CHAPTER 13

Acute Stress at Work

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13.1 INTRODUCTION

A bank employee becomes a victim of a hold-up. A large company is sud-
denly confronted with the suicide of one of its workers. A moment of inat-
tentiveness and suddenly a school teacher has to deal with a serious accident
affecting a pupil. Fire-fighters discover in a burned house the corpse of one
of their colleagues. These are all forms of acute stress in work situations.
Unsuspectedly, an employee has to cope with an overwhelming experience
at work which he or she can hardly handle.

The consequences of acute stress at work can be serious and sometimes
long lasting for those involved. One can discern direct emotional reactions,
like dismay, shock and disbelief. These are followed by reactions like fear,
anger, depression and tiredness. The employee concerned will be angry for
some time because such an experience happened to him or her, or will fear that
it might happen again. Sometimes victims blame themselves for not having
done enough. All of these reactions influence work performance and function-
ing at home. The employee finds it difficult to concentrate, suffers from
forgetfulness and has difficulties in communicating with others. After some
time tensions at work may develop, which become apparent through deteri-
oration of work performance, irritations, fatigue, burnout and absenteeism.

The interest of scientists in the consequences of acute and extreme stress
has a long history. Already in the second half of the nineteenth century
scientists and clinicians dealt with the psychological reactions from train
accidents (for example, Erichsen, 1866; see for an overview Trimble, 1981).
The studies into the consequences of war stress in and after the Second World War (Grinker & Spiegel, 1945) and into the effects of brief, taxing circumstances (Basowitz et al., 1955) are also examples of this interest. However, in the domain of work and health the attention of researchers has been directed mainly to chronic stress, as is shown by the many studies on work overload and role insecurity. Only since the 1990s have scientists as well as practitioners turned their attention to the impact of acute stressors at the workplace.

In this chapter we will deal with the characteristics and consequences of acute stress in the work situation – especially confrontations with violence – and with aspects of victim assistance and organizational health care. Acute stress phenomena will be analysed from a trauma perspective. Many painful and extraordinary experiences have been associated with traumatic stress: rape, criminal violence, sexual abuse of children, torture, combat, natural disasters, technological disasters and traffic accidents (Keane, Marshall & Taft, 2006; Van der Kolk, McFarlane & Weisaeth, 1996). Findings and concepts concerning various consequences of traumatic stress and disturbances in the process of adaptation with traumatic experiences will be used in this chapter, as well as insights on mental health care with regard to traumatic events, in particular trauma counselling.

13.2 WHAT IS ACUTE STRESS?

Whenever persons are required to do something which they cannot or do not want to do, they may experience stress. Using the well-known transactional definition of stress (Lazarus, 1981), the concept refers to a discrepancy between the demands of the environment and the resources of the individual. This discrepancy generally takes the form of the demands taxing or exceeding the resources.

‘Acute’ means that this discrepancy occurs suddenly. The term does not imply that the stressor should necessarily be an extreme event. However, this is usually the case. A short argument at work does not get attention, unless it leads to intense emotions or is part of a long slumbering conflict.

The following forms of acute stress at work can be discerned:

- Extreme experiences during work, such as confrontations with violence or with accidents. Examples of persons who experience work-related violence are employees of banks, money transport companies, supermarkets and shops, but also prison guards and police officers. Examples of people who experience accidents are fire-fighters (Wagner, Heinrichs & Ehlert, 1998), ambulance service workers (Van der Ploeg & Kleber, 2003; Van der
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Velden, Kleber & Koenen, 2008) and railway employees who have to deal with traffic accidents and suicide attempts, and employees of industrial plants confronted with explosions, fires and other calamities.

- Radical changes in company structure – reorganization, collective discharge, bankruptcy – resulting in a situation in which people suddenly lose their security with regard to work and have to deal with a completely changed situation.

- Extreme experiences in social networks. For example the suicide of a coworker in a situation in which it may be supposed that the reasons for the suicide are related to problems in the work setting.

- Extreme experiences from outside, like technical, natural and environmental catastrophes. For instance, rescue workers have been sent to catastrophes, such as the sinking of the ferry, The Herald of Free Enterprise, a disaster on a drilling platform (Hull, Alexander & Klein, 2002), the explosion of a fireworks storage facility in a city (Van der Velden et al., 2006), airplane crashes and terrorist acts, such as the attack on the Twin Towers in New York. These workers are confronted with diverse stress reactions during and after their work (Paton & Violanti, 1996).

In this chapter we will focus especially on the category of extreme experiences during work, in particular the confrontation with acts of violence in the work situation. Bank robberies or hold-ups (Leymann, 1988) may serve as the prototypical examples here, but it should be kept in mind that hold-ups also occur in other settings, for instance gas stations, hotels, catering industries and shops. Other examples of the confrontation with violence are sexual assault at the workplace and aggressive clients who attack paramedics, doctors or the nursing staff of psychiatric institutions (Haller & Deluty, 1988; Merecz et al., 2006). Violence is inherent to our society, and there are many situations, also at work, in which we are confronted with it (Spector et al., 2007). It is remarkable to notice that, nevertheless, not many studies on the impact of work-related violence have been conducted.

13.3 THEORETICAL BACKGROUND

Well-known scientific approaches to job stress can hardly be used for the analysis of acute stress. The Michigan approach to organizational stress (French & Caplan, 1973) or the job demand-control model (Karasek & Theorell, 1990) approach are mostly directed on long existing sources of problems and their consequences. That is why we start from a comprehensive perspective on coping with extreme stress which is based on cognitive perspectives on trauma combined with concepts from social and cognitive psychology (Brewin & Holmes, 2003; Kleber & Brom, 1992).
An extreme event characteristically causes an intense powerlessness. During a violent crime a person is reduced to a thing, an object used by the perpetrator to attain something. This experience disrupts the normal certainties of existence. It contrasts with our functioning as an independent individual, which is based partly on obvious and mostly implicit expectations and suppositions. For instance, everybody implicitly assumes invulnerability: ‘something like this will not happen to me’ (Perloff, 1983). Daily life generally seems to be predictable and secure. There is an expectation of being treated honestly. These implicit ideas are useful and meaningful. They prevent continuous vigilance for all possible hazards, which would constitute high levels of enduring distress.

Then suddenly an actual threat takes place, against which one is almost powerless. The normal control over one’s life is disrupted and feelings of security are superseded by feelings of (death) anxiety. At once the victim realizes that he or she can be confronted with a violent crime again and again. Certainties and suppositions which constitute basic trust and stability vanish after traumatic events. The core beliefs or basic assumptions – which could also be called illusions – are shattered (Janoff-Bulman, 1992).

Incidents like violent crimes and disasters are followed by a variety of psychological processes that are labelled as ‘coping with traumatic stress’ (Kleber & Brom, 1992). This is a form of coping that is typical for these kinds of events, during which mainly intra-psychic ways of dealing with the stressor are important. After all, the incident has already taken place. Nothing can change that. The person has to learn to live with what has happened to him or her. He or she has to regain or restore feelings of security, control and trust in one way or another.

### 13.4 THE PROCESS OF COPING

The process of coping with acute stress develops in the following way. During an extreme situation the person concerned will first react with disbelief and bewilderment, although usually acting reasonably adequately at the same time. Panic and aggressive resistance, for instance, do not often occur. It is as if victimized employees automatically respond in such a way that possible escalations are minimized. In a few cases a total blocking of emotions is reported, that is, the overwhelming emotions are directly inhibited and the person responds with derealization, depersonalization and disorientation. This phenomenon is called peritraumatic dissociation (Shalev et al., 1996).

When the event is over and the person concerned begins to realize what has happened, various kinds of emotions emerge, predominantly emotions of fear, anger, despair and self-blame. These emotions are often accompanied
by physical reactions, such as headache, trembling or the inclination to vomit. In some cases these reactions occur a few days after the event when there are no special commands any more. This is seen especially in victims who have to deal with all kinds of matters directly after the event, like the management of a bank confronted with a robbery.

The alternation between two central psychological processes – intrusion and denial – is characteristic for the psychological coping process after extreme events (Creamer, 1995; Horowitz, 2001). Intrusion refers to reexperiencing the traumatic event. It takes a number of forms, the most common being the involuntary recollection of the stressor. A person continuously deals with what has happened. Memories and emotions come up again and again. Nightmares and repetitive dreams are also a common way in which thoughts, feelings and images related to the event are re-experienced. At night the person sleeps restlessly and has bad dreams about the event. Finally, there are startle reactions in situations that resemble the original situation. For instance, employees victimized by an industrial disaster report distress triggered by the smell of gasoline or by loud noises. The psychological process of denial has to do with a general numbing of psychic responsiveness. It is expressed by not wanting to talk about it, by avoiding the location of the event and other avoidance behaviours, by diminished interest in significant activities, and by emotional numbness.

In itself, this alternation between denial and intrusion can be regarded as a normal and necessary process. After all, old certainties and expectations which have been overthrown by the event need to be restored or replaced by new ones. This cannot be done at once: the victim would be overwhelmed by emotions. The person lets, as it were, the experience permeate bit by bit. That is why intrusion – being preoccupied by the event – is alternated by denial – avoiding memories about the event.

An important element in the coping process is the search for a meaning, that is, the victim looks for a way to understand the situation by means of interpretations of what has happened to him (Janoff-Bulman & Frantz, 1997). For instance, victims ask themselves: ‘why has this happened to me?’ or ‘how could this happen?’. They may also blame themselves for having made mistakes. In these ways, they try to regain control over their own life (Thompson, Armstrong & Thomas, 1998). Especially in cognitive-oriented approaches of coping with traumatic stress, much attention has been paid to this process of attributing meaning and replacing old ideas by new ones (Schok et al., 2008).

The coping process furthermore affects the energy level of a person. He or she becomes tired and exhausted after even small activities at work or at home. The normal interest in significant others or activities decreases, and minor problems with the spouse or the children easily evoke impatience.
and aggression. Irritation about the unsafe work situation is vented off on colleagues and relatives. Hypervigilance and jumpiness after violent events are other prominent reactions. These are often of a specific nature – that is, they are connected with the characteristics of the violent situation. For a prison guard who has been beaten up, a screaming prisoner again evokes the fear for aggression. A bank employee who has been involved in a hold-up approaches every client suspiciously and feels continuously on his or her guard. Intrusive thoughts are provoked in the same way. Looking at a television programme about a hostage induces painful memories of the colleague who was used as a hostage. The smell of burned food provokes images of the dead child who was found by a fire-fighter.

Adaptation takes time. After a few weeks to a few months the symptoms of intrusion and denial as well as the various emotional, behavioural and somatic reactions decrease in frequency and intensity. Sometimes it takes longer, much longer even, as research on the aftermath of war and violence has shown (Keane et al., 2006). The coping process is completed when the person only suffers occasionally or not at all from intrusion and avoidance as well as other symptoms related to the event. The person can think of the event without being overwhelmed by emotions and the memory of what has happened does not have to be avoided any more.

### 13.5 LONG-TERM DISTURBANCES

Some persons who are struck by an extreme incident suffer from permanent psychological problems. Overviews of empirical studies into the consequences of extreme events (Breslau, 1998; Kleber & Brom, 1992) have shown that about 10 to 30% of all victims suffer from serious malfunctioning. These disturbances may take the form of a mood disorder (which is manifested in – among others – major depression), a posttraumatic stress disorder, substance abuse, burnout or other mental disturbances. Prevalence rates for posttraumatic stress difficulties among rescue workers are generally lower (Van der Velden et al., 2006).

Posttraumatic stress disorder (PTSD) is the well-known and well-established diagnostic term for mental problems after extreme experiences. The lingering and painful effects of the Vietnam war in the United States led to the introduction of this concept in the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association. The distinctive criteria of the disorder are: (i) an extreme stressor; (ii) persistent intrusive and reexperiencing symptoms; (iii) permanent avoidance of stimuli associated with the traumatic experience and numbing symptoms; (iv) symptoms
of persistent hyperarousal; (v) a duration of the symptoms of at least one month; and (vi) significant impairment in social, occupational, or other important areas of functioning, such as problems with work and relationships (APA, 2000). Since its introduction in 1980, a vast amount of articles and books has been published on the aetiology and diagnostics of PTSD as well as on the various forms of counselling and psychotherapy. There is also a growing stream of publications indicating that posttraumatic stress disorder is associated with abnormalities in psychobiological processes, in particular mechanisms in neurotransmitter and neurohormonal systems (Olff, Lange-land & Gersons, 2005).

PTSD can be assessed by standardized questionnaires, such as the Self-Rating Scale for Posttraumatic Stress Disorder (SRS-PTSD; Carlier et al., 1998), the PTSD Symptom Scale (PSS; Foa et al., 1993) and the Impact of Event Scale (IES; Horowitz, Wilner & Alvarez, 1979; Van der Ploeg et al., 2004). The assessment of a structured interview conducted by a professional (such as the Clinician Administered PTSD Scale – CAPS; Weathers, Keane & Davidson, 2001) is considered as the golden standard. It has been found that PTSD rates from diagnostic interviews are considerably lower than estimates from standardized questionnaires (Engelhard et al., 2007). PTSD is the most widely recognized posttraumatic disorder (although not without dispute; Rosen, Spitzer & McHugh, 2008), but also depression, anxiety disorders, substance misuse and adjustment disorders may develop. These, along with non-psychiatric issues causing distress (e.g., finances, lack of information and relationship breakdown), should be considered in addition to PTSD in patients with mental health problems after violence and disaster. Damage to the victim’s health also becomes manifest in an increase of sick leave, in enduring stress at work, in fatigue and in burnout. For instance, in a Dutch study of ambulance workers (Van der Ploeg & Kleber, 2003) it was found that more than a tenth suffered from a clinical level of posttraumatic distress, that a tenth reported a fatigue level that put them at high risk for sick leave and work disability, and that nearly a tenth suffered from burnout. In the same way that chronic stress may be associated with financial costs and with decreases of production and identification with the organization, acute stress may be followed by similar negative consequences.

Finally, the absence of a disorder such as PTSD does not imply the absence of difficulties in the adaptation with acute stress. Although, the majority of people struck by these experiences will show a form of resilience, a large part of the victimized persons will suffer from specific symptoms which interfere with work, such as irritations, sleeping disturbances, fatigue at the workplace and concentration difficulties. Nevertheless, in most cases these problems disappear after some time and the person’s functioning will return to an adequate level.
13.6 RISK FACTORS

In acute stress the nature of the stressor plays a dominant role. However, the nature and seriousness of the consequences of an acute stressor are moderated or mediated by several social and psychological variables. A distinction could be made here between risk factors present before, during and after the event. One should realize that none of these factors is by itself capable of producing chronic disturbances (Kleber & Brom, 1992; Ozer et al., 2003).

Earlier stressful life events or recently experienced critical events are a major risk factor for long-lasting coping disturbances (Breslau, 1998). It was found that some bank employees became victims to several hold-ups in a period of a few months (Van der Velden et al., 1991). This accumulation of violence causes permanent damage to the feeling of security of the persons concerned. Repeated violence enhances the feeling of powerlessness and fear (Rothbaum et al., 1992). Furthermore, pre-existing psychological problems can augment mental health problems after critical incidents (Breslau, 1998; McFarlane, 1989).

Risk factors during the event are the severity of the stressor itself as well as so-called peritraumatic factors, such as sustained physical harm, vehement negative emotions and the already mentioned dissociative responses. It has been shown that injuries as well as immense powerlessness and anxiety can be important risk factors (Kilpatrick et al., 1989). The victims’ perception of the seriousness of the threat may even be of more significance that the objective circumstances (Brewin & Holmes, 2003; Lazarus, 1981). Furthermore, peritraumatic dissociation had been found to be a determinant of later disturbances (Marmar et al., 1996), but recent studies have shown that this factor is not as important as assumed. Results indicate that initial mental health problems, among other factors, might be better predictors of PTSD symptomatology (Van der Velden & Wittmann, 2008).

Besides personal factors and the seriousness of the incident, social factors after the event play an important part in the coping process. On the one hand the support from the social network (family, relatives, friends, colleagues) may have a positive influence on the coping process (Ullman, 1995). On the other hand, negative interventions of others (like police, media, insurance companies, medical authorities) can aggravate the consequences (Figley & Kleber, 1995), a process that is called ‘secondary victimization’ (Symonds, 1980). Victims of violence are often not adequately informed about police and legal procedures. When employees of banks and money transport companies are questioned, they often get the impression they are under suspicion themselves. Most people regard this as a serious breach of confidence. In addition, chronic and re-occurring organizational stressors may influence mental health problems. They can even be better predictors for consequent
mental health problems than confrontations with violence and death, as was found in a New Zealand study of police officers (Huddleston, Stephens & Paton, 2007).

### 13.7 INTERVENTION

Those who are confronted with acute stress show various symptoms, such as sleeplessness, irritability, absenteeism, feelings of insecurity and lower work performance. Undoubtedly, personality characteristics play a part, but it should be remembered that most victims have hardly any responsibility for what has happened. Banks and supermarkets happen to get robbed and employees of social welfare services are sometimes confronted with clients who threaten them (or members of their family) physically. Because the incident has to do with the nature of the work setting itself, intervention at the work level is appropriate.

Intervention programmes for victimized employees are a development of the 1980s and 1990s. They can take different forms. Firstly, there is primary intervention. This ensures that situations of acute stress occur as infrequently as possible. Such an approach is, of course, justified, but many unpleasant and extreme incidents can hardly be prevented. Accidents and violent crimes do take place, however adequate the prevention policy of the company.

It is also possible to make sure that the employees are optimally prepared for the event and its consequences. This is the aim of trainings in the field of ‘stress management’ and ‘aggression regulation’ (Mitchell & Dyregrov, 1993; Parks & Steelman, 2008). Bank employees are prepared for hold-ups, police officers for shooting incidents and railway employees for suicide attempts or accidents involving trains. However, one should not overestimate the efficacy of this preparedness: anticipation is only useful when the stressor is reasonably expectable and not too complex (Sarason et al., 1979). For instance, if a hold-up takes place two years after the training, the content of the whole training programme may have faded away.

This is the reason why secondary prevention is important. The organization should explicitly pay attention to the consequences of acute stress at work and to the possibilities of direct assistance afterwards, so that employees will feel supported and will be better prepared to deal with the aftermath of the overwhelming experience.

#### 13.7.1 Intervention Elements

Based on the theoretical approach of coping with extreme experiences described above, a number of intervention elements can be discerned. Firstly,
stress reactions should not be interpreted as symptoms of mental disorders in intervention programmes after extreme incidents. Instead, the normal character of the reactions to an acute stress situation is emphasized (Kleber & Brom, 1992). Going through an experience of violence can be seen as a job risk. One should avoid the medicalization of reactions to such an event and the resulting danger of stigmatizing the person(s) concerned. Employees should be taken seriously. People should be supported in such a way that they will not get stuck in their problems, but will be able to function again at work and in their personal lives as before.

Secondly, the person needs recognition and (practical) support after the extreme experience. Recognition is a highly relevant element in the support of victims. Often this is what victims are looking for: recognition that they have gone through a very unpleasant situation. Support from the organization and especially from superiors is often limited. In several investigations (Day & Livingstone, 2001; Van der Ploeg & Kleber, 2003) it has been found how much victimized employees appreciated support and recognition, and how little of this support was often received. It has also been established that the social atmosphere in many police departments deteriorated because of inadequate support after shooting incidents (Anshel, 2000; Gersons, 1989). The reason why colleagues and superiors pay little attention is often due to misunderstandings about the coping process and social support. They often assume that attention and questions about what happened will increase the psychological problems of the victims concerned or, instead of serious attention, they make jokes about the event with the intention to distract the victim. Supplying information is also important. The person concerned wants to know what can be expected. People who fall victim to violence while performing their work have to deal with all kinds of judiciary and business consequences afterwards. Information is crucial. However, information not only concerns practical matters and juridical affairs, but also psychological aspects, that is, the characteristics of the coping process and stress reactions. Rendering this information while stressing the normality of the psychological reactions provides rest and assurance. It prevents victims (and their family) from getting upset about unexpected stress reactions.

Another goal is to create an opportunity to express the thoughts and feelings which accompanied the critical event. The person may vent personal thoughts with regard to the event and emotions like fear, anger and sorrow. In individual or group meetings he or she gets the chance to talk about the experience of the hold-up, the related thoughts and feelings, and the influence on work and personal life. Experimental studies in social psychology have shown that disclosure about traumatic experiences (e.g. talking or writing about one’s experience) has a strong positive effect on various indicators of physical and mental health (Pennebaker, 1997). However, disclosure has
to do with all aspects of the experience, not only the emotional aspects. In the last decade many authors on early interventions after trauma (e.g. Solomon, 1999) have emphasized that one should be very careful with the ventilation of emotions and that this element is not as important as originally assumed. The focus on emotions negatively affected psychological recovery in some trauma victims, as was found in a randomized controlled study in the Netherlands (Sijbrandij et al., 2006). Too much emphasis can be harmful.

This brings us to another goal of the intervention programme: confrontation with what has happened. It may be important to recollect the event in a detailed way, because of the person’s need to recognize what he or she has been through. Such a confrontation may enhance the coping process and the integration of the experience in his or her personal life. However, some victims do not show this need and prefer to refrain from such a detailed recollection.

### 13.7.2 An Illustration of an Intervention Programme for Victimized Employees

Many organizations are confronted with employees victimized by some kind of violence, such as robberies, hijackings, hold-ups and physical abuse. Intervention programmes for banks, transport companies and rescue workers have been developed in the Netherlands by representatives of the Institute for Psychotrauma (Brom & Kleber, 1989; Brom, Kleber & Hofman, 1993; Van der Velden, Hazen & Kleber, 1999; Van Loon, 2008). Manton and Talbot (1990) developed a somewhat similar approach to victims in Australia in which the bank permanently hires specialists.

An intervention programme can only be successful if one starts with explicit principles. Such concepts have been formulated (Dunning, 1988; Mitchell & Dyregrov, 1993; Van der Velden et al., 1999) during the development and implementation of various intervention programmes in organizations. The aim is twofold: to reduce sources of new stress (called psychosocial crisis management) and to enhance self-efficacy, normal coping and recognition of problems (called victim assistance). These principles are as follows:

1. Violence and disaster are accompanied by crisis. Primary task is, therefore, psychosocial crisis management aimed at reducing sources of stress and chaos. Those responsible and in charge – mostly superiors or management – must develop a general idea of problems and needs of those involved. Based on this assessment, plans for the coming days and week should be formulated. Vital questions are: what are the direct
consequences of the event, which problems might be expected on the longer term, which measures are best suited to diminish these negative consequences, and which persons will conduct necessary interventions? Dependent on the impact and nature of the event, it is also necessary to develop plans for dealing with the media.

2. Concrete and practical assistance is offered directly after the event. Directly after a hold-up police and management have to deal with other matters, which usually is not in accordance with the employees’ interest. Support of the employees during contact with the police is useful to protect the victim. For instance, an employee of a money transport company immediately becomes a suspect when his van has been robbed.

3. The fact that victims are sometimes very emotional directly after the event, does not necessarily indicate that they are at risk for posttraumatic stress disturbances. As mentioned before, these are normal reactions after abnormal events. However, it may be necessary to have several contacts during a longer period with affected persons. It is important to follow these employees in this process, also because the concern from the near environment soon tends to ebb away. Dependent on the needs and the intensity of the posttraumatic reactions, an intervention programme consists of several contacts over a period of four to six or eight weeks. The differences between the meetings are described below. However, when employees are involved in a legal process or formal investigation, they ought to be supported over a longer period, such as to prepare them for possible stressful developments.

4. All employees who have been involved in some way with the acute stressor should be offered support and recognition. Those at risk for ongoing posttraumatic stress reactions should be invited to take part in a specific intervention programme (however, participation is not mandatory). In other cases, ‘watchful waiting’ is a recommended approach since the probability that they will develop event-related mental health disturbances is low.

5. Intervention programmes can be offered by people from within the company, like superiors, social workers and personnel officers, after the required specialized training. Such support programmes find themselves on the intersection of volunteer assistance and professional assistance. The organization appoints an employee who is explicitly responsible for the intervention programme. This employee may be a professional, but this is not necessarily the case. Sometimes, a close colleague or direct supervisor is better suited for the task. Preferably, the person receives training crisis management as well as in the field of social skills and assistance to victimized persons. It is important to notice that this person should be accepted by the other employees and should be available at any moment.
6. During the aftermath of the event interventions and current needs should be regularly evaluated, in order to be able to formulate additional plans or measures. It is evident that the duration of the aftermath is dependent on the nature of the event and the specific problems.

7. The intervention programme is introduced formally as a programme within the organization. This also means that all procedures should be laid down in an explicit plan or intervention strategy. Explicit rules make clear who in the organization is responsible for the intervention programme and which rules exist within the organization for it.

8. The organization allows certain changes in the work situation, for instance special rules if an employee needs extraordinary leave after an extreme incident.

9. When, after the introduction of an intervention programme in an organization, everything is going as it is supposed to, professionals from outside the company are only called in during or after large-scale disasters and, of course, in case of serious disorders that necessitate specialized assistance. The organization should be able to refer the employees concerned to specialized assistance, such as a psychotherapist.

Before describing more details of the intervention programme, it must be realized that a concrete assistance programme is never a direct copy of the model described above. Any model for company-directed assistance has to be specified in an actual programme, depending on the specific problems raised by the incident and the specific characteristics of the organization and the work setting (see Section 13.7.5 for a differentiation in approach). Thus, in some case the above mentioned crisis intervention or victim assistance may be dominant, while in other cases crisis management will be sufficient to reduce sources of stress.

Furthermore, self-coping efficacy of affected employees as well as social support from their unaffected colleagues should not be underestimated. In addition, in trying to solve the adverse effects of critical incidents and prevent further sources of stress, one might be confronted with existing problems, such as organizational problems and conflicts. In these cases, the critical incident reveals what was going on for a longer period. In these circumstances one needs to be careful to attribute mental health problems solely to the event. This may imply other interventions than described here.

With respect to individual care, these interventions most often consist of meetings lasting about one or two hours. The aims of the various contacts differ. During the first contact mainly providing structure and social support should be offered. In addition, needs of the participants are assessed and discussed. Dependent on their needs, attention is given towards their own experiences of the incident. The aim is to reduce arousal levels and enhance
coping efficacy. For some persons concise information about possible stress reactions (for instance about nightmares and sleeping problems that may appear during the first nights) is helpful: it decreases fear about their own stress reactions.

If needed, a couple of days or weeks after the first contact the second meeting can be scheduled. Again attention is given towards their experiences, thoughts and feelings, and remaining needs of the participants are assessed and discussed. General education about stress symptoms and the coping process after critical incidents is usually provided while the victims talk about their own stress reactions.

Possible further contacts are especially aimed at monitoring the development of the coping process and enhancing self-coping efficacy. Attention towards the coping process prevents dominant avoidance tendencies. Furthermore, positive and negative reactions are discussed and ways to counteract sceptical and obnoxious responses from colleagues and significant others are explored. About 4–6 weeks after the incident the process is evaluated, that is: the presence of the aforementioned avoidance reactions, intrusive thoughts and other stress reactions is systematically assessed. The period of 4–6 weeks (in some cases 8 weeks) is chosen – note that the diagnosis of PTSD can be made after one month – because it gives a better insight in presence or absence of lasting coping disturbances. When most stress reactions have dissipated, possible changes in personal values and attitudes towards work and family life are investigated and discussed. If various stress reactions are still very intense and normal functioning has not returned yet, psychotherapy is proposed to the victim. This offer should be made carefully because victims often associate therapy with personal weakness or ‘being mad’. These ideas are often accompanied with feelings of shame and fear that it will jeopardize their career.

13.7.3 Psychological Debriefing

Rescue workers have to do their work under high pressure and in difficult circumstances. Acute stress is part of their job. Moreover, they sometimes do not work in a permanent organization and soon disperse after the event. For assistance to various categories of rescue workers after calamities Mitchell developed a group-directed assistance programme called ‘Critical Incident Stress Debriefing’ in the early 1980s (Mitchell, 1983; Mitchell & Everly, 1995).

Maximally three days after an extreme situation a team of rescue workers comes together in a debriefing session, headed by a specialized helper, for ‘emotional ventilation’ and ‘stress education’. The event as well as the resulting thoughts, reactions and emotions it has evoked are discussed in the
peer group. The specialized helper emphasizes that such emotions and stress reactions are normal after extreme events and informs the participants about the various consequences. Usually there is only one such a group meeting, although it preferably should be followed by a follow-up meeting some time after the event.

The method of debriefing, as developed by Mitchell, as well as the term debriefing itself became immensely popular in the 1990s. However, in the second half of the decade strong criticisms were directed at this method. The central point of this disapproval was that the effects of debriefing are rather poor or even non-existing. Debriefed rescue workers may not suffer from posttraumatic stress symptoms to a lesser extent than comparable non-debriefed groups. This criticism has proven to be justifiable. Controlled studies on one-session forms of counselling have shown that this kind of help does not have any effect or has only very minor effects (Bisson, 2003). Indeed, some evidence even indicated that these debriefings are harmful. As a result, crisis debriefing was placed on a list of treatments that have the potential to cause harm in clients (Lilienfeld, 2007).

However, the debate on debriefing also showed that the term itself was used in an improper way. Nearly all kinds of early intervention were called debriefing and the specific criticisms on debriefing were therefore also generalized to these other types of assistance. This generalization is not justifiable. First of all, research has shown that early and brief forms of psychotherapy are quite successful (Foa & Meadows, 1998). Furthermore, expectations with regard to debriefing have been quite exaggerated. One can hardly expect that people will recover from a horrible experience in just one session. Next, it is also questionable whether all forms of early interventions focus so much on emotion ventilation and on PTSD prevention. Research findings in experimental social psychology (Rimé et al., 1998) indicate that people show positive improvements with regard to job satisfaction, social support, general outlook on life, physical health, but not so much on emotional recovery. ‘Sharing an emotion cannot change the emotional memory’ (Rimé, 1999, p. 177).

The debate on early interventions after acute stress is still going on (Devilly, Gist & Cotton, 2006), but it is by now clear that one-session forms of trauma counselling should be avoided. It has also become clear that proper counselling is not the same as just talking about one’s emotions and finally that it is important to pay proper attention to the social context of the people involved.

13.7.4 Brief Psychotherapy

An intervention programme is essentially different from psychotherapy. It is focused on stimulating normal coping with extreme stress, not on
disturbances in these coping processes. Such a programme of crisis counselling consists of a broad range of basic intervention tools. It is concerned with information supply, practical advice and assistance from the management of the company as well as psychological support.

Nevertheless, psychotherapy may be necessary, namely in case of employees who suffer from serious disorders, for instance after a very dangerous incident or after repeated violence. Such treatments usually are of short duration (usually 5 to 15 sessions of therapy). Various effective short-term psychotherapies for the treatment of PTSD, in particular cognitive behavioural therapy (e.g. exposure) and EMDR (eye movement desensitization and reprocessing), are available (Bisson et al., 2007b; Brom, Kleber & Defares, 1989; Foa & Meadows, 1998).

Relatively new developments are early psychotherapies focused on acute disturbances after traumatic experiences. These therapies are somewhere between multiple-session standardized intervention programmes and normal psychotherapy. They focus solely on individuals with clear and serious disturbances after acts of violence and other calamities, but in contrast to normal psychotherapy they are rather brief: 3–5 sessions. They mostly follow a protocol based on cognitive behavioural therapy (Bryant et al., 2008; Creamer, 2008). Randomised controlled studies have shown that this trauma-focused cognitive-behavioural therapy within three months of a traumatic event are effective for individuals with traumatic stress symptoms, especially those who meet the threshold for a clinical diagnosis. They have been found to be more effective than waiting lists or supportive counselling conditions (Roberts et al., 2009).

### 13.7.5 Variation in Individual Care

Originally, many intervention programmes for victimized employees were directed at all people involved in the violent event. Such a standardized approach has an ‘outreaching’ nature. Studies into victim support (for example, Maguire & Corbett, 1987; Van der Ploeg & Kleijn, 1989) had shown that this kind of health care was usually more appropriate than a more passive approach. Risk groups were also reached better in this way. Indeed, stress reactions and disorders have been found to appear especially with victims who would rather avoid (professional) assistance (Weisaeth, 1989). The goal of such a standardized outreaching approach is also to avoid an association between victim assistance and personal weakness.

Nevertheless, most people affected by violence are able to recover by themselves and with a little help. They need support and information, but not specialized help. Shortly after a traumatic event, it is important that
those affected be provided with practical support and information about reactions, coping strategies and help from those around them. We should not underestimate the resilience of people (Bonanno, 2004). The perspective in this approach is called watchful waiting (Driffield & Smith, 2007). At the same time some people (e.g. individuals who show hyper arousal responses) get overwhelmed by a straightforward approach and need specialized help. As mentioned above, brief psychotherapy has proven to be quite effective for subgroups of victims. Therefore, one should make a distinction in groups of affected victims and in time. Most people will receive a low level of support (Bisson et al., 2007a). Those who show serious indications of disturbances will receive an offer for treatment. The issue in this kind of stepped care model is, of course, the question of how to make a distinction between the two groups. As we showed earlier, there are many risk factors, but none of these factors is decisive.

13.8 CONCLUSIONS

Acute stress at work can take different forms, one of which is confrontation with violence during work. One of the direct consequences is crisis and chaos.Victimized employees experience a shattering of their personal autonomy and their confidence in others. The diversity of reactions is usually large: bewilderment, anger, fear, listlessness, absenteeism. Employees experience a general feeling of insecurity; often people in the near environment who were not victimized themselves suffer from this as well (Figley & Kleber, 1995). In general, adjusting to these experiences takes longer than assumed beforehand.

Fighting the causes of violence in the company is, of course, necessary, as is preparation for the possible occurrence of these extreme events, but acute stress cannot always be prevented. Intervention after the event is useful, in order to reduce sources of stress and chaos, to enable employees to realize the meaning of what they have been through, to provide recognition of their thoughts and emotions, and to prevent, as far as possible, undesired stress reactions.

In many organizations a structured assistance approach exists for victims of acts of violence and other calamities. The experiences with it are positive and employees are mostly quite satisfied with it. The target groups of these approaches have been broadened in the last decade: first the banking business, then the police, later supermarkets, fire-fighters and rescue workers. The introduction of the assistance mostly takes place in an ad hoc fashion, usually in response to a violent incident that has drawn attention to the
problem. Regrettably robust studies on the efficacy and effectiveness of these intervention programmes are still rather scarce.

An integral approach of acute stress is essential. An approach that is only directed at the individual side has little use if crisis management is not addressed and the care is not accepted by the management of the organization. The fact that employees are emotional during the first hours or days, does not necessarily imply that individual care for affected employees should be provided by an ‘expert’. Adequate psychosocial crisis management may be important to effectively reduce sources of stress: in several cases ‘talking about their experiences’ with the affected employees is only part of the solution. Before any interventions are undertaken, first an adequate taxation of raised and possible future problems need to be made.

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