AND SUPPORT AUDIT

1) STRESS & SUPPORT

A. IN YOUR LIFE

List the sources of support in your own life

Which are formal (constructed) and which are informal (natural)?

What are your major coping strategies and ways of being resilient?

List the sources of stress in your life

How much control do you have over each of these stress factors?

What needs to be done to gain more control over these factors?

B. IN YOUR WORK

List the sources of support in your work

Are these informal or formal supports?

What are your major informal coping strategies and ways of being resilient?

What are the formal coping strategies, systems and processes available to you?

List the sources of stress in your work

How much control do you have over each of these factors?

What needs to be done to gain more control?

2) INCIDENTS & SUPPORT AUDIT

Review your sources of support for stressors in your work, as above.

Which of the informal supports would you use after a critical incident in the workplace?

What sort of support would they offer?

Review the formal support structures in your workplace

Which are appropriate to use in the event of a critical incident?

Which are available to use in the event of a critical incident?

Which might you use?

Agnes Adamson, 1998-2005