THAT WAS BLOODY STRESSFUL! – WHAT'S NEXT?

TRAUMATIC EVENTS & STRESS REACTIONS

"As relaxing as a shift at the hospital" is a phrase that's yet to make its way into everyday speech – it doesn't sound quite as familiar as "as relaxing as having a glass of wine by the pool".

There's no avoiding stress in any walk of life, but because we work in health care we're bound to get our fair share of exposure to high-emotion & high-stress situations.

Most of the time most of us get by without our reactions to stressful situations getting on top of us. We cop it, we cope with it, we get over it then we get on with it.

That's the good news.

For many of us (a good many of us) there will be times when we find our emotional resources severely tested by the circumstances that come our way.

It's not always easy to know what to do, what to say or where to go for help when you or a workmate are feeling stressed out.

This 6-page pamphlet isn't going to solve all these problems, but it should serve as a useful starting point for staff in these circumstances.

It gives an overview of:

- the sort of things that make a traumatic event traumatic
- how you can manage and/or minimise the impact of your reactions to stress
- how others can help
- when to seek help
- how to seek help
- defusing vs debriefing vs CISM (critical incident stress management)
- finding further information

There is no "normal" reaction to an abnormal situation.

WHAT MAKES AN EVENT TRAUMATIC?

There's no objective criteria that can provide an answer to this question. Research shows that many people can undergo the same or similar experience, but react quite differently.

A traumatic event may be a life-threatening event, or one that provokes a sense of betrayal, helplessness or fear. Incidents that fit this description don't always make the TV news – for example: ever had a needle-stick injury or trouble with a confused patient?

For those of us working in health care we can also expect to be exposed to traumatic events that affect others. This may give rise to another phenomena dubbed "secondary traumatisation".

Secondary traumatisation may be known by other names: "burn-out" is the most common one. Should there be any, the symptoms of secondary traumatisation are not as likely to be as severe as the symptoms experienced by those who experience the trauma first-hand. Nevertheless, it may still have a detrimental effect on your career, home-life or ability to perform as you would like.

Multiple or chronic exposure to secondary traumatisation can predispose us to a stress reaction – this cumulative stress can have the same effect as a single traumatic event.

Other factors will also determine our reactions: our empathetic sensitivity to the suffering of others, and any unresolved emotional issues that relate (either symbolically or factually) to the suffering we see.

Baldwin, D (1998) *About Trauma*

ideas on how to protect against stress on page 3

AFTER A TRAUMATIC EVENT

Let's assume that you have experienced a traumatic event. Although the event itself is now completed, you **may** experience some strong emotional or physical reactions. It is very common for people to experience some "emotional aftershocks" when they have been exposed to an event of this nature.

There is no predicting how you will be affected, or if you will be adversely affected at all. Sometimes those "emotional aftershocks" (let's call them stress reactions) appear immediately after the event. Sometimes they may appear a few hours or a few days later and, less commonly, weeks or months will pass before stress reactions appear.

The signs and symptoms of a stress reaction may last a few days, a few weeks, or, occasionally, even longer – this usually depends on the severity of the traumatic event. With some understanding and support from others stress reactions usually resolve without formal assistance.

Some times for some people the stress reaction is so severe and/or so prolonged that assistance from a counsellor is necessary. This does **not** imply that the person is weak or crazy. It simply indicates that the situation has been too powerful for one person to handle alone.

RECOGNISING PROBLEMS

Some common signs & symptoms of a stress reaction follow – it's not an exhaustive list, but it'll give you an idea of what to look out for.

(see how you're holding-up by playing "tick-a-box")

Physical

- ❑ nausea
- ❑ upset stomach
- ❑ tremors
- ❑ feeling uncoordinated
- ❑ profuse sweating
- ❑ chills
- ❑ diarrhoea
- ❑ dizziness
- ❑ muscle aches
- ❑ sleep disturbances
- ❑ chest pain*
- ❑ rapid heartbeat*
- ❑ rapid breathing*
- ❑ high blood pressure*

* = seek prompt medical advice

Thinking

- ❑ slowed thinking
- ❑ racing thoughts
- ❑ preoccupation
- ❑ can't make decisions
- ❑ difficulty with problem solving
- ❑ confusion
- ❑ disorientation
- ❑ difficulty concentrating
- ❑ difficulty calculating
- ❑ memory problems
- ❑ "losing" everyday words
- ❑ distressing dreams

Emotional

- ❑ anxiety
- ❑ fear
- ❑ guilt
- ❑ grief
- ❑ depression
- ❑ feeling lost
- ❑ feeling abandoned
- ❑ feeling isolated
- ❑ worry about others
- ❑ wanting to hide
- ❑ wanting to avoid others
- ❑ anger/irritability
- ❑ feeling numb
- ❑ can't seem to get enjoyment from anything
- ❑ startled/shocked
- ❑ helplessness
- ❑ despair

SEEK HELP WHEN...

- ❑ you have any of the symptoms marked with an asterisk (*) check them out with your GP pronto!
- ❑ you feel unable to handle the intense feelings, thoughts or physical sensations
- ❑ you feel that your emotions are not returning to normal over a period of time
- ❑ you continue to have physical symptoms
- ❑ you have nightmares &/or disturbed sleep
- ❑ you have no person or group that you can share your emotions with
- ❑ your relationships &/or work seem to be suffering
- ❑ you are having accidents
- ❑ you're using more alcohol &/or drugs than usual
- ❑ you're starting to wish for accidents or thinking about self harm
- ❑ people you can usually trust are telling you things like "you're not yourself lately"

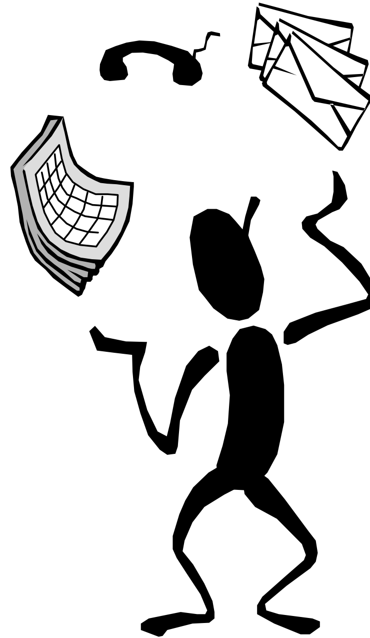
trying to keep moving forward while your mind's looking back can get a little bit tricky sometimes...

HELPFUL HINTS

Try some of these hints to either overcome or prevent a stress reaction:

For Yourself:

- try to rest & indulge in quality relaxation more than usual
- contact friends you can talk to, people you can trust
- have someone stay with you for at least a few hours over the first day or so
- re-occurring thoughts and dreams, &/or "flashbacks", aren't all that unusual, particularly in the short-term. They're part of the healing process, but don't try to deal with them alone – talk about it with someone you can trust
- maintain most of your usual routines & schedules if you can – particularly with sleep patterns & alcohol/drug use
- if you can't sleep don't toss & turn in bed – get up & do something else for a while until you feel tired again
- eat healthy, well-balanced & regular meals – even if it's the last thing you feel like
- EXERCISE! – at least keep a reasonable level of activity:
  if you're feeling lethargic exercise will give you some "pep", and/or;
  exercise will help you burn-off extra energy and help you sleep better
- fight against boredom
- don't use alcohol, sleepers or illicit drugs as a relaxation & coping thing (Yes: really! - it's been tried by a lot of people & it doesn't work – *dulling* your feelings & **dealing** with your feelings aren't quite the same thing)
- go easy on stimulants too (tea, coffee, tobacco, cola, chocolate etc.) – they can agitate the body more than it already is
- try to take part in things that you enjoy: be kind to yourself – you're still allowed to feel relaxed & happy
- find a good counsellor if your feelings become prolonged or too intense



Even if someone is having obvious difficulty trying to juggle all their commitments, thoughts & emotions, it isn't necessarily true that they will ask for help.

Sometimes jugglers are very, very independent people.

Sometimes jugglers want to prove or test their abilities.

Sometimes jugglers feel that asking for help will somehow lower other people's opinion of them.

Sometimes the juggler is so busy looking at all the things they're juggling that they don't see anything else (like the sabre tooth tiger that's about to bite you on the bum, for instance).

If you're a juggler don't forget to listen for warnings;
if you're a juggler's friend, don't forget to give them.

For Family, Friends & Workmates:

- offer your assistance and a listening ear – don't wait to be asked
- listen carefully to what the person has to say – it might not be the sort of thing you were expecting
- be genuine
- be empathetic
- you're not expected to have all the answers or to magically make things better – overcoming a traumatic event is a process, or a journey, that the person has to take. Your job is to let them know that they don't have to take it alone. There's a book title which sort-of sums this up, it is: "Don't do something! Just sit there."
- try not to take anger or other feelings personally – it's likely that your friend just needs to "blow off steam"
- avoid the temptation to slip in cliches like "you're lucky it wasn't worse" – traumatised people usually are not at all consoled or comforted by these sort of statements
- help your friend with everyday stuff – something like cooking a meal can be very helpful - ask what they'd like you to do to help
- give them private space & time, and (here's the tricky part) try to make sure they don't spend too much time alone
- if your friend's stress reaction is prolonged &/or is having a profound effect on them, you might need to encourage them to seek out counselling – when we're trying to deal with a lot of stress, we might need somebody to prompt us into seeking the help we need: this is especially true for us jugglers.

COUNSELLING

There's nothing particularly spooky or magical about counselling – it's a process whereby a trained professional helps a person along with their self healing. You're still the main player in the recovery game, but it's probably going to be a lot easier if you have a skilled coach assisting you.

(In case you're wondering: Yes. That is an oversimplification of the whole counselling thing, but it'll have to do for this handout – OK?)

You may wish to seek out your own options for counselling – perhaps a friend can give a recommendation. It's difficult for this brochure's author [a mental health clinician] to recommend a therapist who doesn't hold a qualification and certificate of registration with a recognised legislated body. That said, it needs to be acknowledged that people outside the health system, such as chaplains & church ministers, have a track record of being helpful.

Prices and the approach to counselling can vary quite a bit between & within the professions. Since the introduction of the "Better Access to Mental Health Care" program, with a GP referral Medicare will provide a rebate for Psychiatrists (ie: a Medical Practitioner who has specialised in psychiatry) and Psychologists, Nurses & other Allied Mental Health workers (ie: a clinician with training specific to the resolution of emotional & personal difficulties). Some private health funds will also contribute to these expenses.

Other sources of counselling include Lifeline (☎ 131 114) and Centacare (☎ 4044 0130); you'll also find some other agencies listed in the White Pages section titled "Community Help".

EMPLOYEE ASSISTANCE PROGRAM (EAP)

☎ 1300 360 364
www.benestar.com

Employee Assistance Program (EAP) offers confidential, free counselling and crisis support, assistance for a variety of work situations, and resources to help you live well and achieve a healthy work-life balance.

The CHHHS Employee Assistance Program is delivered by Benestar.

For more info contact Benestar or search for EAP on the Cairns QHEPS site.
qheps.health.qld.gov.au/cairns

CENTRALISED INTAKE SERVICE (CIS)

(previously known as ACT)

☎ 1300 64 2255
(1300 MH CALL)

Usually Queensland Health staff members prefer to access support from outside of Queensland Health, but if things are getting very difficult for you and/or you're having thoughts about hurting yourself you should access CIS. CIS staff are used to maintaining confidentiality. CIS will conduct a thorough assessment & collaborate with you on a plan for your safety, which will likely include referral on to a team/agency that will best meet your needs.

NURSE & MIDWIFE SUPPORT

☎ 1800 667 877
nmsupport.org.au

Nurse & Midwife Support is for all nurses and midwives, nursing and midwifery students, employers, educators and concerned family and friends. Nurse & Midwife Support provides free confidential advice and referral, promoting better health for nurses, midwives and students.

DOCTOR'S HEALTH IN QUEENSLAND

☎ 3833 4352
dhq.org.au

DHQ provides an independent, confidential, colleague-to-colleague support service to assist doctors and medical students.

stress reactions &/or depression can make you uncharacteristically irritable

DEFUSING, DEBRIEFING & CRITICAL INCIDENT STRESS MANAGEMENT [CISM]

What is Debriefing?

The routine use of single session debriefing is not supported. No evidence has been found that this procedure is effective & there is some suggestion that it may increase the risk of PTSD and depression. (Rose et al 2002)

So, if we're going to think about debriefing at all, we should be thinking of it in terms of critical incident stress management.

What is Critical Incident Stress Management (CISM)?

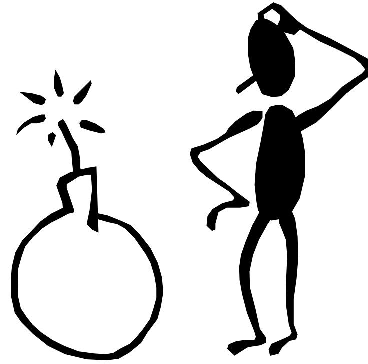
CISM is a comprehensive, multi-component crisis intervention system, which speaks of 3 distinct phases:

Pre-Crisis:
Strategies include things like this brochure & any other strategies that build stress management & stress resistance education.

Acute:
Strategies are around keeping people safe during & immediately after the event – see "what is defusing" for more info.

Post-Crisis:
Strategies that encourage people to confront their experiences & reactions in a manner and at a rate that is appropriate to the individual.

So, the strategies of CISM are not a "cure" for emotions, it's more like a journey *through* emotions. The route, the rate you travel, and the destination of this journey can be worked on with the help of the support people listed on page 4.



What is Defusing?

Defusing is a bit like emotional first aid... it's undertaken as soon as possible after the event - definitely within the first 24 hours. By being prompt, defusing takes advantage of a window of opportunity where emotional support to is most likely to be requested and required.

In keeping with "emotional first aid" analogy, defusing doesn't delve into underlying or unresolved issues. Instead it takes a "here and now" approach to supporting those involved in the incident, and perhaps bringing people together as an informal support group.

Defusing may be facilitated by a trained mental health professional, but many work groups will arrange their own informal defusing sessions – although they might not be recognised or named as such.

If your workgroup responds to stressful days by getting together at the end of the shift, or making sure that staff most involved in a stressful incident get a break together, you're on the right track.

Defusing supports people when they need it most, goals are:

1. to allow people to relate & compare their experience, reaction & coping strategies
2. help people to feel supported enough to finish their shift &/or get home safely
3. identify the professional and personal support systems available to them to use as requested/required

There's no need to wait for somebody else to declare an event traumatic. You are entitled to request, or decline, defusing: it's a good idea to take responsibility for your self care.

Fluffy New Age Crap?

Although some of the jargon words (eg: defusing, debriefing, stress reaction, critical incident stress management and post-traumatic stress) are relatively new additions to the vocabulary, the concepts have been around for ages.

In ancient Rome, soldiers were encouraged to spend some time in rural areas after battles so they could "decompress" before returning to the hustle and bustle of the city. There was a similar arrangement for the samurai warriors of Japan too.

Last century "shell-shocked" was the generic WWI & WWII term for what we'd now call either acute stress reaction, adjustment disorder, reactive depression or post-traumatic stress disorder. The research, understanding and treatment of these mental health issues didn't really become mainstream until the Vietnam War – before that the problems were hidden away & not discussed in polite company.

Anyway, the point is that it isn't just new age crap. The reactions to stress are now better understood, as are the ways to prevent or minimise the long-term effects on people. Also, it's been finally acknowledged that war is not the only cause of stress reactions.

There's been a significant shift in attitudes too. Sizeable workplaces and most large unions have policies on managing critical incidents, which include stress management procedures and considerations. People are more prepared to discuss stress and stress management as part and parcel of working life.

Stress is a part of all of our lives – exploring strategies to manage this stress is plain common sense, not fluffy new age crap.

if you've heard enough you can skip this page

CLINICAL SUPERVISION

Clinical Supervision (CS) is a formally structured professional arrangement between a supervisor and one or more supervisees. It is a purposely constructed regular meeting that provides for critical reflection on the work issues brought to that space by the supervisee(s). It is a confidential relationship within the ethical and legal parameters of practice. CS facilitates development of reflective practice and the professional skills of the supervisee(s) through increased awareness and understanding of the complex human and ethical issues within their workplace.

For many years it has been recommended that all Queensland Health mental health practitioners have clinical supervision (aka guided reflective practice) in place. Some professions (eg: Psychology and Social Work) mandate clinical supervision as a component of safe practice. In April 2019 a joint statement was released recommending CS for all nurses and midwives irrespective of their specific role, area of practice and years of experience.

MORE INFORMATION

The following list of references is not exhaustive, but includes the papers that informed this handout.

Blacklock, E
'Critical incident stress debriefing'
The Queensland Nurse
March/April 1997, vol 16, no 2

Blacklock, E
'Workplace stress: a hospital team approach'
Professional Nurse
August 1998, vol 13, no 11

Cuijpers P, Van Straten A, Smit F. *Preventing the incidence of new cases of mental disorders: a meta-analytic review.* J Nerv Ment Dis. 2005 Feb;193(2):119-25.

Rose S, Bisson J, Churchill R, Wessely S. *Psychological debriefing for preventing post traumatic stress disorder (PTSD).* Cochrane Database of Systematic Reviews 2002, Issue 2.

Santamaria, N & O'Sullivan, S
'Stress in perioperative nursing'
Collegian July 1998, vol 5, no 3

Shearer, R & Davidhizar, R
'Recognising a post-traumatic stress disorder in a Nursing Student' Journal of Nursing Education May 1998, vol 37, no 5

van Emmerik AA, Kamphuis JH, Hulsbosch AM, Emmelkamp PM. *Single session debriefing after psychological trauma: a meta-analysis.* Lancet. 2002 Sep 7;360(9335):766-71.

There's a book titled: *"Avoiding burn-out in remote areas Surviving the day to day hassles: a guide for remote health practitioners"* – despite the specific title, it'd be a book that most health professional anywhere could relate to & benefit form. You can find it the Cairns Base Hospital library.

As we all know, some internet sites are pretty dodgy, but these ones are considered credible:

headtohealth.gov.au
www.connecttowellbeing.org.au

THANKS

Parts of this package have been blatantly plagiarised from the work of others: years ago I came across some photocopied handouts, which I've dipped into for this paper. The handouts didn't name or credit the authors so, unfortunately, neither can I.

Jan Whitby & Linda Williams gave the leeway & encouragement to compile the original version in 1998. At the time Clif Nelder, Sandy Shinkfield, Stella Green, Fiona Hall, Kerrie Kelly, Jo Field and John Hurley all gave quality advice, input and support to the development of this resource.

In 2001 Catherine Wright & Prue Harding encouraged updates & more access to the resource, as has Robin Crittenden in 2007, and Gerry Rudolphy & Sally O'Kane in 2008. In 2012 Melissa Dalzell encouraged another update. The 2017 launch of Australia's Nurse & Midwife Support prompted the 2017 update. The April 2019 & October 2021 updates capture changes to the EAP service provider, some new(ish) local support options, and the ACN, ACMHN + ACM joint statement re clinical supervision for nurses and midwives.

Many of the people who have used the resource during difficult times over the last 20+ years have also made valuable suggestions.

Sincere thanks to you all.

Paul McNamara
Clinical Nurse Consultant
October 2021