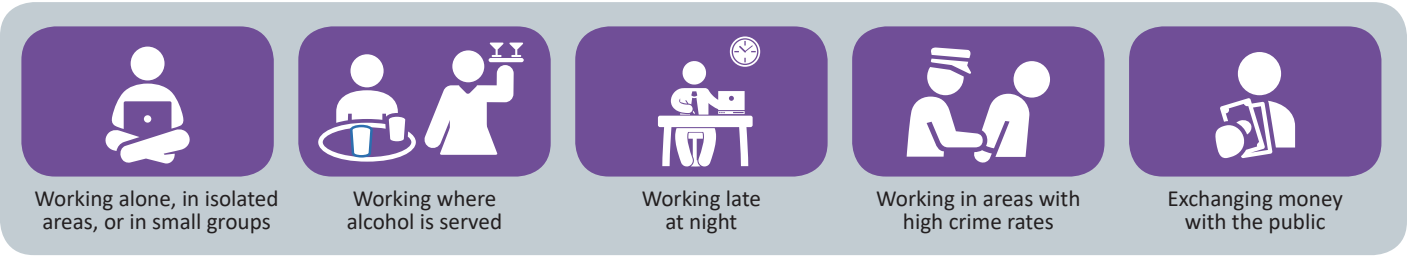
Not all victims of worksite trauma sustain physical injuries

By Tammy Bradly, VP Clinical Product Development

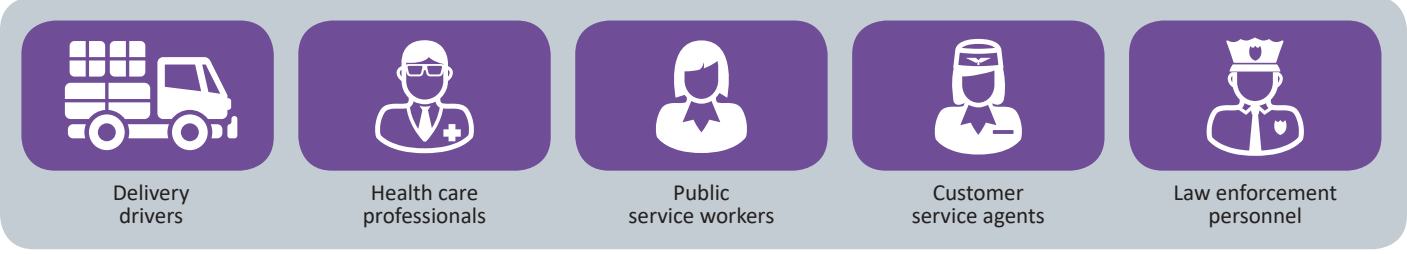
Anyone who has ever witnessed a traumatic event understands the mental anguish it can cause. You don't have to be physically injured to suffer a mental blow. In workers' compensation, we often do a great job caring for the physical injuries, especially those that are commonplace. But what happens following the less-common yet more severe incidents? Do we adequately care for or even acknowledge those unfortunate individuals who witness a catastrophic event? Too often the answer to both of those questions is no. It doesn't have to be this way. Addressing bystander trauma through crisis intervention can be good for workers and for the workplace.

Workplace injuries occur every seven seconds, according to the National Safety Council,[1] so it's to be expected that some of these are going to be severe. Nine in 10 people in the U.S. will be exposed to at least one traumatic event in their lifetimes.[2] For some, the events will carry lasting consequences. The estimated lifetime prevalence of post-traumatic stress disorder (PTSD) in the U.S. is 8.7 percent.[3] For first-responders such as paramedics, the rate is as high 20 percent.[4]

Some of these traumatic events can unfold at work. Nearly two million American workers report having been victims of workplace violence each year.[5] Even that large number understates the problem because many cases go unreported. Research has identified factors that might increase the risk of violence for workers in some situations. These include:



Certain occupations can face heightened risk as well. These include:



According to the Labor Department, violence and other injuries by persons or animals increased 23 percent to become the second-most-common fatal event in 2016. Workplace homicides increased by more than 80 cases to reach 500 in 2016. More than one third of deaths were among older workers. Those age 55 and above suffered nearly 1,850 fatal injuries—the highest number for this group since reporting began in the early 1990s.

The numbers around workplace fatalities are sobering yet even those don't necessarily give the full picture. In fact, even overall numbers about workplace injuries don't capture all of the possible ripple effects from an injury. In 2016, for example, there were 4.5 million work-related medically consulted injuries. And costs for workplace injuries came to an estimated $151.1 billion.[6] That figure reflects lost wages and productivity, medical costs, administrative overhead, motor vehicle property damage, and employer costs. Yet despite broad categories such as employer costs, it's likely that the figures fail to incorporate the full fallout from the more traumatic incidents in the workplace. This is all the more likely when fatalities occur.

For most every death, there are knock-on effects for those who are injured, for those involved and for those who simply witness these events. In workers' comp, we know what to do when someone is catastrophically injured. We can marshal an array of clinical resources to coordinate care for the injured employee. But oftentimes those who witness a catastrophic event without sustaining physical injury might be overlooked. Crisis intervention seeks to address the needs of those who are exposed to a critical event. Depending on the jurisdiction, psych as a primary diagnosis may be considered compensable. Regardless, a traumatic event can upend the workplace. A psychological crisis is a response to a critical incident that might disrupt a person's psychological balance and usual coping mechanisms. Trauma can disrupt a worksite in many ways. Employees who witness a traumatic event may experience acute psychological crisis. An employee's response might vary depending upon factors such as proximity to the incident, relationship to the individuals involved, or ability to cope with stressful situations. A crisis situation at the worksite can reduce employees' motivation, hamper productivity, and even cause some people to leave a job. These effects can ripple through the organization. Chaos and disorganization can harm overall productivity if employees are unable to cope or are absent from work.

There are three common psychological reactions to a traumatic or crisis event:

- **Eustress** — This is the good stress that motivates the person to move forward.
- **Distress** — This is excessive stress though most people show resilience at this level of interference.
- **Dysfunction** — This is when a person is impaired to the point it affects his ability to perform normal activities of daily living.

Is there anything we can do to support employees who witness a traumatic event? Can we, in some cases, prevent the normal distress reaction from developing into PTSD? The answer is yes.

The field of crisis intervention dates to WWI. However, the field of disaster mental health has been developing since the 1990s. In that time, groups including the American Red Cross and the Salvation Army, among others, have created disaster-response teams.

Critical Incident Stress Management (CISM) is a comprehensive, systematic, and multifaceted approach to managing traumatic stress within an organization or a community. It focuses on assisting both individuals and groups that have experienced a traumatic event. The goal is to mitigate the effects of a critical incident and assist employees in recovering as quickly as possible. Often referred to as psychological first aid, crisis intervention can be administered with small groups (e.g., debriefings) or with individuals. This allows employees to share their thoughts and feelings about an incident while a crisis interventionist watches for signs of stress and discomfort. This professional can then offer to hold

one-on-one meetings with any employee who wishes to participate. Typically, it's best to limit individual meetings to one or two sessions. Anything more than that likely would require psychological intervention through the employer's employee-assistance program (EAP) or through a health plan and/or community resources.

Keep in mind that most individuals exposed to a traumatic event will need some level of intervention. Participation should be voluntary unless the individual displays maladaptive behavior or appears as though he may harm himself or others. And someone should not be required to talk about or relive an event unless she volunteers to do so. Being forced to do so can risk reintroducing the trauma.

The goal of any crisis intervention is to mitigate the harmful effect of traumatic stress, to provide support, and to offer encouragement in order to accelerate recovery. Doing so is not only the right thing to do, it can also mitigate losses to productivity at an individual and organizational level. And crisis intervention should seek to make appropriate referrals to qualified mental health professionals and other providers when indicated. If the needed resources are not available through an EAP or through an employer health plan, a referral should be made to community resources.

To gain deeper insight into how crisis intervention works, we asked two of Coventry's crisis intervention case managers to discuss their work. Eleanor Armstrong-Head and Michelle Volpe have seen how the proper response after a traumatic worksite incident jumpstarts the recovery process and promotes positive outcomes. Here is an excerpt from the discussions:

Tammy: Intervening after a traumatic event is challenging work. What skills or tools make a crisis intervention case manager successful?

Michelle: We have our standard protocol for conducting the intervention and I always review that before going in. But the one thing I've found to be very true—and I've been doing this for 11 years—it's very important to be your true self. When you're with a group of people who lost a coworker, for example, you need to be genuine to establish trust and engagement or it won't work.

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Tammy: That's true. I imagine reading from a script or seeming like you're taking a formulaic approach would make it harder to establish trust with the folks you're meeting with. And we know building trust and making a connection is critical to helping people recover from an incident and get back to their best performance at work and in life. But making a connection can be easier said than done. Do you find it difficult to get groups of workers to talk after a traumatic incident?

Michelle: I recently did a session where a young man was killed on a job site. The group I met with was mainly young men who were not comfortable sharing their feelings. So I sat there and I talked to them like I was in their living room. I used their terms and used language they would understand, not clinical terminology. The most important piece was being genuine. I said "I don't know what you're going through, but I am here to help where I can. I have tools that could help." It was a difficult discussion from the get-go. These were 20-somethings—big, strong guys—and it took a little longer to hit that spot. But I just kept going until something clicked and someone started to talk. I told them they were having very normal reactions. You are kind of pushing buttons with them and then they open up. By the end, half of them hugged me before I left.

Tammy: That's incredible. It also makes me think you both must have to really think on your feet as you see how a debriefing is unfolding. What do you do to prepare?

Eleanor: Well, before a session begins, I try to observe group dynamics (who is hanging out with who), what's their body language, what's the energy in the room with the group. Are they nervous? Are they scared? Are they looking at the floor? Who is the leader of the group? Then I begin to react as the discussion unfolds.

Recently, I had a pretty large group of folks. I separated the workers who spoke only Spanish from the English speakers. I also speak Spanish so I met with that group while a colleague met with other group. I brought some snacks to keep it casual. Then I just observed who they were looking at the most. We started talking and they began to open up. I listened to their belief systems. I learned that there was going to be a massive walkout of the Hispanic male community at that employer. I pressed them a little more and realized they had a spiritual belief that they could still see their former

coworker in the area around the equipment where the fatality occurred. At work, people often are afraid to speak about religion. Crisis intervention allowed us to get to this place and talk about their faith and their superstitions.

We also had an employer that allowed it. They were willing to be creative and responsive to get to a better outcome. They brought in a chaplain—a Catholic priest—to bless the site. Before that, there had been a lot of absenteeism. It took a lot of listening and observation. Then you take them through the steps of crisis intervention. Active listening and observing body language are key. These workers felt listened to; they felt like someone understood. It's the ability to shift and meet them at their needs. There was not one walkout. The manager said it was an extraordinary turnaround among the workers.

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Tammy: That's amazing and, I imagine, not what the employer expected. But expecting the unexpected makes sense because a critical incident can take many forms. What are some of the types of calls you get?

Michelle: I had a client who was working at a convenience store. She was cleaning the bathroom and was dumping the trash when she stepped on a syringe; she was afraid she had contracted HIV. I worked with her for a few sessions to help her through that until her medical tests came back negative. Then I had another case where a frequent guest at a hotel took his own life in his car in the parking lot. I provided counseling for the hotel staff that found him. Another time I worked with a highway crew working overnight that saw an accident involving a two-car collision and one driver died immediately. Then another car hit some of the crew members and injured two of the workers very badly. In all of these cases, people often feel like they will never un-see it. But I explain that it won't always feel as intense as it does right now.

In another case, I had one young woman working at a convenience store who was robbed on her shift. The attacker was caught and then released. I conducted telephonic counseling with her. She returned to work and at the end of her first day back she called me at 4 a.m. to say she'd gotten through her shift and was doing better.

Tammy: That's quite a variety. What are some of the techniques you use to gently encourage individuals or groups into sharing what they might be feeling?

Michelle: I just say to each person, "Tell me from your perspective what happened. How did you feel after? How did you react? What's been going on with you since then?" The most common answer is "I should have, I could have done something to help or to change it." I try to do a reality check with them to say, "Realistically, what could you really have done given the situation?" It helps. I try and give people tools to unpack their feelings. They can use them at home on their own to deal with the trauma. These are normal feelings and there are tools you can use. At 3 a.m., when you're in the dark by yourself, that's when you're going to feel these things. And that's when you need to have a reality check with yourself. It's about support, education, and teaching them to manage on their own.

Tammy: What are some of the signs you see that someone might be struggling more than he or she lets on?

Eleanor: Many times you'll see people who are self-medicating—drinking, taking medication, whatever is handy. Some will go to a doctor to say they aren't sleeping but not tell the doctor about this tragic incident at work so it's not diagnosed properly. We educate the employer to look for signs and also identify those that would be at risk for developing more issues. These might include witnesses to an incident or those that didn't engage in our initial session.

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Tammy: How do you know your efforts are working?

Michelle: I focus on active listening and empathetic responding. The best scenario is where the group starts talking to each other. That happened in a session with a group of managers not too long ago. They took the ball from me and were communicating with each other. That was a great sign that they would be able to support each other and their crew after I was gone. I told them when we started that these are techniques you can use when dealing with your crew. So it's education for the management team as well. It's providing them with the tools they need.

Tammy: What are some of the mistakes you see employers make following an incident?

Eleanor: Employers do make mistakes. They're human, too. Sometimes their reaction is, "Get out of here and go back to work." They just want keep everyone else out of the area where an incident occurred. They're meaning well and want to

take their employees away from a bad situation. Preparedness can help employers know what to do when something happens rather than just reacting without a plan.

I had one manager say he didn't know so much could be done in one afternoon. They're just surprised by how much can come from this and how much people can be helped by debriefing.

Michelle: Things happen. And you can't assume that you're going to be safe in any workplace whether it be somebody attacking you or simply an accident. This is something employers have to prepare for just as much as they do the physical injuries.

Tammy: Have you seen employers miscalculate how widespread the fallout is from an incident?

Eleanor: Yes, I would say probably on every crisis intervention I've had. In one case, we had a projection for a maximum 10 people participating and it turned out to be almost double what the management thought. I had 100 percent participation. Honestly, we got so many letters and calls from that employer and so much praise for how much help our solution provided. The manager was literally searching to see what he could do. He was actually a nurse; he just had no idea that this kind of crisis intervention existed. I always do a follow-up call with the employer to get their feedback. I had one manager say he didn't know so much could be done in one afternoon. They're just surprised by how much can come from this and how much people can be helped by debriefing. They're seeing people smile again. It's one of the things that I love about my job. I love being able to help who I can help for as long as I can help them and get them going in the right direction.

Tammy: That's fantastic. It must feel great to help traumatized workers though I imagine it's also difficult to interact with workers so soon after a workplace incident. Is that the case?

Michelle: Yes. I hate the reasons for these cases but I love working on them. It's something where you know within a very short amount of time you've made an impact. As a counselor, you take away something from every case that you have and you learn how to do something a little better and you learn different approaches for reaching people. Everybody comes out of it a little changed. The one thing I would say from a case-management perspective is don't go into this lightly. It does take a lot out of you but it can give you some of the most satisfying moments of your work. It's one the hardest things I've ever done but it's one of the best things I've ever done. I truly believe it's a great service.

Tammy: Thank you both for the great work you do.

Eleanor Armstrong-Head is a nurse, a clinical research coordinator, a bilingual case manager, and a field case manager.

Michelle Volpe is a certified rehabilitation counselor, a vocational case manager, a forensic specialist, a disability specialist, and a crisis response specialist.

About Tammy Bradly

Tammy Bradly is vice president of clinical product development for Coventry. Bradly is a certified case manager with more than 25 years of comprehensive industry experience through service delivery, operations management, and product development. She holds several national certifications, including certified case manager (CCM), certified rehabilitation counselor (CRC), certified program disability manager (CPDM), and critical incident stress management (CISM).

About Coventry

Coventry offers workers' compensation cost- and care-management solutions for employers, insurance carriers, and third-party administrators. With roots in both clinical and network services, Coventry leverages more than 30 years of industry experience, knowledge, and data analytics.

1. *National Safety Council, "Workplace Injuries By the Numbers"*
2. *Ogle, Rubin, Bernsten, and Siegler (2013)*
3. *Kessler, Chiu, Demler and Walters (2005). Bennett et al (2005)*
4. *Bennett et al (2005)*
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6. *National Safety Council, "Injury Facts"*