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The perceptions of accident and emergency nurses regarding a structured debriefing programme in a private hospital in Gauteng

by

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Give thanks to the LORD, because he is good; his love is eternal.
(Psalms 106)

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Marius van Heerden

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DECLARATION

Student number: 9810043

I, Marius van Heerden, hereby declare that:

The perceptions of accident and emergency nurses regarding a structured debriefing programme in a private hospital in Gauteng

is my original work, and that it has not been submitted before for any degree or examination at any other institution. All the sources that have been used or quoted have been acknowledged by means of complete references in the text and bibliography.

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MARIUS VAN HEERDEN **DATE**

ABSTRACT

The perceptions of accident and emergency nurses regarding a structured debriefing programme in a private hospital in Gauteng

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The aim of this study was to determine Accident and Emergency (A&E) nurses' perceptions of a structured debriefing programme based on the model of SP Hattingh. Objectives of the research were to train A&E nurses as peer debriefers to be able to implement a structured debriefing programme, to then implement it and finally to determine the debriefed A&E nurses and debriefers' perceptions of the structured debriefing programme. A contextual, explorative, descriptive research design, using qualitative methodology, was adopted. The population for this study was all registered nurses working in an A&E unit in a private hospital in Gauteng. Three main themes were identified, namely: positive aspects, negative aspects and recommendations for implementation. Recommendations were made to optimise the use of this programme in the future.

Key terms:
Accident and Emergency nurses; structured debriefing programme; model of SP Hattingh; peer debriefers; qualitative methodology; perceptions; positive and negative aspects; recommendations.

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LIST OF ABBREVIATIONS

A&E	Accident and emergency
APA	American Psychiatric Association
CISD	Critical incident stress debriefing
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders - 4th Edition
e.g.	For example
i.e.	*id est* (that is to say)
ICU	Intensive care unit
PTSD	Posttraumatic stress disorder
SANC	South African Nursing Council
Unisa	University of South Africa
UP	University of Pretoria
USA	United States of America
WCA	Workmen's Compensation Act

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Chapter 1

THEORETICAL FOUNDATION AND ORIENTATION TO THE STUDY

Vision without action is merely a dream
Action without vision just passes the time
Vision with action can change the world
Joel Arthur Barker

1.1 Introduction

The personal health of Accident and Emergency (A&E) or trauma nurses, in particular their psychological safety, is of paramount importance. Nurses who give care and attention to patients involved in serious incidents are exposed to events that would be psychologically disturbing to anyone who witnesses them. To reduce the risk of developing long-term psychological symptoms due to exposure to horrific events, all rescuers (including A&E nurses) should have access to and be allowed to attend debriefing sessions on request.

In a study conducted by Ewers, Bradshaw and McGovern (2002:470-6), the need for A&E nurses to be properly debriefed was assessed. The conclusion was that providing A&E nurses with better understanding of serious mental illnesses related to traumatic events and training them in a broader range of interventions would help them develop a more positive attitude toward their clients/patients, and reduce negative experiences of stress resulting from their caring role. The relationship between A&E nursing, health hazards and the psychological well-being of the A&E nurse has been explored by different authors.

Health hazards (things, events or situations that can harm the safety of a person) also involve the psychological well-being of the A&E nurse (Dolan & Holt 2000:21). These authors emphasised the importance of looking after the psychological well-being of trauma nurses and suggested proper debriefing of trauma personnel. They stated that, before the initial assessment or primary survey of a patient was carried out, the concept of debriefing should have been introduced to the healthcare providers involved.

The objectives of the initial assessment or primary survey of a patient are to rapidly identify and correct life-threatening injuries. In order to assess for health hazards, the health hazards assessment standard, set out as (H) - H, H, A, B, C, D, is used in an A&E unit. Every letter in this health hazards assessment standard or (H) represents a crucial action to be taken by the A&E nurse in order to treat a patient to the best of their capability. The hazards assessment standard with its six components is set out below.

- **Health hazards assessment standard (Hazards)**

The first H (in brackets) refers to the hazards assessment standard, or Hazards for short. Hazards is used by the A&E nurse in order to observe for anything that may endanger the health of the nurse or the patient, such as exposure to blood borne diseases (O'Shea 2005:41). This assessment standard, which is aimed at ensuring the safety of the A&E nurse and the patient, has the following six components (represented by the letters H, H, A, B, C, D):

- **H**ello (Say hello).
- **H**elp (Call for help).
- **A**irway (Establish and open the airway).
- **B**reathing (Assess for breathing).
- **C**irculation (Assess for circulation).
- **D**isability (Assess for disability).

  (Dolan & Holt 2000:21).

These initial assessment actions are also endorsed by the Resuscitation Council of Southern Africa and constitute the golden standard for treating a patient who is in need of urgent medical care.

However, safe patient care depends, among other things, on the psychological safety or well-being of the A&E or trauma nurse. Trauma nurses could become a hazard not only to themselves, but also to the patients, if they were not being debriefed properly and regularly or looked after psychologically. Trauma nurses who are experiencing the effects of stress after a critical incident may be less effective in applying appropriate treatment (Dolan & Holt 2000:21). This strong likelihood accentuates the importance of debriefing.

Morrow (1998:2) states that critical incident stress debriefing (CISD) is provided by professionals that are specially trained in this technique. Typically, there will be one to two debriefers per debriefing group. A group will last two to three hours, depending on the number of participants and the severity of impact of the critical incident. Follow-up services usually include a combination of individual and/or group sessions, depending on employee needs during the first few days after the incident.

The effects of serious traumatic events on A&E workers can be catastrophic. If critical incident related stress is not treated timeously and properly, it can lead to a decrease in the quality of patient care. To promote the mental health of A&E nurses in South Africa and ensure safe patient care in A&E units, debriefing of nurses has to be standardised practice.

However, a literature search did not yield any standardised programmes for the debriefing of A&E nurses in South Africa. In contrast, various foreign countries lead by researching and implementing standardised debriefing programmes for trauma nurses working in A&E units. Conducting research on the debriefing of A&E nurses in South Africa is necessary and imperative in order to promote the mental health of A&E nurses in South Africa and ensure the effective application of patient care.

A research study conducted by Dr SP Hattingh in South Africa in 2002 resulted in the design, implementation and evaluation of a model for the training of peer debriefers in the emergency services (Hattingh 2002). Peer debriefers trained by Hattingh conducted structured debriefing among emergency workers that were exposed to critical incidents on South Africa's roads.

Hattingh's structured debriefing programme does not focus specifically on A&E nursing personnel in a hospital setting. However, as this model applies to a South African context and addresses the training of peer debriefers in the emergency services, which by definition include A&E nursing services, the researcher realised that it could be trialed in the A&E unit of a South African hospital. The researcher decided to implement a structured debriefing programme based on Hattingh's model, as it was designed for a South African context. By conducting this study, the researcher wanted to determine the perceptions of A&E nurses on a structured debriefing programme.

Aspects of Dr Hattingh's study will be dealt with in more detail in Chapters 2 and 3 of this research report.

1.2 Problem statement and research question

A nursing practitioner working in an A&E unit has to have the necessary skills and knowledge, as well as the correct attitude. Ideally, a registered nurse working in an A&E unit should function with maximum efficiency. In order to ensure optimum nursing care in the unit, the potential hazard of a psychologically unsafe nurse should be excluded. Personnel working in an A&E unit are exposed to various traumatic incidents, and experience high levels of stress as a result. The researcher realised that stress could become unbearable.

While working as nursing practitioner in an A&E unit, an environment marked by high volumes of critical incidents, the researcher observed the negative effects of high levels of stress on the functioning and work performance of nurses. The

researcher realised that CISD could have a positive effect in instances where nurses were adversely affected by traumatic experiences in the unit.

Unfortunately, in the unit where the researcher was employed, adequate debriefing programmes or frameworks were not in place to support nurses that experienced work-related stress. As no structured debriefing programmes existed in the unit, the researcher decided to implement such a programme. Until then, the experience of A&E nurses in the unit regarding debriefing had not been explored. Thus, a need was perceived to investigate A&E nurses' perceptions of structured debriefing in a private hospital in Gauteng Province, South Africa.

To summarise, the problem researched in this study evolved from the observation that A&E nurses were exposed to a high frequency of critical incidents leading to high levels of stress. Because of the non-existence of a structured debriefing process in the specific unit, nurses did not manage their stress, nor did they function optimally. It seemed that the effects of work-related stress, combined with the absence of a structured debriefing programme, negatively influenced overall patient care in the unit.

The researcher, therefore, decided to invite Dr SP Hattingh to train A&E nurses as peer debriefers and to implement a structured debriefing programme, based on Dr Hattingh's model, in the A&E unit in order to debrief A&E nurses. However, the researcher was unsure what the perceptions of the A&E nurses would be regarding the structured debriefing programme. The following research question was formulated in order to determine the perceptions of A&E nurses on structured debriefing:

What are the perceptions of A&E nurses regarding a structured debriefing programme in a private hospital in Gauteng?

1.3 Aim and objectives of the study

The aim of this study was to implement a structured debriefing programme based on Dr SP Hattingh's model in the A&E unit of a private hospital in Gauteng and to determine the A&E nurses' perceptions structured debriefing.

To reach this aim, the following objectives were defined, namely to:

- Train debriefers in the A&E unit to be able to implement a structured debriefing programme based on the model by Hattingh;
- Implement the structured debriefing programme;
- Obtain data from debriefed A&E nurses and debriefers about their perceptions of the structured debriefing programme; and to
- Make recommendations regarding the future use of this structured debriefing programme.

1.4 Assumptions

Assumptions are statements that are taken for granted or considered true even though these statements have not been scientifically tested (Burns & Grove 2001:45). According to Mouton (2003:123), assumptions function as essential background beliefs, underlying other decisions in the research process. By stating assumptions the researcher is bracketing personal knowledge with a view to understanding the phenomenon from a different perspective.

The following assumptions were made by the researcher in this study:

- Psychologically healthy nurses can deliver quality patient care.
- A&E nurses in the research context are exposed to severe critical incidents and experience high levels of stress.
- A need exists for structured debriefing after a critical incident has occurred.

- The feelings, opinions and attitudes expressed by study participants that were exposed to critical incidents in an A&E unit will be better understood in a study design that is descriptive and contextual in nature (Mouton 2003:123-4).
- Perceptions of nurses are human behaviours that are not quantifiable and thus are best studied within the context of a qualitative research design (Mouton 2003:123-4).
- The implementation of structured debriefing after a critical incident can have positive effects on the well-being of A&E nurses.

1.5 Clarification of key concepts

Key concepts defined for the purposes of this study are as follows:

- *A perception* is defined as a representation of what is perceived. It is a way of conceiving something and is part of a basic cognitive process to conceptualise a concept. (Lewis 2002).

- An *A&E nurse* is any registered nurse with specialised training or experience, providing emergency health care to the clients in an A&E unit in the research context.

- The *structured debriefing programme* in this study refers to the programme that was developed by Dr SP Hattingh in her study in 2002 for the training of peer debriefers in the emergency services. Following the training of selected A&E nurses as peer debriefers, the programme will be implemented and trialed in an A&E unit in a private hospital in Gauteng.

- The *A&E unit* is any unit staffed by trained professionals, who deliver emergency health care to patients. As opposed to a level 1 unit that has radiology facilities and a specialist surgeon on site 24 hours a day, a level 2 unit has radiology facilities next door and specialist surgeons on call for

patients in need of specialist care. For the purposes of this study, an A&E unit refers to a level 2 unit.

- *Stress* in this study can be defined as stress that occurs in emergency healthcare professionals as a response to any demand on the physical, mental, psychological, social and spiritual reserves of the person (Hattingh 2002:38).

- *Critical incidents* are extraordinary or traumatic events that cause extraordinary stress reactions. A critical incident should be seen as an event that has the ability to cause undesirable physical, emotional and behavioural signs and symptoms (Hattingh 2002:39).

- *Debriefing* is a meeting or discussion about distressing critical incidents, designed to mitigate the impact of a critical incident and to assist the participants to recover as quickly as possible from stress caused by the event (Hattingh 2002:39).

- Within the context of this study, a *debriefer* is a selected registered A&E nurse who has been trained by Dr SP Hattingh to conduct a structured debriefing session or programme. Debriefers have one common goal, namely to reduce critical incident stress in A&E nurses (Hattingh 2002:41).

1.6 Research design and methodology

A brief overview of the research design and methodology follows. A detailed and thorough description of the research methodology will be provided in Chapter 2.

1.6.1 Methodology

A contextual, explorative, descriptive research design, using qualitative methodology, was adopted for this study.

Qualitative research can be defined as a method of inquiry to deal with the issues of human complexity by exploring these issues directly (Polit & Hungler 1997:14-5). Qualitative research also tends to focus on dynamic, holistic, and individual aspects of phenomena and attempts to capture those aspects in their entirety, within the context of those who are experiencing them.

Contextual design in this study refers to the fact that only one facility was used for research purposes. In the case of a contextual design, study findings cannot be generalised, as they are relevant to only the research context.

Exploratory studies are designed to increase knowledge about a field of study (Burns & Grove 2001:374). They are conducted to gain insight into a situation, phenomenon, community or individual (De Vos, Strydom, Fouché & Delport 2002:109).

Descriptive research presents a picture of the specific details of a situation, social setting or relationship, and focuses on ‘how’ and ‘why’ questions (Burns & Grove 2001:248).

In this study, six motivated A&E nurses will be selected to receive training in debriefing for a period of one week. After the one-week training is completed, the structured debriefing programme will be implemented in the A&E unit. The phenomena that will be explored are the perceptions of A&E nurses regarding structured debriefing in a private hospital in Gauteng.

1.6.2 Population and sample

The population for this study will be all registered nurses working in an A&E unit in a private hospital in Gauteng Province. The researcher will make use of purposive sampling. Purposive sampling is a type of non-probability sampling, for which inclusive criteria are stipulated (Polit & Hungler 1997:229-30).

The first ten informed A&E nurses in the unit, who has volunteered to participate, will be included as participants in the study.

The inclusive criteria are stipulated in Chapter 2.

1.6.3 Data collection and analysis

The researcher will make use of an unstructured, in-depth, one-to-one interview as data collection instrument. These interviews will be conducted between the researcher and each of the participants. During these unstructured interviews, one central open-ended question will be asked, and the participants may respond to this question verbally and in a manner they are comfortable with. The interviews will be recorded, and the recordings transcribed. The central research question and the research process are explained in detail in Chapter 2.

According to Polit and Hungler (1997:321), data analysis refers to the systematic organisation and synthesis of research data. Each participant's response will be transcribed verbatim. The transcribed interviews will be analysed by means of a qualitative content analysis. Rossouw (2003:160) describes content analysis as a systematic method of studying the contents of messages and how they are handled. However, a qualitative content analysis is more than just a systematic study method, it is also a method of observation. Verbal communication will be observed, recorded, transcribed verbatim, presented in a written format, and then coded and classified.

Findings will be categorised into subcategories, categories and superordinate themes. The researcher will make use of external co-coders to validate coding and categorisation of data.

1.6.4 Measures to ensure trustworthiness

To ensure the trustworthiness (or truth value) of this research project, the four constructs *credibility, transferability, dependability* and *confirmability*, as proposed by Lincoln and Guba, and explained in De Vos *et al.* (2002:351-2), will be used. These constructs will be elaborated on in Chapter 2.

1.7 Ethical considerations

In conducting this study, it was important for the researcher to consider the ethical rights of the participants.

- To protect the rights of the A&E nurses participating in this study, the research proposal was reviewed and approved by the Ethics Committee of the Faculty of Health Sciences at the University of Pretoria (UP).

- Consent will be obtained from the participants as well as the private hospital in Gauteng where the study is to be conducted. All consent documents will be kept in a safe place by the researcher. A copy of the informed consent document that has to be completed by the participants in this study, as well as the letter of approval obtained from the UP Faculty of Health Sciences Ethics Committee, is attached to the study report. See Annexures A and B.

- The anonymity of the participants will be preserved throughout the research study and afterwards. The researcher will keep all copies of the tape-recorded interviews safely.

- The participants will not be exposed to any harm during, or as a result of, the research study.

- Informed consent does not imply that the participants are under any obligation to remain part of the research study for its full duration, and they may discontinue their participation or withdraw their consent without giving any reason.

1.8 Background to the study

Multiple debriefing models exist and the researcher reviewed some of the most frequently used models and techniques. The researcher decided to use only Dr SP Hattingh's model, as the research for the development of this model was conducted in a South African context. With the exception of this model, the researcher could not find any other significant research about structured debriefing of emergency personnel that was conducted in a South African context.

Relevant literature has been thoroughly reviewed in order to understand the context and background of debriefing. To fully understand CISD, the concepts 'stress', 'critical incident stress', and 'critical incident stress that A&E nurses are exposed to' need to be understood. These and related terms are discussed below.

1.8.1 Stress

Stress is difficult to define, but it can be described as an upset feeling or response. Several researchers have defined stress as the body's physiological and psychological response to a stressor (Harris 2001:47-52).

There are helpful and harmful levels of stress. When an individual is under stress, his or her adrenalin level increases and this heightens their awareness

of the environment. Heightened awareness, as well as an increased mental and physiological response, enables the individual to function at an optimum level. However, harmful levels of stress produce the opposite reaction. Stress can be harmful when an individual is confronted by different types of stressor at the same time. If one were repeatedly exposed to stressful events for a long period of time, even a minor situation might produce harmful levels of stress.

People perceive stress differently; however, perception of work-related stress is almost always the same. Work-related stress reduces one's level of physical and mental functioning. It affects patient care because nurses who experience stress at work are more likely to make mistakes. Stress caused by stressful events in the emergency care environment also leads to friction among staff, management, families and patients. The more stressful a situation becomes, the more irritable and impatient people become (Harris 2001:47-52).

1.8.1.1 Stress among emergency nurses

Adeb-Saeedi (2002:19-24) stated that high levels of occupational stress are experienced by healthcare personnel, especially nurses working within the critical care environment. A British study by Helps (1996:48-53) found that, out of a sample of A&E nurses, one third had suffered high levels of stress, a significant number of whom also reported symptoms of posttraumatic stress disorder (PTSD). The stress experienced by those nurses was related to team cohesion and interpersonal relationships - issues that were both sources of stress and sources of satisfaction.

1.8.1.2 What nurses experience as stressful

The most common cause of stress reported by nurses in Australia was dealing with patients' pain and suffering and the heavy workload in the emergency department (Adeb-Saeedi 2002:19-24).

Curtis (2001:33-8), researching nurses' experiences of working with trauma patients, reported recurring themes such as communication, workload and scarce resources as causes of stress. The majority of the respondents surveyed also indicated that looking after a trauma patient was more stressful than caring for other patients.

Research by McGowan (2001:33-8) into the effects of stress on nurses found the following issues to be stressful (also in a trauma setting):

- Shortage of resources;
- Dealing with aggressive people; and
- Job dissatisfaction.

According to the Canadian researchers Laposa, Alden and Fullerton (2003:23), work-related stress in the emergency department has previously been linked to depression and burnout; however, these findings have not been extended to the development of anxiety disorders, such as PTSD. Three sets of factors have been shown to contribute to stress in emergency department personnel by these authors:

- Organisational characteristics;
- Patient care; and
- Interpersonal environment.

Fifty-one (51) emergency department personnel (mainly emergency nurses) from a hospital in a large Canadian urban centre partook in this study. The respondents had to complete a questionnaire that measured PTSD and sources of work-related stress. It was found that interpersonal conflicts were significantly associated with PTSD symptoms. The majority of the respondents (67%) believed they had received inadequate support from hospital administrators following a traumatic incident and 20% considered changing jobs as a result of the trauma. Only 18% attended CISD and none sought outside help for their distress. (Laposa *et al.* 2003:23).

The Canadian study showed the need for hospital administrators to be aware of the extent of workplace stress and PTSD symptoms in their employees. Improving the interpersonal climate in the workplace may be useful in alleviating PTSD symptoms.

1.8.1.3 Traumatic events

According to the American Psychiatric Association's (APA's) Diagnostic and Statistical Manual of Mental Disorders - 4th Edition (DSM-IV), a traumatic event includes experiencing an event directly or personally that involves actual or threatened death or serious injury; or witnessing an event that involves death, injury, or threat to the physical integrity of another person; or learning about unexpected or violent death and/or serious harm. The person's response to the event must involve intense fear, helplessness or horror. (APA 1994:242).

Trauma is experienced as a result of events such as car accidents, natural disasters (floods, fire, earthquakes *etc*.), child abuse, assault or robbery and rape.

Laposa *et al.* (2003:26) listed the following six occurrences in the emergency department as most upsetting events:

- Providing care to a patient that is a relative or close friend and is dying or in a serious condition;
- Physical assault of self;
- Multiple trauma with massive bleeding or dismemberment;
- Death of a child;
- Providing care to a traumatised patient that resembles oneself, a family member or friend in age or appearance; and
- Caring for a severely burned patient.

Although the actual cluster of symptoms experienced by any individual will vary, the following two lists include common reactions following exposure to a

traumatic event. Typically, a traumatised individual will alternate between two distinct phases of hyperarousel and avoidance and his/her symptoms will reflect this alternating pattern (Van der Kolk 1994:101).

Hyperarousel is expressed through symptoms of:

- Nightmares;
- Recurrent and intrusive thoughts about an event;
- Acting or feeling as if the experience is happening again in the present;
- Flashbacks;
- Difficulty in concentrating;
- Sleep problems – the person has difficulty falling and staying asleep;
- Hypervigilance – the person frequently feels on guard;
- Anger problems – irritability and outbursts of anger.

Avoidance is manifested by:

- Attempts made to avoid thoughts or feelings associated with trauma;
- An inability to recall an important aspect of the event;
- A restricted range of feelings, *i.e.* the person feels numb or spaced out, or is unable to have loving feelings;
- Feelings of detachment or estrangement;
- A markedly decreased interest in pleasurable activities.

For most people, these symptoms will subside within a period of 30 days, with complete disappearance of nearly all symptoms in a few months. For others, these reactions will persist, and the resulting disruption of their ordinary day-to-day functioning can become chronic. When this occurs, PTSD can be diagnosed. (Van der Kolk & Fisler 1995:88).

1.8.2 Posttraumatic stress disorder - PTSD

DSM-IV defines PTSD as a set of typical symptoms that can develop after a person has seen, heard or been involved in an extreme traumatic stressor (Kaplan & Sadock 1998:617). Bryant (2000:1-8) describes this mental disorder as an acute stress reaction that occurs in the individual up to a month after exposure to a severe traumatic event or critical incident.

The author uses the following criteria to define PTSD:
One should:

- Suffer a traumatic experience;
- Display at least three acute dissociative symptoms;
- Have at least one symptom that is reexperienced;
- Display marked avoidance;
- Display marked hyperarousal; and
- Experience these symptoms between two days and four weeks after the traumatic event.

A more standardised scale, the Posttraumatic Diagnostic Scale, was developed and used by Laposa *et al.* (2003:25) to assess PTSD in nurses that were exposed to traumatic events. This scale defines the diagnostic criteria for PTSD in more detail. These criteria are:

- Experiencing, witnessing or being confronted with a life-threatening event, a person responded with intense fear, helplessness or horror;
- Reexperiencing the event (*i.e.* experiencing upsetting thoughts/images or bad dreams about the event; feeling emotionally upset when reminded of the traumatic event);
- Numbing and avoidance of things associated with the trauma (*i.e.* avoiding talking about the event; avoiding things that remind them of the event; feeling distant from others or emotionally numb);
- Increased arousal (*i.e.* trouble sleeping or concentrating);
- Duration of the above for more than one month; and

- Clinically significant distress or impairment in important areas of life functioning.

1.8.3 Critical incident stress debriefing - CISD

1.8.3.1 Critical incidents

A critical incident is any situation that causes unusually strong emotional reactions. Such an incident has the potential of interfering with the affected individual's ability to function at home, school or work. In the workplace, critical incidents may include robbery, assault with (or brandishing of) a deadly weapon by a co-worker, injury or witnessing the injury or death of another, being held hostage, and other similar out-of-the-ordinary events (Morrow 1998).

Davis (1998) defines a critical incident as a physical or psychological threat to the safety or well-being of an individual or community regardless of the type of incident. Such an incident causes a distressing, dramatic or profound change or disruption in the physical (physiological) or psychological functioning of a person faced by it. There are often unusually strong emotions attached to the event, which have the potential to interfere with that person's ability to function either at the crisis scene or away from it.

Clinically, critical incidents and their impact on individuals are fairly predictable. When a person has been exposed to a critical incident, whether briefly or over the long term, this exposure can have a considerable impact on their global functioning (Morrow 1998).

In time, researchers began to find evidence that emergency workers, public safety personnel, responders to crisis situations, rape victims, abused spouses and children, stalking victims, and media personnel, as well as individuals who were exposed to a variety of critical incidents such as fires, earthquakes, industrial disasters and workplace violence, had developed high levels of stress and were in need of CISD (Morrow 1998).

There is considerable anecdotal evidence that nurses experience critical incidents in the course of their work. In terms of A&E nursing, a critical incident is defined as an extraordinary clinical event that has the potential to cause unusually strong emotional reactions (Everly, Jeffrey & Mitchell 1997).

1.8.3.2 Types of clinical event perceived as critical incidents

Serious injury, death of a child, death of patients, emergencies and violence were typically viewed as critical incidents for nurses (O'Connor 2003:52). In O'Connor's study, respondents viewed the sexual abuse or death of a child as the most critical event and an emergency situation as the most frequent and stressful critical incident.

The clinical events identified as critical incidents by O'Connor's Australian respondents are consistent with events identified as critical incidents by respondents in North American studies, with sexual abuse or death of a child listed as the most critical event (O'Connor 2003:52,59).

However, evidence did not support the notion that nurses working in a critical or emergency care area suffered a greater deal of stress than those working in other areas. Dealing with an emergency situation, such as respiratory or cardiac arrest, or multiple traumatic events in a short period was found to be most stressful (O'Connor 2003:54).

1.8.3.3 Symptoms experienced by A&E nurses exposed to critical incidents

According to Morrow (1998:1), A&E nurses exposed to critical incidents and traumatic events may experience the following symptoms:

- Inability to concentrate;
- Anxiety or panic;

- Periods of crying;
- Confusion, slowness of thought;
- Repetitive thoughts of the event;
- Irritability, restlessness, agitation;
- Workaholism, hyperactivity;
- Nausea or gastrointestinal upsets;
- Avoidance of reminders of the event;
- Anger, rage or blame;
- Difficulty returning to normal activities;
- Loss of judgement;
- Impaired decision-making;
- Difficulty sleeping, nightmares;
- Depression and withdrawal;
- Muscle aches and pains;
- Increased use of alcohol/drugs;
- Family and relationship problems; as well as
- Increased colds, flu, and headaches.

Each individual will have their unique combination of symptoms - normal reactions to an out-of-the-ordinary event. These symptoms, however, can result in reduced productivity, increased use of sick leave, failure to return to work, increased hiring expenses and the need to utilise workmen's compensation benefits (according to the Workmen's Compensation Act - WCA) (Morrow 1998).

According to Potter (2003), the team that work directly with the people involved in the incident can often be classified as the most neglected people in the aftermath of a traumatic incident. These workers often fail to recognise the full impact of the event on their life. They focus on the people directly involved and affected by the incident and fail to pay attention to themselves. Working in the area of trauma takes its toll on the helping teams in much the same way as the event overpowers the people involved.

After several years of working in the trauma environment, the researcher became concerned that the most experienced, and thus most called-upon, trauma nurses were gradually leaving the profession or expressing feelings of being 'burnt out'.

As crises and disasters become epidemic, the need for effective crisis response capabilities becomes obvious. Thus, intervention programmes (such as stress management programmes) are recommended and even mandated in a wide variety of community and occupational crisis response settings. CISD represents a powerful, yet cost-effective, approach to managing trauma nurses (Everly *et al.* 1997:13).

1.8.3.4 The objectives of CISD

According to Morrow (1998:2), the objectives of CISD are to facilitate the quick return of affected employees to their pre-incident level of functioning, to mitigate the development of any long-term (chronic) psychological disabilities, and reduce absenteeism and the utilisation of employee healthcare benefits.

1.8.3.5 Defining CISD

The term 'debriefing' has been used at random to refer to various stages of support in a traumatic or critical incident context, including on-site informal support, defusing (discussion of feelings shortly after coming off shift) and formal debriefing (hours or days after the incident, in a large group setting, with mental-health teams or peer-support personnel as leaders) (Moran 1998:2).

Davis (1998) defines debriefing as a specific technique designed to assist others in dealing with the physical and/or psychological symptoms that are generally associated with trauma exposure. Debriefing allows those involved with the incident to process the event and reflect on its impact.

According to Everly *et al.* (1997:1), CISD is a comprehensive, integrative, multicomponential crisis intervention system. CISD is considered comprehensive because it has multiple crisis intervention components that functionally span the entire temporal spectrum of a crisis.

Rose, Bisson and Wessely (2003:2) defined debriefing as psychological treatment intended to reduce psychological morbidity after exposure to trauma. Its origins can be traced to efforts to maintain group morale and reduce psychiatric distress among soldiers immediately after combat. It became prominent in the 1980s when its principles were transferred to nurses working in the A&E setting.

Compared to Rose *et al.,* Morrow (1998:1) gave a more detailed description of debriefing when she stated that CISD is a structured process that provides a confidential group environment where affected employees can share their experiences during and after an incident. As the A&E nurses' stories unfold, the debriefer is able to normalise the usually wide range of reactions, encourage the connection with emotional support systems (both at work and at home), instruct on appropriate self-care, and assess the need for follow-up services in the days immediately following the event. Morrow concluded that debriefing is not an operational critique; rather, participants are encouraged to share their thoughts and feelings as a first step toward recovery.

Debriefing is aimed at effecting the ventilation of emotions and thoughts associated with the crisis event. It should be provided as soon as possible, and preferably within the first 24 to 72 hours after the initial impact of the critical event. The more the length of time between exposure to the event and CISD increases, the less effective CISD becomes. A close time relationship between the critical incident and initial debriefing is imperative for this technique to be most beneficial and effective (Davis 1998). Davis (1998) suggests that debriefing be conducted on or near the site of the event.

In order for staff to render quality care, they have to feel cared for, stated Van Wyk, Pillay, Swartz and Zwarenstein (2003:1). Lees and Ellis (1990:946) also

concluded that having social support helped staff cope with work-related stress. Explorative studies indicated that staff showed greater confidence, collegiality and understanding of their own and others' emotional reactions while caring for patients if they had support. Characteristics such as confidence, collegiality and understanding result in improved patient care and lead to better patient outcomes, including increased satisfaction, adherence to treatment, and improvements in morbidity and mortality.

Debriefing has two principal intentions. The first is to reduce the psychological distress that is found after traumatic incidents. The second, related intention is to prevent the development of psychiatric disorders such as PTSD. (Rose *et al.* 2003:3).

1.8.3.6 Negative results of CISD

During a comprehensive literature search, the researcher came upon one study, conducted by Rose *et al.* (2003:1), that found that single-session individual debriefing did neither reduce psychological distress nor prevent the onset of PTSD. Those who had received the intervention showed no significant short-term improvement (3-5 months) in the risk of PTSD. To the contrary, it was noted that there was a significantly increased risk of PTSD in those who had received debriefing. The study also produced no evidence that debriefing reduces general psychological morbidity, depression or anxiety.

These results are included for the sake of scientific objectivity, to give a more complete overview of the concept and to indicate that there might be different views about the efficacy of introducing debriefing to personnel who were exposed to traumatic events.

1.8.3.7 Methods and components of CISD

The literature search yielded several methods and components that constitute several approaches to debriefing.

However, all these approaches to CISD incorporate one or more aspects of a seven-part model described by Davis (1998:5). Davis suggested using the key points of the seven-part model as general guidelines when addressing stress in emergency workers who regularly respond to the demands of critical or traumatic events.

A debriefer or debriefing facilitator (also called an emergency/crisis intervention response specialist) should lay the groundwork for an initial assessment of the impact of the critical incident on the trauma nurses involved in trauma exposure by carefully viewing their level of involvement before, during and after the critical incident (Young 1994:24).

1.8.3.8 Seven CISD protocol key points according to Davis

On the website www.aaets.org/arts (Davis 1998), the following CISD protocol key points were identified:

- *Assess the impact of the critical incident on A&E workers:*

  First, the debriefer or debriefing facilitator assesses the individuals' situational involvement, age, level of development and degree of exposure to the critical incident. Individuals, for example, may respond differently based on their age group and developmental understanding of the event.

- *Identify problems (immediate issues) involving safety and security:*

  Second, the debriefer should identify issues regarding safety and security, particularly with respect to children. Feeling safe and secure is a major concern when the life of a person is shattered suddenly and without warning by tragedy and loss.

- *Use defusing to effect the ventilation of thoughts, emotions and experiences associated with the event, and provide 'validation' of possible reactions:*

  Thirdly, ventilation and validation are important, as each individual, in their own way, needs to discuss their exposure, sensory experiences, thoughts and feelings tied to the event. Ventilation and validation are necessary to give the individual an opportunity to emote.

- *Predict events and reactions that might happen or surface in the aftermath of the critical incident/traumatic event:*

  Fourth, the debriefer assists the individual in predicting future events. This involves education about and discussion of the possible emotions, reactions and problems that might be experienced after exposure to trauma. By predicting the potential psychological and physical reactions to the stressful critical incident, the debriefer can help the individual prepare and plan for the near and long-term future. Such preparation may help avert any long-term crisis reactions produced by the initial critical incident.

- *Conduct a systematic review of the critical incident and look for maladaptive behaviour or responses to the crisis or trauma:*

  Fifth, the debriefer should conduct a thorough and systematic review of the incident in order to determine its physical, emotional, and psychological impact on the individual. The debriefer should carefully

listen to the person being debriefed and evaluate this person's thoughts, mood, affect, choice of words and perceptions of the critical incident. The debriefer should also look for potential clues suggesting maladaptive behaviour or responses to the crisis or trauma.

- *Bring closure to the incident; 'anchor' or 'ground' the person being debriefed to community resources to initiate or start the rebuilding process (i.e. help identify possible positive experiences from the event):*

  Sixth, a sense of closure is needed. Information regarding ongoing support services and resources is provided to individuals. Assistance is rendered with a plan of action to help 'ground' or 'anchor' the person during times of high stress following the incident.

- *Assist in the 're-entry' process, i.e. assist the persons being debriefed to return to the community or workplace and do their duties:*

  Seventh, debriefing assists in short-term and long-term recovery as well as the re-entry process. A thorough review of the events surrounding the traumatic situation can be advantageous for the process of healing. Debriefing is not a critique but a systematic review of the events leading to, during and after the crisis.

Davis (1998) suggests incorporating these seven key points into the debriefing process when rendering assistance to A&E nurses. Debriefing can be done in large or small groups or one to one, depending on the situation.

1.8.3.9 The seven core components of CISD according to Everly et al.

In order to structure a proper debriefing framework, Everly *et al.* (1997:1) used seven different core components.

These components are:

- Pre-crisis preparation: This includes stress management education, as well as stress resistance and crisis mitigation training for both individuals and organisations.

- Large-scale incident, traumatic exposure and community support programmes: These include mobilisations, informational briefings, and staff deliberations.

- Defusing: This is a three-phase, structured, small-group discussion held within hours of a crisis for the purposes of assessment, triage, and acute symptom mitigation.

- CISD: In this protocol by Everly *et al.* (1997:1), CISD refers to the Mitchell model, a seven-phase, structured group discussion, usually held one to ten days after exposure to the traumatic event, and designed to mitigate acute symptoms, assess the need for follow-up actions and, if possible, provide a sense of post-crisis psychological closure. The Mitchell model constituted the core component of the study conducted by SP Hattingh and will also form the basis of the structured debriefing programme to be applied in this research.

- One-to-one crisis intervention/counselling or psychological support throughout the full spectrum of events.

- Family crisis intervention as well as organisational consultation.

- Follow-up and referral mechanisms for assessment and treatment if necessary.

1.8.3.10 A different approach to CISD

The Internet website www.earthlink.net contains a debriefing handout that has been used by the International Critical Incident Stress Foundation since 1996 (Debriefing 2002). Because the debriefing framework found on this handout does not constitute a formal programme or a structured model, there is no clinical proof that this is indeed an effective method. The researcher reasoned that it would be more useful to incorporate the suggested framework into a more structured programme/model.

The handout, written in a chatty style, provides the following informal framework for debriefing after a traumatic incident or *'Things to Try'*:

- Within the first 24 to 48 hours after the incident, periods of appropriate physical exercise alternated with relaxation will alleviate some of the physical reactions.
- Structure your time – keep busy.
- You are normal and are having normal reactions – do not label yourself crazy.
- Talk to people – talk is the most healing medicine.
- Be aware of numbing the pain with overuse of drugs or alcohol - you do not need to complicate this with a substance abuse problem.
- Reach out – people do care.
- Maintain as normal a schedule as possible.
- Spend time with others.
- Help your co-workers as much as possible by sharing feelings and checking out how they are doing.
- Give yourself permission to feel rotten and share your feelings with others.
- Keep a journal; write your way through those sleepless hours.
- Do things that feel good to you.
- Realise those around you are under stress too.
- Do not make any big life changes.

- Do make as many daily decisions as possible, which will give you a feeling of control over your life.
- Get plenty of rest.
- Recurring thoughts, dreams or flashbacks are normal – do not try to fight them; they will decrease over time and become less painful.
- Eat well-balanced and regular meals (even if you do not feel like it). (Debriefing 2002).

In order to determine the perceptions of A&E nurses regarding a structured debriefing programme in a private hospital in Gauteng, the researcher decided to make use of the CISD programme originally developed by Jeffrey T Mitchell (Mitchell & Everly 2001) and adapted for the South African context by SP Hattingh.

1.8.4 The SP Hattingh model

Assessing the need for A&E nurses to be properly debriefed, Ewers *et al.* (2002:470-6) concluded that providing A&E nurses with better understanding of serious mental illness relating to traumatic events and training them in a broader range of interventions not only help these nurses to have a more positive attitude toward their clients/patients, but also help them deal with the negative effects of occupational stress.

Morrow (1998:2) stated that CISD should be provided by professionals who have been specially trained in this technique. Typically, there are one to two debriefers per debriefing group. A group lasts two to three hours, depending on the number of participants and the severity of impact. Follow-up services vary according to employee needs during the first few days after the incident but normally include a combination of individual and/or group sessions.

If the effects of serious traumatic events on A&E workers in South Africa are not properly addressed, the results can be catastrophic. This probability emphasises the need for standardised debriefing in South Africa.

Although the need for standardised debriefing is widely accepted, and even regarded as indisputable by some, the researcher, while planning and researching this study, had not come across any standardised concept for debriefing A&E nurses in South Africa.

However, research conducted by SP Hattingh in order to formulate a model for the implementation of a structured debriefing programme for emergency workers in South Africa could serve as background to this research. Hattingh found that there were insufficient debriefing programmes to support the emergency workers in this country who are exposed to a serious amount of critical incident stress. Emergency workers that fulfil their duty on South Africa's roads as paramedics and other paramedical healthcare workers comprised Hattingh's study population.

Hattingh's study was based on a programme that was developed by Dr Jeffrey Mitchell in 1980. Dr Mitchell developed CISD as a group programme to help emergency services personnel deal with critical incident stress. It is still used among healthcare workers in the United States of America (USA) today (Mitchell & Everly 2001).

The usefulness and applicability of the programme developed by Mitchell was highlighted once again when emergency workers in the USA had to cope with the aftermath of the 2001 September 11 attacks on the World Trade Centre in New York. People's awareness of work-related stress and the need for the development of psychological support and debriefing systems for healthcare workers was renewed.

Hattingh researched and explored Mitchell's programme and adapted Mitchell's CISD model for the South African context. However, Hattingh's research could be traced back as far as the Westdene tragedy in 1985 when a bus packed with school children crashed into the Westdene dam in Bloemfontein, killing 42.

Hattingh's research was conducted on the principles of Mitchell's, and a formal debriefing process was developed for the South African context to assist

emergency healthcare workers to deal with critical incidents. The debriefing process consists of definite steps that follow a particular order. The process, however, is not rigid, and changes may be made during the debriefing session.

The debriefing process is applied in order to enable the victim (emergency healthcare worker/A&E nurse) to integrate, at a cognitive and emotional level, the profound personal experiences caused by trauma and critical incidents. However, in the words of Hattingh it should be warned “stress debriefing is not a magical amnesia” (Hattingh 2004). Debriefing cannot remove from a person’s mind all the pain and emotional suffering caused by trauma or critical incidents.

To reiterate, the debriefing session takes place 24 to 72 hours after the incident has occurred and lasts from thirty minutes up to three or five hours, depending on the group being debriefed and the impact of the incident. Debriefings conducted within 24 hours of the incident are often ineffective, as the victims are cognitively and emotionally too overwhelmed to discuss their feelings about the incident. However, according to Hattingh (2001:26), debriefings undertaken several weeks after the incident can still be effective.

Hattingh’s structured debriefing process consists of the following seven steps:

Step 1 - Introductory phase

During this phase, the debriefer and team members introduce themselves to each other, and explain their involvement and roles during the incident. The rules of the session are also laid down and explained by the debriefer. Two of the rules that should be observed are the rules of confidentiality and voluntary participation. Team members may speak only on their own behalf and not for or about any other person. Confidentiality is assured unless suicide concerns exist, and no disclosures will be made to superiors or the press. Group members are not obliged to speak during the session but the use of paper and premature departures are not permitted. Debriefings are not situational critiques or performance appraisals; they are aimed at effecting emotional ventilation.

Step 2 – Fact phase

In order to get a clear picture of the incident, all the facts about the incident are collected during this phase. Each participant tells their story of the incident as they experienced it. Participants are requested to describe facts regarding themselves, the incident and their activities during the incident. Participants are requested to state who they are, their rank/position, where they were, and what they experienced and did as they worked in and around the incident. Each person takes a turn, adding details until the entire incident is recreated.

Step 3 – Thought phase

In this particular phase, the participants are required to say what their FIRST and only their first thought was during the incident. Each participant must verbalise to the group their first thought upon exposure to the critical incident. They are requested to reveal the first thoughts they were aware of during the incident. The revelations that follow help the participants to tap into the more personal aspects of the situation. This phase affirms that one's thoughts are important and not to be hidden behind the facts of the incident.

Step 4 – Reaction phase

The reaction phase exposes the reactions of the participants to the trauma experienced during the incident. This phase is often referred to as the emotional phase, as participants are given the opportunity to express what they felt during the incident. Attention is directed to the participants' reactions during and subsequent to the incident. Participants are encouraged to discuss their reactions to the incident, as well as the effects that their reactions had on not only themselves, but also their friends, colleagues, family, neighbours, and spouse.

Step 5 – Symptoms phase

Participants are required to indicate physical symptoms of stress that they experience due to the critical incident.

Step 6 – Teaching phase

This phase is a natural development in the course of debriefing and logically follows the symptoms phase. During this phase, the facilitator (debriefer) provides group members with information about normal reactions to an abnormal event, reassuring the participants that their reactions were normal and a result of the critical incident. The debriefer also provides information about stress management skills that team members can implement or use in order to manage their stress. Some of these skills are exercising, discussing the critical incident with a trusted friend, and relieving stress through stress relief techniques. The facilitator identifies physical, emotional and behavioural symptomatology that is characteristically associated with stress. Emphasis is placed on the normal expectation that personnel will experience stress in relation to their duties. Participants are advised on the signs of stress, and taught techniques that are effective in reducing excessive stress.

Step 7 – Concluding phase

In the concluding phase, an overview is given of the debriefing. Issues are clarified. Respect, encouragement and support are expressed by the debriefer. Questions are encouraged, reassurance is given, and action plans established. The participants also receive information, such as the contact details of debriefers, should they need assistance at a later stage. Participants are encouraged to seek counselling if necessary, and referral resources made available.

1.8.4.1 Model comparison

When Hattingh's model is compared with the approaches followed by Davis (1.8.3.8) and Everly *et al.* (1.8.3.9), some similarities are evident. However, neither the approach followed by Davis nor the framework suggested by Everly *et al.* has the structure that is visible in Hattingh's model. The model by Hattingh is a process that needs to be followed step by step, whereas the other two approaches represent basic debriefing guidelines.

1.9 Significance and contribution of this study

This study is focused in such a way that it will have some significance for each participant. The researcher took the risk-benefit ratio into consideration and determined that the benefits outweighed the risks in the following manner:

- Every participant would have the opportunity to attend a structured debriefing session to manage their psychological stress and the critical incident stress that goes hand in hand with working in an A&E unit.

- Should this study show that the perceptions of A&E nurses about structured debriefing are mainly positive, a programme for structured debriefing could be implemented in the unit where these nurses are working. Its implementation in A&E units nationally and even internationally is also not excluded. Positive perceptions of the programme may indicate an improvement in the psychological well-being of the participant A&E nurses, and lead to an improvement in their management of patients (Dolan & Holt 2000:21).

- If perceptions were found to be positive, the further use of the programme in the unit where the research was conducted would be justified and recommended. Such a finding should also prove beneficial to all A&E units in private and public sector hospitals in South Africa.

- The researcher will also assess the experiences of the debriefers in this study as to determine their perceptions of a structured debriefing programme and to make future recommendations on the training of peer debriefers.

1.10 Limitations of the study

Because purposive sampling will be applied, the sample may not be representative of the population. Purposive sampling also implies a risk of bias and limits the opportunities to generalise findings.

The sample will be drawn from only one private hospital in Gauteng and findings will be valid for that specific context only. Due to the small size of the sample, the generalisability of the data may be limited.

1.11 Chapter division

The chapter division is as follows:

Chapter 1: Theoretical foundation and orientation to the study
Chapter 2: Research design and methodology
Chapter 3: Data analysis and presentation of research findings
Chapter 4: Recommendations, reflection and guidelines

1.12 Conclusion

In this chapter, the research topic, namely the perceptions of A&E nurses regarding structured debriefing, has been introduced. The lack of structured debriefing programmes was identified and researched. The objectives of this study, namely to train debriefers in the A&E unit, implement a structured debriefing programme based on the model developed by Dr SP Hattingh, and to

obtain data from debriefed A&E nurses and debriefers about their perceptions of the structured debriefing programme, were explained. Recommendations will be made about the future use of this structured debriefing programme within the research context and nationally.

In addition, new insights may be gained regarding the psychological status of nurses exposed to traumatic incidents in A&E units. The expectation is that the interaction between debriefers and participant nurses will lead to an improvement in the quality of patient management in the unit under discussion.

In Chapter 2, the research design and methodology used to reach the desired objectives will be discussed in greater detail.

Chapter 2

RESEARCH DESIGN AND METHODOLOGY

2.1 Introduction

What follows will be a description of the specific methodology that was used in order to conduct this study. Whilst doing an extensive literature review, the researcher realised the need for the implementation of a structured debriefing programme in A&E units in South African hospitals. Also in terms of occupational health legislation it is of utmost importance to ensure the psychological well-being of personnel that are exposed to occupational stress and trauma (South 1993).

2.2 Research question and aim

The research question on which this study is based is:

What are the perceptions of A&E nurses regarding a structured debriefing programme in a private hospital in Gauteng?

In order to answer this research question, the researcher adopted a contextual, explorative, descriptive research design using qualitative methodology.

2.3 Research design

A research design can be defined as a plan or blueprint of how one intends conducting the research (De Vos *et al.* 2002:137).

The rationale behind using a contextual, explorative, descriptive research design and qualitative methodology will be discussed.

2.3.1 Contextual design

Context is defined as 'the circumstances in which a particular event occurs' (Munhall 2001:9). Contextual design in this study refers to the context of the study and the fact that only one facility was used. Data can therefore not be generalised to all A&E units.

The context needs to be well defined. The facility used in this research study was an A&E unit in a private hospital in Gauteng, South Africa. This facility is a level 2 A&E unit that serves a large part of the city. On average, this unit services 1000 patients per month. Of these patients, approximately 10% is priority 1 patients, *i.e.* patients that are in need of acute emergency treatment. In the majority of priority 1 patients, the incidents can be seen as critical. A&E nurses caring for these patients are exposed to a high number of critical incidents, and therefore the work-related stress experienced by these nurses is increased by exposure to critical incidents in the unit.

At the time of this study, the total number of nurses in the unit was eighteen (18). Fourteen (14) of these nurses were registered nurses with additional tertiary training in A&E nursing or intensive care nursing. Assistant nurses and staff nurses with no tertiary education comprised the remainder of the group. The ages of the nurses ranged from 24 to 48 years. The number of nurses allocated to this specific nursing unit was insufficient; therefore, a high standard of nursing care could not be maintained. Critical incidents were not properly managed. Staff shortages thus contributed to the already high levels of stress experienced by A&E nurses in the workplace.

From a personal and professional perspective, none of the staff had similar backgrounds, and therefore the researcher could make the deduction that every staff member was an individual in their own right and with own beliefs. Each and

every staff member, the researcher included, represented a different world or way of living. This observation is important, as the perceptions of the participant A&E nurses could not be separated from their personal and professional backgrounds. Munhall (2001:168) confirmed that the context of the study (which, in this case, also included the background of the participants) needed to be articulated well.

All the participants in this study came from very different educational and occupational backgrounds. All did their basic training at different institutions. Some had tertiary qualifications, and these qualifications might have included psychiatric training. Some of the participant nurses were previously in non-nursing occupations. Some had previous experience in emergency care, while others had worked in other nursing units. Demographically the individuals differed, and that contributed to the uniqueness of the research context.

2.3.2 Descriptive, explorative design

Descriptive studies are designed to gain more information about characteristics within a particular field of study (Burns & Grove 2001:248). Descriptive research presents a picture of the specific details of a situation, social setting or relationship, focuses on 'how' and 'why' questions, and are usually non-experimental in nature.

Cormack (2000: 213,217) states that descriptive research is an appropriate design for areas of nursing where little theoretical or factual knowledge exists. It is concerned with description or classification rather than explanation. In this research study, the researcher aimed to describe the perceptions of A&E nurses who participated in a structured debriefing programme at a private hospital in Gauteng.

The aim of using descriptive research in this study was to discover new facts about debriefing (such as the perceptions of A&E nurses about a structured debriefing programme) and to describe and present these facts to the scientific

community. Such descriptive research could form a basis for further research on the topic. In the context of this study (Cormack 2000:213), the perceptions of A&E nurses regarding a structured debriefing programme were not previously explored.

Because the intent was not to explain or understand the underlying causes of the variables of interest, a nonexperimental design was appropriate (Polit & Hungler 1997:168). During this study, the researcher did not try to control the variables, nor did he try to conceptualise the study to have independent or dependent variables. No attempt was made to control or manipulate any aspect of the setting under study. (Polit & Hungler 1997:198). The researcher wanted to get a clear picture of the perceptions of the study participants about debriefing and participation in a structured debriefing programme. Therefore, protection against bias was an important consideration (Cormack 2000:213). The perceptions of the participants would be explored during one-to-one interviews, a data collection method that ensures protection against bias.

Opinions differ as to whether exploratory research should be classified as 'descriptive', and therefore some research texts do not include exploratory designs in this category. For the purposes of this study, the two concepts 'descriptive' (describe) and 'explorative' (explore) are used as two separate concepts (Cormack 2000:217).

Exploratory studies are designed to increase knowledge in a field of study that was not adequately explored previously (Burns & Grove 2001:374). In this study, exploratory research was conducted to gain insight into the phenomenon of the perceptions of A&E nurses regarding a structured debriefing programme (De Vos *et al.* 2002:109). The researcher explored the contents of the research data (the verbatim transcriptions of the interviews) in order to answer the research question.

2.3.3 Qualitative research

2.3.3.1 Introduction to conducting qualitative research

Qualitative research can be defined as a method of inquiry to deal with the issues of human complexity by exploring these issues directly. Qualitative research usually focuses on the inherent complexity of humans, *i.e.* the ability of humans to shape and create their own experiences and the idea that truth is a composite of realities. Thus, by collecting and analysing narrative, subjective (*i.e.* qualitative) materials, understanding of the human experience as it is lived is promoted (Polit & Hungler 1997:14,15). Qualitative research tends to focus on dynamic, holistic and individual aspects of phenomena, and attempts to capture those aspects in their entirety, within the context of those who are experiencing them.

In this study, in order to discover the perceptions of a group (A&E nurses), the researcher studied people in their natural setting, talking to and interviewing individuals within the group (Holloway & Wheeler 2000:1). The researcher collected data in a real world, a naturalistic setting, and strived to study the phenomenon in its natural context (Polit & Hungler 1997:199). The researcher realised that qualitative research would be useful in this study because little was known about the area of study and the particular problem in the specific setting or situation (Holloway & Wheeler 2000:2). Only A&E nurses could provide the views regarding the issue.

It was also acknowledged that both the participants and the researcher had their own values and realities; thus, multiple realities existed (refer to subsection 2.3.1). Qualitative research is based on the belief that knowledge is socially constructed. The researcher decided to use a qualitative research approach to explore these multiple daily realities and experiences of A&E nurses. A&E nurses that were exposed to critical incidents on a daily basis were debriefed and their perceptions regarding the debriefing process could therefore be explored. As a form of enquiry, qualitative research can be used in any social

science or healthcare discipline, and has frequently been used in nursing research. (Holloway & Wheeler 2000:1).

That the approach in this study is on the everyday life of people and their experiences is another reason for using qualitative methodology. Qualitative research gives a person-centred, but holistic perspective, and develops understanding of human experiences, in this case, the perceptions of A&E nurses about a structured debriefing programme. This kind of research is important for healthcare professionals who focus on caring, communication and interaction, especially in the A&E setting. (Holloway & Wheeler 2000:2).

2.3.3.2 More arguments for using qualitative methodology in this research

In sub-subsection 2.3.3.1 above, the use of qualitative methodology in this study was substantiated. Holloway and Wheeler's explanation of qualitative research presents more specific arguments for using the qualitative paradigm when exploring the perceptions of A&E nurses about structured debriefing.

The following elements of qualitative research, as set out by Holloway and Wheeler (2000:3-8), can be related to this study:

- Qualitative research takes the emic perspective, *i.e.* the insider's view. In this research, A&E nurses can be seen as the insiders, as their perceptions regarding structured debriefing are studied.
- Researchers immerse and involve themselves in the setting and the group under study. In this study, the researcher was part of the A&E team under study and was also an A&E nurse exposed to critical incidents.
- The data has primacy; the theoretical framework is not predetermined by the data but is rather derived from it.
- The research methodology includes a thick description of the data.

- Within the research context, a close relationship exists between the researcher and the respondents, and this relationship is based on a position of equality.

The abovementioned arguments and their application to this research will be elaborated on under the following headings.

- **The emic perspective**

In this study, rather than imposing a framework of his own that might distort the ideas of the participants, the researcher chose to examine the perceptions of A&E nurses about structured debriefing. This research was based on the premise that individuals within the research context (the insiders or A&E nurses) were best placed to describe (in their own words) the situations, feelings and perceptions relating to the structured debriefing programme (Holloway & Wheeler 2000:4).

- **Immersion in the setting**

Immersion in the setting of the study refers to the fact that in this study the researcher was part of the staff of the A&E unit. Through interaction and unstructured interviews the researcher determined the perceptions of colleagues on the field of study. The researcher was familiar with the occupational environment of A&E nurses who were exposed to critical incidents and CISD (Holloway & Wheeler 2000:5).

The researcher actively participated in the research process. According to Holloway and Wheeler (2000:5), being an active participant is one of the main tools of qualitative research.

- **Primacy of data**

With primacy of data, any preconceived ideas are ignored. It was the intention of the researcher to involve A&E nurses in this study and to determine their perceptions about the research topic, so that future steps regarding structured debriefing could be planned. Assumptions will not be made regarding the research context, but a detailed account of reality will be presented because the data collected (the words and perceptions of the participants gained through conversation) will be analysed. (Holloway & Wheeler 2000:6).

Rich data were collected from the participants. There was no restriction placed on the duration of the interviews, and participants were allowed to converse until they were satisfied that they had said all they wanted. From the data, ideas are generated, and these ideas can help to modify existing theories.

- **Thick description**

Thick description can be described as in-depth explanation. In this study, it involved detailed portrayals of the A&E nurses' perceptions of structured debriefing. This research would go beyond a report on surface phenomena to their interpretations, uncovering feelings and perceptions regarding the topic. A dense description would be given of the data and the context (Holloway & Wheeler 2000:7).

In this study, thick description will help the reader of this research in the sense that knowledge is shared (Holloway & Wheeler 2000:7).

- **The research relationship**

Being a healthcare professional and registered A&E nurse (and therefore having certain characteristics) helped the researcher to establish a close research relationship with the participants (Holloway & Wheeler 2000:8). Such

a relationship was important because it enabled the researcher to fully understand the occupational context and frame of reference of the participants, and gain their trust. According to Holloway and Wheeler (2000:8), unstructured interviews used in this study by the researcher are similar to the patient assessment process whereby nurses gain information by talking to patients, listening and interpreting what they hear.

The following characteristics of a healthcare professional (and of a good interviewer) helped the researcher to establish a close research relationship with the respondents:

- Good listening skill.
- Non-judgmental attitude.
- Friendliness.
- Openness and honesty.
- Flexibility.

(Holloway & Wheeler 2000:8).

In order to conduct qualitative research, a certain order of events or research procedure had to be followed. This procedure included defining the population, selecting participants to participate in debriefing sessions (sampling), selecting and training debriefers, conducting structured debriefing, and collecting data by interviewing both debriefers and participants in the debriefing sessions.

2.3.4 Research procedure

2.3.4.1 Population and sampling

The population for this study consisted of all registered nurses working in an A&E unit in a private hospital in Gauteng.

A group of people (a sample of the population) had to be chosen in order to obtain information about the whole population. In this study the researcher

made use of purposive sampling. Purposive sampling is a type of non-probability sampling, in which inclusive criteria are stipulated. Non-probability sampling involves selecting a sample through non-random methods. (Polit & Hungler 1997:226, 229-30).

In this study, it is not so much the sample size that is important; it is the typical qualities or features of the sample group. The reliability of the results depended less on sample size than on the representativeness of the sample. The researcher purposively selected participants that were typical of the population under study. Purposive sampling in this context is based on the fact that the researcher uses his knowledge about the population in order to handpick the cases to be included into the sample population. (Polit & Hungler 1997:229).

Purposive sampling is also used to obtain information from experts on the research topic (Polit & Hungler 1997:229). With reference to this study, A&E nurses that were exposed to critical incidents and structured debriefing could be regarded as experts regarding their own emotions and perceptions of structured debriefing. The first eight A&E nurses that were informed and willing to participate, and that were working in the specific unit identified by the researcher, were included as study participants.

The participant A&E nurses had to meet the following inclusive criteria:

- Registration with the SANC;
- Working in the A&E unit of a private hospital in Gauteng;
- Should have had exposure to a critical incident or experience of severe traumatic events in the A&E unit.

At the time of the research, the participants were working at least 42 hours per month in the research setting. All were registered with the SANC, had exposure to critical incidents and were willing to partake in a structured debriefing programme. In order to implement such a programme, debriefers had to be selected and trained.

2.3.4.2 Selecting and training debriefers

In order to train debriefers, the following steps were followed:

- Suitable candidates were selected to attend a debriefer training programme. These candidates, who were purposively selected by the researcher, voluntarily completed the training programme. The researcher chose the more senior personnel in the unit to be trained as debriefers because they had extensive experience in A&E nursing and were exposed to a variety of critical incidents. They also had considerable life experience and skills that could prove invaluable in a debriefing situation. These personnel (debriefers) had four or more years of experience in the unit where the research was to be conducted and were therefore seen as senior personnel.
- After the selection, the candidates attended a debriefer training programme conducted by Dr SP Hattingh. The candidates were given proper instructions about performing debriefing according to Dr Hattingh's model.
- The debriefers gained practical experience during debriefing sessions that were held at the specific A&E unit where the research was to be conducted.
- Since critical incidents occurred in the unit under study, debriefers had ample opportunity to conduct debriefing sessions on their own and to gain valuable experience.
- After the implementation of the structured debriefing sessions, the participant A&E nurses and trained debriefers were interviewed in order to collect data on the research topic.

The data collection process included formulating a central research question, interviewing the participant A&E nurses and debriefers, and tape-recording the interviews. The data collection process will be discussed next.

2.3.4.3 Data collection process

The researcher used an unstructured, one-to-one interview as data collection instrument. An in-depth interview was conducted with each of the eight participant A&E nurses and debriefers. During these unstructured interviews, one central, open-ended research question was put to each interviewee, and they responded to this question verbally and in a relaxed and comfortable manner. The interviews were tape-recorded, and the recordings transcribed verbatim.

All the participants responded to the following central research question:

As A&E nurse, what are your views, perceptions, ideas, and opinions about the structured debriefing programme that was implemented in this A&E unit?

The participant's response to the central research question led to the researcher to ask more probing questions. The answers to these probing questions helped the researcher to obtain a more complete picture of the perceptions and opinions of the participants about structured debriefing. Interviews were conducted until data saturation was achieved. The first eight interviews produced a large amount of data and indications were that no new information could be added; therefore, data saturation had been reached. The information obtained could then be analysed.

The interviews were tape-recorded and transcribed. The verbatim transcriptions were read and re-read by the researcher, and subcategories, categories and themes identified. The data were analysed by experts who worked independently of one another. Consensus meetings were held, and the subcategories, categories and themes discussed and confirmed by two independent experts in qualitative analysis. Conducting independent analyses, seeking consensus and confirming the identification of subcategories,

categories and themes contributed to the trustworthiness of the research results.

2.4 Data analysis

The data analysis or coding procedures will be discussed in more detail. Data were obtained from the eight transcribed interviews. However, valuable data were also obtained during a pilot study.

2.4.1 Pilot study

A pilot study is a smaller version of the actual study. It is conducted for the purposes of refining the research methodology and assessing the interview technique and research question. Its functions are to determine whether the proposed study were feasible, to develop and refine the steps in the research process and to identify problems with the design (Burns & Grove 2001:48).

A pilot study was conducted by debriefing and interviewing one A&E nurse that met the sampling criteria. The purpose was to identify any problems that might be encountered during the study. As a result of the pilot study, the researcher realised that a better response to the central research question could be obtained by asking more probing questions.

The researcher also realised that the data obtained from the transcribed pilot interview could be included for data analysis, as the results of that interview also contributed to answering the research question.

2.4.2 Content analysis and coding procedures

Qualitative content analysis involves an analysis of the content of narrative data in order to identify prominent themes and patterns among themes. It can also

be defined as the process of organising and integrating narrative, qualitative information according to emerging themes and concepts. In this study, content analysis refers to the procedure for analysing verbal communications in a systematic and objective fashion. (Polit & Hungler 1997:393,454).

The data obtained from the interviews (the verbatim transcriptions) were carefully analysed, so that they could be turned into subcategories. Coding further involved grouping subcategories with similar characteristics under categories. When all the data was coded into relevant categories, the researcher, in cooperation with two independent expert coders, decided on specific themes that were related to the study and its specific context. Consensus meetings were held to compare data and to reach consensus on coding of data.

2.4.3 Literature control

A literature study was conducted in order to formulate and refine the research question. However, theory or literature was not used to identify the subcategories, categories and themes that emerged during the data analysis. Relevant literature was incorporated into the data as a control measure. By comparing the results of the data analysis to relevant literature, the reliability of findings could be confirmed.

The literature control, therefore, contributed to the trustworthiness of the study.

2.5 Trustworthiness

To ensure trustworthiness in a qualitative research project, four constructs, namely credibility, transferability, dependability and confirmability, as discussed by De Vos *et al.* (2002:351,352), are used. These four constructs are relevant to this study.

2.5.1 Credibility

Credibility refers to the quality of being believable; therefore, credibility contributes to the truth value of the study (De Vos *et al.* 2002:351). Sufficient (prolonged) involvement is an aspect of credibility. This means the researcher has to be entrenched in the field of study. It also implies prolonged interaction with the respondents. (Rossouw 2003:180). Prolonged engagement was achieved by the researcher because, at the time of conducting this research, he had been working in the research setting for two years. Initially no structured debriefing was available in the unit after critical incidents.

The credibility of the study was also enhanced by the fact that a literature review was conducted, and data were validated by relevant literature. After studying current literature on the phenomenon, the researcher identified the need for a structured debriefing programme. The literature was used to measure the credibility of the data obtained during the interviews.

Consistency contributed to the credibility and trustworthiness of the study. Dr SP Hattingh gave the researcher permission to use and implement the structured debriefing programme that she had developed. Following training in debriefing by only Dr Hattingh, the peer debriefers conducted debriefing sessions according to Dr Hattingh's model. These consistent qualities and actions enhanced the credibility of the research findings.

To enhance impartiality (neutrality) in this study, the interviews were conducted by only one person. The same central research question was put to each interviewee. These consistent measures further enhanced the truth value of the data obtained.

To further ensure credibility, bracketing was used in this study. According to Polit and Hungler (1997:215), bracketing refers to the process of identifying and holding in abeyance preconceived beliefs and opinions about the phenomenon

under study. The researcher has to bracket out the world and any presuppositions in an effort to confront the data in pure form.

Credibility was also achieved by means of triangulation, *i.e.* data were collected from several different sources and in different ways in order to provide a fuller understanding of the phenomenon. Triangulation involved using the following methods:

- Information was gathered by interviewing participant A&E nurses and debriefers and the data were confirmed by the respondents.
- A literature control was conducted by using journal articles and Internet sources, and by accessing computer databases, *e.g. Medline*. A literature review was done to determine whether similar experiences had been documented.
- The data were analysed by the researcher and compared with the independent analyses of co-coders.

2.5.2 Transferability

According to Polit and Hungler (1997:307), transferability refers essentially to the generalisability of data. Transferability has to do with the standard of the applicability of the research. By means of inductive argumentation, it is argued that the findings of the research, as implemented within a particular sample, can be transferred to a larger similar target population (Rossouw 2003:181-2). Sufficient descriptive data are presented in this research report; therefore, consumers can evaluate the applicability of the data to other contexts (Polit & Hungler 1997:308).

The researcher could not specify the external validity of this study because it was essentially not a quantitative study. However, the researcher could provide thick description. Thick description is a term that is widely used among qualitative researchers. It refers to a rich and thorough description of the research setting and context, the transactions and processes, and the perceptions observed during the enquiry and data collection. Thick description

is necessary to enable readers interested in making a transfer to reach a conclusion about whether transfer can be considered a possibility. (Polit & Hungler 1997:308).

It is the researcher's opinion that some aspects relating to the structured debriefing programme and the findings of this study could be transferred to similar nursing settings in South Africa. Nurses working in A&E units experience similar traumatic situations and critical incidents and, for this reason, transferability of some aspects of this study could be possible.

Some of the aspects of this study may even be transferred to similar nursing settings in foreign countries. During a visit to Karlskrona, Sweden, as exchange student, the researcher had informal discussions with Swedish nurses. These nurses came to the conclusion that there was a definite need for structured debriefing after exposure to critical incidents in their country as well. However, the researcher has to establish proof of transferability by providing sufficient information to permit judgements about contextual similarities (Polit & Hungler 1997:308). The researcher strived to achieve transferability by providing dense description of the data and the research context.

2.5.3 Dependability

In qualitative research, dependability (or replicability) is achieved by giving a complete description of the research methods and research context so that the opportunity for replicating the research can be created (Rossouw 2003:183). Dependability is also the alternative to reliability, in which the researcher attempts to account for changing conditions. For example, in this study, reliability would imply accounting for different types of critical incident and the influence of uncontrollable external factors, such as family crises or any factor that might influence the dynamics of the specific nursing unit or the A&E nurses themselves (De Vos *et al.* 2002:352). A detailed description of the research procedure and research context is therefore given in this chapter.

A relationship does exist between credibility and dependability. According to Polit and Hungler (1997:306), there can be no credibility in the absence of dependability. To further ensure dependability in this study, the researcher used independent co-coders to analyse the data, and compared these analyses, as stated previously.

Another technique used by the researcher in this study to ensure dependability is called inquiry audit. This involves a scrutiny of the data and relevant supporting documents by an external reviewer (Polit & Hungler 1997:307). In this study the researcher made use of several external reviewers from different settings of nursing and different universities, such as the Blekinge Institute of Technology in Karlskrona, Sweden. An expert from the University of South Africa (Unisa) was also consulted. Supervisors from UP scrutinised the data and relevant documents during the course of the study.

The inquiry audit approach also has a bearing on the confirmability of the data.

2.5.4 Confirmability

According to Polit and Hungler (1997:315-16), confirmability refers to the objectivity of the data. Two or more independent people have to agree on the data's relevance or meaning. In qualitative studies, the issue of confirmability does not focus on the characteristics of the researcher but rather on the characteristics of the data. The question is asked: Are the data confirmable?

In this study, confirmability of data was achieved by enlisting the help of independent co-coders and by conducting a literature control to evaluate the results of the data analysis. Research findings were compared with relevant literature to confirm or deny the results, thereby enhancing the trustworthiness of the study.

Strategies employed to ensure the trustworthiness of this study are summarised in Table 2.1 on pages 55 and 56.

TABLE 2.1: STRATEGIES EMPLOYED TO ENSURE THE TRUSTWORTHINESS OF THE STUDY

Construct	Strategy/Criterion	Application
Credibility	Varied field experience	Unstructured interviews were conducted with respondents that participated voluntarily in the research. One study leader had experience relating to qualitative nursing research literature, and the other to the field of research. Respondents with different learning and occupational backgrounds and therefore varied experience were interviewed.
	Prolonged engagement	The researcher was employed as A&E nurse in the A&E unit that served as research setting during the course of the research. The researcher had experience in structured debriefing.
	Triangulation	Information gathered by interviewing both participant A&E nurses and debriefers was confirmed by interviewees. Data were analysed by the researcher and independent co-coders. Information obtained from journals, the Internet and computer databases, *e.g. Medline,* was used to conduct a literature control. A literature review was done to determine whether similar experiences had been documented.

	Peer examination	Informal discussions were held with professionals in the field, discussing similar issues.
	Neutrality and bracketing	The interviews were held by only one person and only one central research question was put to the interviewees in order to acquire neutrality and to prevent bias.
	Literature control	A literature review was done and a literature control employed to enhance the truth value (credibility) of the study.
Transferability and applicability of research	Thick description	The research methodology used in this study was fully described, interviews were transcribed verbatim, and the results of the data analysis validated by a literature control. Relevant quotes were included in the results.
Dependability (Replicability)	Thick description	The research methodology, the transcription of interviews, the data analysis and literature control were fully described. Relevant quotes were given.
	Peer examination	The researcher consulted independent co-coders about the data analysis and research findings. An independent coder that was also a registered nurse assisted with the data analysis.
Confirmability	Triangulation	Interviews; literature control; literature review; data analyses.

2.6 Ethical considerations

In conducting this study it was important for the researcher to consider the ethical rights of the participants. To protect the rights of A&E nurses participating in this study, the research protocol was reviewed by the Faculty of Health Sciences Ethics Committee at UP. The researcher received written approval to conduct the study (See Annexure A).

Informed consent was obtained from the participants as well as the private hospital in Gauteng where the study was to be conducted. All informed consent documents are kept in a safe place by the researcher. A copy of the informed consent document signed by the participant A&E nurses is attached as Annexure B.

The anonymity of all the participants in this study will be preserved. All recordings and transcriptions are stored safely by the researcher. No harm came to the participants as a result of their participation in the study. The participants were not obliged to participate in the study, and had the opportunity to withdraw from the study, without stating reasons.

2.7 Conclusion

This chapter presented an in-depth description of the research methodology adopted for this study. The research procedures, including the data collection and the analysis of data, were fully described. This chapter also included a discussion on the employment of strategies that would ensure the trustworthiness of the study. Data obtained in response to a central research question put to participants were analysed, and findings validated by means of a literature control. The aim of this study was to determine the perceptions of A&E nurses regarding structured debriefing. A description and analysis of the data collected during this research study will be presented in the next chapter.

Chapter 3

DATA ANALYSIS AND PRESENTATION OF RESEARCH FINDINGS

3.1 Introduction

In this chapter, the methods of data analysis and the findings are discussed.

As mentioned in subsection 2.4.2, the researcher analysed the data collected by means of a process that is known as 'coding of data' or 'qualitative content analysis'. Coding is a series of actions according to which data is broken down, conceptualised and put back together in new ways. In this study, open coding was used. Open coding refers to the naming and categorising of phenomena through in-depth examination of data. The researcher categorised the data into subcategories and categories, and subsequently into superordinate themes (De Vos *et al.* 2002:346).

According to Mouton (2003:167-8), content analysis is the analysis of the contents of texts and documents such as interview reports, *i.e.* it is the analysis of all words, themes or messages that are communicated. The author also describes content analysis as an unobtrusive method that avoids errors that are associated with interaction between researchers and subjects. The two concepts 'coding of data' and 'content analysis' are used interchangeably by some authors.

3.2 Biographical data

The researcher realised that the study participants were individuals with very different backgrounds. Relevant information about the respondents, including training, occupational background and years of experience in an A&E unit, is summarised and displayed in Table 3.1. Demographically the individuals differed, and that contributed to the uniqueness of the research context.

Table 3.1 displays the biographical data of the respondents according to age range in ascending order.

TABLE 3.1: SUMMARY OF THE BIOGRAPHICAL DATA OF THE PARTICIPANTS IN THIS STUDY

Gender	Age range	Qualification	Type of training institution	Experience in A&E unit	Debriefer
Female	20-25	Assistant	College	4 years	No
Female	25-30	RN	College	3 years	No
Male	25-30	A&E	University	4 years	Yes
Female	30-35	RN	College	13 years	Yes
Female	30-35	A&E	College	15 years	Yes
Female	30-35	A&E	College	15 years	Yes
Female	35-40	RN+ A&E	University	10 years	No
Male	45-50	A&E	College	20 years	Yes
Male	45-50	RN	College	20 years	Yes

Key: *RN:* *Registered nurse*

A&E: *Accident and emergency training and registered in this capacity with the SANC*

Assistant: *Assistant nurse (Registered as assistant nurse with the SANC)*

All the nurses in the participatory unit were involved in the debriefing process but, due to purposive sampling, only the abovementioned nine respondents

were selected to form part of the data gathering and analysis process. Data gathering continued until saturation of data was achieved.

3.3 Analysis, coding process and research findings

Data obtained from the transcribed unstructured interviews were coded and analysed. The researcher, as well as two independent co-coders, performed coding. Involving co-coders contributed to the trustworthiness of the coding process. Consensus meetings were held with the co-coders to discuss the findings of the coding process. Discussions continued until consensus was reached on the themes, categories and subcategories.

Three main themes emerged from the coded data, namely:

- Positive aspects regarding the debriefing programme.
- Negative aspects regarding the debriefing programme.
- Recommendations made by participants regarding the debriefing programme.

With respect to each theme, the following three categories were identified:

- Aspects relating to the programme itself.
- Aspects regarding the implementation of the programme.
- Aspects regarding the debriefers that underwent debriefer training.

The themes, categories and subcategories will be discussed in detail in this chapter.

The research findings are displayed in Table 3.2 on pages 61 and 62. The first column displays the main themes, while the categories and subcategories are presented in columns two and three respectively.

TABLE 3.2: SUMMARY OF RESEARCH FINDINGS

Theme	Category	Subcategory
Positive aspects (3.3.1)	Aspects relating to the programme itself (3.3.1.1)	o Successful o Structured o A recipe followed o End goal known to everybody o Addresses both positive and negative aspects of the situation
	Aspects regarding the implementation of the programme (3.3.1.2)	o Makes a difference o Decreases stress o Leads to personal development o Provides people with the opportunity to talk about the crisis o Provides people with the opportunity to talk about emotions
	Aspects regarding the debriefers that underwent debriefer training (3.3.1.3)	o Having insight into problem o Improved listening skills in general o Improved listening skills regarding patient care specifically
Negative aspects (3.3.2)	Aspects relating to the programme itself (3.3.2.1)	o Some individuals function better in a 1:1 scenario o Everybody is not open and honest
	Aspects regarding the implementation of the programme (3.3.2.2)	o Not done regularly o Forgot the process o Did not have the cooperation of the whole team

	Aspects regarding the debriefers that underwent the debriefer training (3.3.2.3)	o Lack of skills
Recommendations made by participants (3.3.3)	Aspects relating to the programme itself (3.3.3.1)	o Should be done on a regular basis o The whole hospital should be involved, and the programme should be implemented in all units
	Aspects regarding the implementation of the programme (3.3.3.2)	o Opportunity should be provided for implementation o Specific time should be allocated for debriefing
	Aspects regarding the debriefers that underwent debriefer training (3.3.3.3)	o Regular exposure to debriefing sessions o Needs to identify individuals that might need further psychotherapy o Needs to be sensitive o Know the community facilities o Voluntary participation o Should have confidence o Should have insight into clinical situation o Needs to be from the same profession as the persons being debriefed o Should have life skills o Should have knowledge of defusing tools

3.3.1 Theme 1: Positive aspects regarding the debriefing programme

Participants experienced some aspects of the debriefing programme as positive. The different subcategories representing positive aspects of the debriefing programme will be discussed under the distinctive categories.

3.3.1.1 Aspects relating to the programme itself

The following subcategories representing positive aspects were identified within this category:

- Successful;
- Structured;
- A recipe followed;
- End goal known to everybody; and
- Addressing both positive and negative aspects of the situation.

It should be pointed out that there are only slight differences between the subcategories 'structured', 'a recipe followed' and 'end goal known to everybody'. However, differences in emphasis should be noted.

- ***Successful***

Participants expressed the opinion that the programme was successful.

'...I think it is a very positive and good programme and was very successful...'

The success of this specific programme could not be validated because no data could be found during a literature search that confirmed the opinion of the respondents. However, in the context of this study, the debriefing programme proved to be successful.

In a study conducted in the USA, nurses from a police department felt that CISD was helpful and successful in managing critical incidents (Alexander 2000:77). Matthews (1998:210), in his report on staff debriefing, also found that workers who received CISD after traumatic incidents reported lower levels of stress, while those who were not exposed to CISD had no significant decrease in stress levels.

- ***Structured***

The respondents were convinced that the debriefing programme was well structured and regarded this as a positive aspect. The following quotation is relevant:

'...due to the fact that you use a structured and systematic procedure...'

Morrow (1998:1) stated that CISD is a structured process that provides a confidential group environment where affected employees can share their experiences during and after an incident. In this sense, debriefing is not an operational critique; rather, participants are encouraged to share their thoughts and feelings as a first step toward recovery. Mitchell and Hopkins (1998:8) were in agreement when they emphasised that debriefing needed to be structured and that certain steps had to be followed during a debriefing session. These steps are elaborated on in Chapter 1 (Refer to sub-subsections 1.8.3.7 to 1.8.4.) Dr SP Hattingh (2002:60) also confirmed that CISD should be structured.

- ***A recipe followed***

Participants who performed debriefing compared their instructions to following a recipe. The prescribed manner in which debriefing had to be done was experienced as a positive aspect of the programme. Every step of the structured debriefing programme that was based on Dr Hattingh's model was clearly defined.

The following quote is relevant:

'...and it is as if you only have to follow a recipe to complete the debriefing...'

No data could be found that validated the respondents' experience that conducting debriefing was like following a recipe. However, Mitchell and Hopkins (1998:8) explained that a CISD structure should set out a specific route with the aim of reaching an end goal. Clear targets, guidelines and a set of instructions (recipe) would facilitate the process of debriefing.

- ***End goal known to everybody***

The fact that the end goal of the structured debriefing programme was known to all involved was seen as a positive aspect of the programme. Thus, the programme's structure, directions and targets were experienced as positive aspects. The following quote is relevant.

'...due to the fact that it is structured, everybody involved knows what the goal is during the debriefing session...'

No data could be found that supported the statement that a clear end goal could be seen as a positive aspect of a debriefing programme. Hattingh (2002:60) stated that debriefing represents a finite beginning and a finite end superimposed upon a traumatic event. This statement, in a sense, confirmed the respondents' opinion that setting of clear targets could be regarded as a positive aspect of the programme.

It is the perception of the researcher that the respondents envisaged the end goal of debriefing as either psychological wellness or a learning and concluding phase. As these are good prospects, knowing the end goal, according to the perception of the researcher, is anticipating a positive result.

- ***Both positive and negative aspects regarding the situation are addressed***

The respondents stated that the debriefing programme did not only deal with the negative aspects surrounding the critical incident, but also addressed positive aspects of the incident. They saw this as a positive aspect of the programme, because they believed a holistic approach to stress management would help them cope with stress, or help them overcome other negative effects of the incident. The following quotation dealt with this issue:

'...So my perception is that this is a complete process that addresses both the positive and negative aspects regarding the critical incident. If I can use an example - comparing debriefing and defusing in different settings and or methods and approaches. Others aren't direct, complete, (are) less structured; other methods are more something that will occur over multiple sessions by a therapist, and each session addresses a different aspect and then you tend to get stuck on certain aspects. But with these [sic] *debriefing session you cover everything...'*

According to Everly *et al.* (1997:1), CISD is a comprehensive, integrative, multicomponential crisis intervention system. CISD is considered comprehensive because it consists of multiple crisis intervention components, which functionally span the entire temporal spectrum of a crisis.

3.3.1.2 Aspects regarding the implementation of the programme

Within this category (aspects regarding the implementation of the programme), the following subcategories representing positive aspects were identified:

- Makes a difference;
- Decreases stress;
- Leads to personal development;
- Provides people with the opportunity to talk about the crisis; and

- Provides people with the opportunity to talk about emotions.

- **Makes a difference**

The majority of the participants felt that the debriefing programme made a difference and had a positive effect on their life. The next quote is relevant:

'...my personal opinion is that this programme made a difference in the way I manage critical incidents...'

Within a South African context, no literature could be found that supported the finding that debriefing makes a difference in the life of people. However, the general opinion of the participants in this study was that, if this programme were fully implemented in A&E units in South Africa, it would make a difference in the way individuals managed critical incidents. That debriefing can make a difference in the life of people was confirmed by Regehr and Hill (2000:69) who conducted a study about the efficacy of crisis debriefing groups within the Australian context. According to these authors, debriefing had made a difference, as respondents reported a decrease in stress levels.

- **Decreases stress**

Some participants stated that the debriefing sessions had reduced their stress levels. One of the participants put it as follows:

'...if the implementation is successful it will definitely reduce my stress levels as the debriefing sessions have already done...'

No South African study could be found that proved that debriefing reduces stress levels. However, in the Australian context, the majority of participants in a study conducted by Regehr and Hill (2000:69) perceived debriefing as beneficial and reported a reduction in stress levels.

- **Leads to personal development**

As a result of the implementation of the debriefing programme in the A&E unit, respondents not only perceived a decrease in stress relating to critical incidents, but also reported personal growth and development. The following quotation is relevant:

'...This programme really contributed to my own personal development...'

In their study, Warrick, Hunsaker, Cook and Altman (1997:91) stated that debriefing could be part of experiential learning. These authors argued that every participant involved in a debriefing session could learn from the experience, and, for this reason, debriefing could contribute to personal development.

- **Provides people with the opportunity to talk about the crisis**

The respondents stated that the debriefing sessions provided them with the opportunity to not only manage their stress but also talk about personal feelings that were experienced as a result of the incident. Refer to the following quotations:

'...Looking at the process of the debriefing programme, it is an opportunity for the debriefed or those exposed to critical incidents to talk about the crisis and their feelings...'

'...I had the opportunity to talk about the crisis or incident I experienced...'

According to Hattingh's model, debriefing allows those being debriefed to talk about the effects of the critical incident and their feelings in this regard (Hattingh 2002). Opportunity is given during the Fact and Thought phases of the programme. (Refer to subsection 1.8.4.)

- **Provides people with the opportunity to talk about emotions**

The following quote is relevant:

'...it was also very nice that I could have talked about my emotions that I experienced during this critical incident...'

According to Davis (1998), debriefing should be conducted on or near the site of the critical event. Debriefing effects the ventilation of emotions and thoughts associated with the crisis event. Therefore, it should be provided as soon as possible but typically no longer than the first 24 to 72 hours after the initial impact of the event. The longer the period between exposure to the event and CISD, the less effective debriefing becomes. A close time relationship between the critical incident and the initial debriefing session is imperative for debriefing techniques to be most beneficial and effective (Davis 1998).

3.3.1.3 Aspects regarding the debriefers that underwent the debriefer training

Within this category (positive aspects regarding debriefers that underwent debriefer training), the following subcategories were identified:

- Insight into problem;
- Improved listening skills in general; and
- Improved listening skills regarding patients specifically.

- **Having insight into problem**

Mitchell, Sakraida and Kameg (2003:47) suggested that debriefing should be conducted by peers. In the case of A&E nurses, debriefing should then be conducted by persons involved in the A&E unit. For the purposes of this study, six A&E nurses were trained as debriefers.

One of these trained debriefers made the following remark:

'...I found that, being an A&E nurse myself, I had more insight into the situation...'

Mitchell *et al.* (2003:47) maintained that CISD was best done when it was conducted by peers or colleagues. These authors stated that persons involved in debriefing sessions tended to be more understanding if they shared a frame of reference.

- **Improved listening skills in general**

The participants stated that the debriefing programme's structure enabled them to improve their listening skill in general. One of the respondents remarked as follows:

'...The debriefer training helped me to make use of my listening skills and therefore I can listen better to my friends and colleagues in general...'

According to the respondents, debriefer training resulted in an improvement in the listening skill of peer debriefers. This is in accordance with a statement by Hattingh (2002:70) that observing and listening is an essential part of being a sufficient debriefer.

- **Improved listening skills regarding patient care**

Those debriefed and the debriefers maintained that the debriefing programme had the additional advantage of helping them improving their listening skill. They also argued that patient care improved as a result of their being more attentive to patients. The following quote is relevant:

'...I found that after the debriefer training I can incorporate the skills with my patient care and improves my own listening skills and those listening skills towards my patients...'

Morrow (1998:1) is in agreement when he stated that debriefing has the result of improving the listening skill of those being debriefed. On the website home.earthlink.net, Morrow stated that as A&E nurses' stories unfold, the debriefer is able to normalise the usually wide range of reactions, encourage the connection with emotional support systems (both at work and at home) and improve their listening skills appropriately for their daily work.

3.3.2 Theme 2: Negative aspects regarding the debriefing programme

Negative aspects regarding the debriefing programme emerged from data that were obtained during the unstructured interviews. These negative aspects should not be seen as negativity or opposition toward the programme, but as opportunities to make recommendations on the programme (theme 3).

Aspects of the structured debriefing programme experienced negatively by the respondents will be discussed according to the categories identified, *i.e.* the programme itself, the implementation of the programme, and the debriefers that underwent the debriefer training.

3.3.2.1 Aspects relating to the programme itself

Within this category (negative aspects relating to the programme itself), two subcategories emerged, namely:

- Some individuals function better in a one-to-one scenario; and
- Everybody is not open and honest.

- **Some individuals function better in a one-to-one scenario**

The respondents pointed out that a group debriefing session might not be of great value to some individuals, as these persons would rather prefer a one-to-one conversation.

The followings quotes address this issue:

'...every one does not operate well in a group...'

'... Some people are better on the one-to-one basis, and I think you can lose some of those guys...'

Contrary to the above statements, a study by Rose *et al.* (2003:1) found that single-session individual debriefing did not reduce psychological distress nor prevent the onset of PTSD in their respondents. A study conducted in an Australian context by Regehr and Hill (2000:69) also questioned the efficacy of single-session one-to-one crisis debriefing. According to these authors, their participants felt that the method was unsuccessful.

- **Everybody not open and honest**

It was the perception of some of the participants that not all group members were open and honest during the debriefing sessions. One of the respondents stated:

'...I also experienced that some people wasn't [sic] *open and honest during the debriefing sessions and that they were hiding some of their feelings...'*

Rose *et al.* (2003:2), in their research on debriefing and the prevention of PTSD, confirmed this perception. The authors stated that not all the psychological debriefing sessions were as successful as planned, as some individuals preferred one-to-one treatment and, for that reason, were uncommunicative.

3.3.2.2 Aspects regarding the implementation of the programme

Within this category (aspects regarding the implementation of the programme), three subcategories representing negative aspects were identified, namely:

- Not done on a regular basis;
- Forgot the process; and
- Did not have the cooperation of the whole team.

- **Not done on a regular basis**

The respondents felt that, in order for them to understand the process better and to ensure the success of the programme, debriefing should be done either more frequently or on a regular basis. Refer to the following quote:

'...I expected to do more debriefings and believe that the more you debrief the better...'

Rose *et al.* (2003:12) confirmed that debriefing was a waste of time if it were not done regularly.

- **Forgot the process**

Some respondents stated that they either did not learn the programme's structure or could not remember its instructions because of lack of opportunity to gain experience. The following quotation is relevant:

'...if you do one debriefing today and maybe one in two weeks time you have already forgotten the whole process and then you have to start all over again to learn the structure of the programme...'

- **Did not have cooperation of the whole team**

The implementation of group debriefing sessions depends on cooperation and participation. However, some of the respondents complained that there was lack of cooperation and interest among group members. The fact that some individuals would prefer an individual session or, because of past events, needed more intensive therapy, was, according to the respondents, a possible reason for lack of cooperation. The following quotes are relevant:

'...The catch is implementation; it is difficult to get everyone to participate and to be interested...'

'...I think in terms of selling and marketing of the thing, we did not have the opportunity to do that. I think it is a shortcoming. We sit with a workable tool, and we don't apply it widely enough; we don't make it known enough. It can work in most situations. A shortcoming - but it's not the goal of the structured debriefing or peer debriefing. Uhm, I think it can occasionally happen that, where you have someone with either a predisposition, someone that previously had a similar circumstances [sic] *where they were more personally involved, for example, someone that were* [sic] *raped before and now they are put into a similar situation where they need to help a rape victim, uhm, I think there is a danger that that person can lose their head, and that you can miss that someone may need long-term therapy, uhm… The short intervention sometimes mean that people who really have a long-term problem and have a long existing problem doesn't* [sic] *get picked up for referral for further therapy. Some people share more difficult with certain stuff, and one session is not necessarily enough for them, and I think a person can miss those people. There is a place for peer debriefing. It doesn't mean it can replace psychotherapy. You must be sensitive and… Also in your training of your debriefers must you look a bit wider and say that you must look out for this and this type of things, so that you know who must be referred further for psychotherapy...'*

'...I also think what you can do is sometimes.... You will say: "Yes, I have given

my participation in the session, I talked and all", and I think there will be persons who will choose to talk individually as well, because everyone does not operate well in a group and this is a group situation...'
[Own underlining]

Rose *et al.* (2003:13) stated that not everyone was interested in CISD, that the process should never be forced onto a person and that debriefers should expect some individuals not to be cooperative.

3.3.2.3 Aspects regarding the debriefers that underwent the debriefer training

Only one subcategory was identified under this category, namely that debriefers lacked skills.

- **Lack of skills**

It was a general perception among the respondents that the debriefers who underwent the debriefer training lacked the necessary skills to conduct a debriefing session. The debriefers also stated that they would like to be better equipped. According to them, they needed more knowledge, skills and tools. The following quote is relevant:

'...The last part, the teaching phase where you can say to people, you can go and walk with the dog, you can go and throw eggs on the road, you can shoot at bottles, you can walk the dog, and those type of thing [sic]*, uhm, there I think the debriefer must almost give you like a library and say: this is* [sic] *techniques; that guy already knows one or two techniques or use even one or two techniques; the one guy will go and try but it won't work for everybody. And he will make a suggestion: go and run tonight, go to the gym, and if someone tells me to go for a run or to the gym, I will most probably send them to another*

place. Yes, I think this way we can equip the debriefers better if we give them sort of an arsenal, and say, this is [sic] *the possibilities, things like your usual relaxation techniques, that of the muscle group constrictions, and those types of things that you yourself can use, demonstrate or do in a session. There is* [sic] *certain books that explain certain techniques very well, and you can use this as a handout, and say this is relaxation techniques that worked for me, and you can try this or that or how it works. There is lot of techniques and I think we …(lack) a big variety...'*

[Own underlining]

Wastell (2002:840) pointed out that debriefers could do more harm than good if they were not properly trained or lacked the necessary skills. Hattingh (2002:68) is in agreement when she stated that, in order for debriefers to deal with the emotional task, they needed to take the time to undergo the special training. Hattingh added that debriefers should be qualified and dedicated, and needed to understand the unique personalities of emergency personnel.

3.3.3 Theme 3: Recommendations made by participants

The participants made recommendations with respect to all three the categories, namely the programme itself, its implementation and the debriefers that underwent training.

3.3.3.1 Aspects relating to the programme itself

Within this category (aspects relating to the programme itself), two sub-categories were identified, namely:

- Should be done on a regular basis; and
- The whole hospital should be involved, and the programme be implemented in all units.

- **Should be done on a regular basis**

In order for them to become fully acquainted with the process of debriefing, the participants suggested that it should be done on a regular basis. They could familiarise themselves with the structure of the programme if debriefing were conducted more frequently. The respondents stated that regular debriefing sessions are necessary to ensure that critical incident stress is managed. The following quotations address this aspect:

'...I would like to do the debriefing more often, for every critical incident...'

'...if we do not debrief that often I can't learn how the debriefing is supposed to go and then I tend to forget the whole thing...'

'...I think we should really debrief more often to really manage the stress that we experience in this unit...'

A study by Wastell (2002:841) concluded that regular debriefing was imperative because suppressing emotional reactions after a critical incident could be detrimental to a person's health.

- **The whole hospital should be involved and the programme should be implemented in all units**

The analysis of data obtained from the transcribed interviews revealed that a structured debriefing programme should be implemented not only in the A&E unit but in all units. According to the respondents, the whole hospital should be involved in such a programme. The following quote is relevant:

'...The programme is very well structured but it needs to be fully in place and should be introduced to the whole hospital and not only the A&E unit...'

In a study conducted by O'Connor (2003:55), the researcher stated that anybody involved in a critical incident (and not only A&E nurses) could

experience stress as a result of the incident and should be debriefed accordingly. The researcher also stated that debriefing could be introduced in any profession or after any incident that was perceived as critical, whether it were an event in a closed environment, such as a hospital, a natural disaster or a terrorist attack.

3.3.3.2 Aspects regarding the implementation of the programme

Within this category (aspects regarding the implementation of the programme), the following two subcategories representing recommendations were identified:

- Opportunity should be provided for implementation; and
- A specific time should be allocated for debriefing.

- **Opportunity should be provided for its implementation**

It was the opinion of some of the respondents that unit management should provide them with adequate opportunity to implement the structured debriefing programme. According to these respondents, debriefing should be performed after each critical incident in the unit. They regarded debriefing as a future routine activity. The following quotes are relevant:

'...I think that we should allow adequate opportunity to implement this programme...'

'...debriefing should form part of our daily nursing actions in the unit like counting the drugs or checking the emergency equipment and also debriefing after a critical incident...'

- **Specific time should be allocated for debriefing**

Following on the above statements, the respondents also stated that the hospital should set aside a specific time for debriefing. It was found in this study that participants were not eager to attend debriefing sessions after a long shift. However, if time were allocated for this purpose, debriefing sessions would be attended. The following quotations addressed this issue:

'...we don't want to debrief after a long 12 hour shift...'

'...hospital management should provide us with a specific off-duty day for a debriefing session...'

It is important to remember that debriefing should be conducted 24 to 72 hours after experiencing the impact of the incident. Debriefings undertaken earlier than 24 hours after the impact of the critical incident are often ineffective, as those exposed to its impact are still too overwhelmed to be debriefed. Hattingh (2002:62) also recommended that debriefing be conducted within the prescribed time limits. Hospital management should take these time limits into account when setting a timetable for debriefing sessions.

3.3.3.3 Aspects regarding the debriefers that underwent debriefer training

Within this category (aspects regarding the debriefer that underwent debriefer training), the following subcategories were identified:

- Regular exposure to debriefing sessions;
- Needs to identify individuals that might need further psychotherapy;
- Needs to be sensitive;
- Should know the community facilities;
- Voluntary participation;
- Should have confidence;
- Should have insight into clinical situation;

- Needs to be from the same profession;
- Should have life skills;
- Should have knowledge of defusing tools.

- **Regular exposure to debriefing sessions**

Respondents who underwent debriefer training stated that regular exposure to debriefing sessions would enhance their debriefing skills, and enable them to become good debriefers. The following quotations are relevant:

'...If regular debriefing sessions and/or training exercises aren't conducted I will definitely start to forget most of the training and expertise that I gained during the training...'

'...We definitely have to make more opportunities available to exercise this debriefing process...'

According to Hattingh (2002:68), debriefers should be informed of the critical incident as soon as possible or be called out to become involved in order to fully understand the extent of the incident and their task in this regard. Regular involvement in critical incidents on this level would help the debriefer develop an understanding of the event, and facilitate scheduling of debriefing sessions.

- **Needs to identify individuals that might need further psychotherapy**

The respondents also stated that a good debriefer should be able to identify individuals during a debriefing session that might be in need of further treatment by a psychotherapist. The following quotations refer to this issue:

'...we must be very observant to identify a person that is not gaining from the debriefing session and that will benefit more from an individual session from a trained professional like a psychiatrist...'

'...we must remember that we aren't therapists and that debriefing aren't therapy and therefore should be able to send or refer individuals that might need further therapy...'

On the website home.earthlink.net, Morrow (1998:1) stated that the debriefer should be able to instruct on appropriate self-care, and assess the need for follow-up services in the days immediately following the event. Hattingh (2002:60) also pointed out that CISD allows for follow-up and that it always represents a mechanism in which individuals who indeed require formal psychological care can be identified and helped as to facilitate total recovery.

- **Needs to be sensitive**

The respondents insisted that debriefers should be sensitive toward the situation and the persons involved in the debriefing session. The following quote pertains to this issue:

'...you must be sensitive in a session...'

According to Laposa *et al.* (2003:25), a debriefer should be careful and sensitive during a debriefing session to prevent making group members feel upset or unwelcome.

- **Should know the community facilities**

It was stated in the data collection phase that the debriefers should be well informed of the availability of community facilities so that the persons being debriefed could be introduced to facilities that could help them manage their stress. Refer to the following quotes:

'...You must know your community facilities well...'

'...If there is only one psychologist in your area, you must know who he is, but if there is 20 psychologists in your area and one of them are specialised [sic] *in*

rape, then you must know (who) he is in order to refer a person to him, so you must know your support systems very well...'

Hattingh's (2002:69) study confirmed that a debriefer should have knowledge of other counselling services, especially those outside the hospital.

- **Voluntary participation**

The data analysis revealed that the respondents were quite adamant in their belief that no person should be forced to be involved in a debriefing session, nor should any person be forced to act as debriefer. The respondents insisted that the programme be based on voluntary participation. The following quotations are relevant:

'...if I don't want to participate in the debriefing session, they should not force me...'

'...I sometimes have a different way to manage certain incidents and if I don't do it out of my own will you can lose my interest very easily...'

Participation in any stress management activity, such as CISD, and training in debriefing should be voluntary. Stress management is in the hands of the person experiencing the stress, and always is a matter of self-management. The motivation to seek help should be that of the participant. Participants should be informed that intervention would always be available (Hattingh 2002:59).

- **Should have confidence**

A primary characteristic of a debriefer is confidence in their abilities. The participants stated clearly that a debriefer should be confident during a session and never show any sign of confusion or fear.

The following quotations are relevant:

'...the debriefer should never show that he is scared of the situation or show signs that they aren't in control...'

'...if the debriefers aren't confident in what they do it might influence the success of the whole debriefing session...'

These perceptions of the respondents are supported by Hattingh's (2002:69) research on the training of peer debriefers. Hattingh stated that a debriefer should have self-knowledge, *i.e.* insight into the self, internal locus of control, confidence, freedom, and independence.

- **Should have insight into the clinical situation**

The respondents also believed that the debriefers should have knowledge of and insight into the critical incident, and know the clinical situation well. They insisted that the debriefer should have previous experience in A&E nursing and similar critical incidents. The following quote is relevant:

'... It is no use if the debriefer has no knowledge of the situation...'

Thus, a debriefer should have not only self-knowledge but also insight into the situation. Hattingh (2002:69) confirmed that a debriefer should have internal locus of control during the critical incident and debriefing session.

- **Needs to be from the same profession as those being debriefed**

All the respondents (the debriefers and the debriefed) were adamant that, for the debriefing programme to be effective, the debriefer should have a position within the nursing profession. They argued that peers in the same setting would have mutual understanding, whereas outsiders might not understand, as they could not comprehend the full extent of the situation.

The following quotes are relevant:

'...external people don't understand the situation and circumstances in the A&E unit and therefore it is important to have a debriefer that is from the same unit and the same profession...'

'... Because I was also in the position of a qualified psychologist, many people have the perception that you sit in a glass palace, and that you don't have an idea about what happens in reality. Uhm, I think about debriefings that I have done before at SASOL. When I left SASOL, when I wasn't co-debriefer anymore, people relate to you in a different manner, and you get a certain group of people that relate more difficult to therapist. Uh, it feels that because there is no one doing the job, they do not understand what it's all about. In that regard, the whole idea of peer debriefing is very important. People know that you were most probably also in such situations, and you understand what it's all about. Uhm you know the background. Uhm, you relate more easily to your, it's not someone that is outside your reference framework, it's not someone to which [sic] *you must suck up to. If they feel they can say "bliksem" (dammit) because you have also said "bliksem" (dammit) in such circumstances; you know the proto (protocol), you know the set-up, so I think that it is a very huge advantage...'*
[Own underlining]

It was the perception of the respondents that only peer debriefers could have insight into their situation. The requirement that the debriefers should be A&E nurses from the same unit seems to a logical deduction and follows the previous subcategory, namely that debriefers should have insight into the clinical situation.

Research by Mitchell, Schiller, Eyler and Everly (Jr) (1999:230) confirms that peer debriefing or debriefing by a person with the same frame of reference is an important concept in the CISD programme. These authors also stated that the debriefer should have first-hand knowledge of the situation and incident that has occurred.

- **Should have life skills**

The respondents clearly stated that debriefers should have the necessary life skills to be able to manage debriefing sessions. Thus, a debriefer should have extensive experience in A&E nursing, and gained knowledge from life and from being in a lot of different situations. The following quotes refer to this issue:

'...a good debriefer should be a person that has been around the block for some times...'

'...you can't make an inexperienced person a debriefer. They should have had experience with the trauma setting and at least some exposure to some critical experience..'.

'...I would like to compare it to allowing a 12-year-old to drive a car. A 12-year-old is not experienced enough to drive a car without causing an accident. And, therefore, the same is valid for debriefing. You can't let an inexperienced person be a debriefer and put them in charge of a debriefing session...'

Current available literature neither supports nor denies these statements. However, the participants in this study clearly stated that, in order for this programme to be effective, the debriefer should have appropriate life skills. The apparent lack of relevant literature in the South African context provides researchers with the opportunity to further explore topics such as the right personal qualities of a competent debriefer and skills needed to conduct a successful debriefing session. In this respect, the analysis of data in this study has indicated that debriefers should have knowledge of defusing tools, as this is needed during a debriefing session.

- **Should have knowledge of defusing tools**

The respondents (including those trained as debriefers) argued that a good debriefer should have sufficient knowledge of defusing tools (stress management tools) and their application in order to accommodate every

member of the debriefing group. The respondents not only emphasised the debriefers' apparent lack of knowledge about defusing tools (refer to subsection 3.3.2.3), but also made positive recommendations in this regard. The following quote is repeated here to illustrate this point.

'...The last part, the teaching phase where you can say to people, you can go and walk with the dog, you can go and throw eggs on the road, you can shoot at bottles, you can walk the dog and those type of thing, uhm there I think the debriefer must almost give you like a library and say this is techniques, that guy already knows one or two techniques, or use even one or two techniques, the one guy will go and try but it won't work for everybody. And he will make a suggestion; go and run tonight, go to the gym...'

'... I think this way we can equip the debriefers better if we give them sort of an arsenal, and say this is the possibilities, things like your usual relaxation techniques, that of the muscle group constrictions, and those types of things that you yourself can use, demonstrate or do in a session...'

'...There is [sic] *certain books that explain certain techniques very well, and you can use this as a handout, and say this is relaxation techniques that worked for me, and you can try this or that or how it works. There are a lot of techniques and I think we (lack) a big variety...'*
[Own underlining]

No support for this finding could be found in the relevant available literature, but data collected during this study indicated that debriefers should have sufficient knowledge of defusing tools to suggest appropriate stress management techniques during briefing sessions.

Hattingh's (2002:69-70) statement that debriefers should receive professional training in areas such as advanced CISD, crisis intervention, general stress intervention, group processes, and human communication skills corresponds with the findings in this study, namely that debriefers should have life skills and knowledge about personal stress management. Hattingh also stated that the

debriefer should be familiar with the A&E environments, thereby supporting this study's findings that debriefers should have insight into the clinical situation and have a position within the A&E setting.

3.4 Conclusion

Data collected during unstructured interviews were coded and analysed. The data were categorised into themes, categories and subcategories, and the findings discussed. Relevant literature was studied in order to validate findings. Despite an extensive search for supporting research, especially in the South African context, the majority of the recommendations made in this study regarding the structured debriefing programme could not be validated. This leaves researchers with the opportunity to further explore these topics in the South African context.

The study's conclusions and recommendations will be discussed in Chapter 4.

Chapter 4

RECOMMENDATIONS, REFLECTION AND GUIDELINES

4.1 Introduction

After the data was analysed, recommendations regarding how this programme could be optimised were made and guidelines formulated.

The first objective of this study was to train debriefers in the A&E unit to be able to implement a structured debriefing programme based on the model by Hattingh. This objective was attained because the debriefers voluntarily attended the debriefer training held by Hattingh. This enabled them to conduct debriefing sessions in the unit considered in this study.

The second objective was to implement the structured debriefing programme. After the debriefers were trained, the debriefing programme was implemented in the A&E unit and debriefing sessions were held when critical incidents occurred.

The third objective of this study was to obtain data regarding the perceptions of the A&E nurses, who were debriefed, and their debriefers, regarding the structured debriefing programme. After the debriefing programme was implemented, the researcher conducted unstructured interviews with the participants of the programme. The data that was derived from these interviews is set out and discussed in Chapter 3.

The fourth objective of this study was to make recommendations regarding future use of this structured debriefing programme. This objective is attained in this chapter as recommendations are made and discussed.

By reaching these objectives, the aim of this study, namely to implement a structured debriefing programme based on Hattingh's model in the A&E unit of a private hospital in Gauteng and to determine the A&E nurses' perceptions of this structured debriefing programme, has been reached.

4.2 Recommendations

The recommendations will be discussed under the following headings: recommendations for trauma clinical nursing practice, nursing administration, nursing education and future research.

4.2.1 Recommendations for the trauma clinical nursing practice

As it appeared that the participants of this study benefited by it, similar studies could be of value in other private hospitals' A&E units as well. This programme could also be implemented in the public hospital sector.

The amount of critical incidents is on the increase in South Africa; therefore, the implementation of such a programme in the trauma and A&E setting will be beneficial to all the members exposed to these incidents. In South Africa, trauma accounts for 12-15% of all deaths, compared to the global figure of 5.2%, and kills an estimate of 65 000 to 80 000 South Africans annually (178 - 218 per day). Trauma, in all its forms, has a vast impact on the economy of South Africa and increases daily (Nicol & Steyn 2004:1).

According to the responses received from the participants in this study, the debriefing sessions that were held reduced stress. It could be assumed that, if implemented correctly, the programme could continue to reduce stress in the A&E setting.

4.2.2 Recommendations for nursing administration

The researcher had informal conversations with nurses from other units, such as the intensive care unit (ICU), in the hospital where the research was conducted. It was clear that there is also a definite need for structured debriefing in these areas.

It is this study's recommendation that the nursing administration of hospitals should allow such a programme to be implemented and should allocate specific time for sufficient debriefing. Debriefing sessions should form part of the A&E nurses' normal working hours. This would benefit every person involved in nursing or otherwise exposed to critical incidents while on-duty.

An infrastructure for CISD should be incorporated into hospital and regional nursing administration to make provision for volunteer and in-hospital workers. In other words, debriefing should not be focussed solely on permanent nursing staff, but should also include volunteer and non-permanent staff, as well as non-nursing hospital personnel that are exposed to critical incidents.

In the course of this study, the researcher came across a policy instituted by the hospital group in 2002 that clearly states that debriefing should be conducted. However, there is still no time allocated to making debriefing part of nurses' tasks. Attention should be given to making these policies a working reality, rather than merely an effort to be legally correct.

4.2.3 Recommendations for nursing education

Every nurse, whether in A&E or ICU units, or even general nursing, is exposed to critical incidents at some point in their careers. However, the current nursing education does not focus on the importance of stress management or debriefing after critical incidents at all. It is therefore recommended that debriefing should form part of the basic nursing education, and that the awareness and development of CISD should be promoted. This would create a mind shift in the nursing profession, be valuable in the maintenance of nursing as a profession and contribute to the overall wellness of nurses in South Africa.

Nurses in the A&E setting in hospitals throughout South Africa should be knowledgeable in the area of debriefing and continuous education in debriefing should be conducted on a regular basis. Nurses involved in critical incidents should also play a part in emphasising the importance of CISD.

Debriefing should form an integral part of the four-year basic training course, as well as of post-graduate training in any specialised field. This should be done in order to train nurses in debriefing and in the role of the debriefer, and should include formal, as well as informal training, such as in-service training.

4.2.4 Recommendations for future research

Considering the recommendations made by and the limitations of this study, there are many avenues of further study in this area.

Because the researcher made use of purposive sampling, which was not representative of the population, a risk of bias exists. The opportunity to generalise is therefore limited. The researcher suggests that future research makes use of other methods of sampling.

During the research process, many comments regarding debriefing were made in the course of informal conversations. Thus participants provided valuable information that was lost due to the fact that it was not recorded immediately. Field notes as part of the research process would have been valuable.

No relevant literature was found that confirmed that debriefing has a marked effect. However, the general opinion among participants in this study was that, if this programme were fully implemented and used for critical incidents that occur in the A&E unit, it would make a difference in the way that individuals manage critical incidents. This creates the opportunity to explore the accuracy of this statement in settings other than the A&E unit. A qualitative study methodology could possibly be used in order to explore this.

The researcher also assessed the experiences of the debriefers in this study, in order to determine their perceptions of a structured debriefing programme, and recommendations on the future training of peer debriefers were made. More in-depth research can be done in this area to determine the requirements in order for a debriefer to successfully manage a debriefing session in this kind of context.

Determining the levels of stress that A&E nurses experience in an environment exposed to critical incidents could be of value in order to elaborate on the need for CISD in the South African context.

The long-term effect of implementing such a debriefing programme should also be explored and monitored.

4.3 Limitations

Various limitations were encountered during this study.

The population of this study was drawn from only one private hospital in Gauteng; therefore the study was only valid for that specific context. Due to the small size of the sample, the generalisation of the data is limited. Generalising findings from a purposive sample to the broader population can be very risky in most instances (Polit & Hungler 1997:230).

Nurses in general do not know about the pros and cons of debriefing and therefore it was very difficult to convince and motivate them to participate. The general attitude of the A&E nurses and those exposed to critical incidents in a hospital setting is that they do cope with the stress related to these incidents and that they do not need any further assistance. However, their behaviour and symptoms suggest that, although they say they do not need debriefing, there is a definite need for structured CISD. This attitude inspired the implementation of this debriefing programme.

4.4 Reflection on this study

As a registered nurse working in the A&E unit, I was exposed to critical incidents. After numerous exposures to such incidents, I realised that there was no system or programme in place to help nurses manage the stress caused by these critical incidents. At that point, I developed an interest in finding such a programme and implementing it in the unit in order to reduce the stress caused by critical incidents.

Due to the fact that no such programme existed, I had to start from the beginning. The appropriate programme was identified and also explored in this study. Dr SP Hattingh, on whose research this study was based, often gave valuable support.

The debriefers were trained by Dr Hattingh in a three-day course. The training was of very high standard and gave those who attended the basic knowledge to conduct a debriefing session, although the training was not sufficient for them to become expert debriefers. The debriefers had to practise the process in their own time and were motivated by the training to implement the programme in the unit involved in the study. The debriefer training was professionally done and, in my opinion, highly successful.

My opinion of the debriefing programme itself is also positive. It is an efficient and well-structured programme and, if implemented well, can be successful in reducing stress related to critical incidents. The most important factor in the success of such a programme is the support of the whole unit and hospital in the development and implementation of this programme. It should not be the responsibility of one person, but rather the responsibility of the unit, the hospital and, most importantly, the hospital management to maintain the programme.

When this programme was introduced in the unit, the majority of A&E nurses were excited. However, some individuals showed some negative attitudes toward the programme. Once the debriefing sessions were conducted, most of the nurses were positive about the future of this programme in the unit.

The reason for the negative attitudes of some individuals was a lack of understanding for the reasons and goals of debriefing. Some thought that the purpose of a debriefing session was to reflect on treatment protocols followed during a specific resuscitation and feared negative critique on the way that they managed patients. After assuring them that the goal of this debriefing programme was not to evaluate or critique their skills as nurses, but rather to help them manage their critical incident stress, they became more positive.

After the debriefing programme was implemented, medical doctors, and even pre-hospital healthcare providers involved in the A&E unit, began to have an

interest in the programme. This provides the opportunity to explore this programme in other professional settings.

The difficulty that I experienced as a researcher was in finding the time to conduct regular debriefing sessions because of the long hours that nurses work, resulting in those involved in the debriefing being tired and uninterested.

4.5 Guidelines to optimise this debriefing programme for A&E nurses

Guidelines for the debriefing process are presented below. These guidelines are formulated so that the debriefing programme implemented in this study can be optimised. The guidelines are built on recommendations that were made by the participants in this study regarding the structured debriefing programme.

- **Guideline One**

Regular debriefing sessions should be held.

Operationalisation

Debriefing sessions should be held after every critical incident that occurs in the unit. Sessions to exercise the programme with the use of role-playing should be held on a regular basis in order to allow those involved to become familiar with the process and develop the confidence to conduct such a session. If this is not done on a regular basis, people tend to forget the process and the system collapses as people lose interest. A role-play video/DVD, to be used as a learning tool in training toward becoming a debriefer, is available from the researcher.

- **Guideline Two**

Complete hospital involvement should be established and enforced.

Operationalisation

Because the whole hospital should be involved in the implementation of such a debriefing programme, it does not have to be restricted to the A&E unit, but can be implemented throughout the hospital. Therefore the programmes' viability in other settings in the hospital, such as ICU or any other setting in which critical incidents are experienced, should be explored.

- **Guideline Three**

Debriefers should identify those in need of further psychotherapy and refer them appropriately.

Operationalisation

It was revealed that some individuals function better in a one-to-one scenario than in a group situation. Debriefers should have the knowledge to identify a person who needs individual attention or further management by an independent mental health-care professional. In other words, the debriefer should be able to identify individuals who might have a need for further psychotherapy.

- **Guideline Four**

Sufficient implementation opportunity should be provided.

Operationalisation

Adequate opportunity should be provided for the implementation of the debriefing programme by the A&E unit. The hospital and the unit should allocate specific time for debriefing. Debriefing should form part of the primary survey, in which nurses assess patients in order to address any hazards to patients and themselves, as stated in Chapter 1.

- **Guideline Five**

Debriefers should be exposed to continuous and regular debriefing and training.

Operationalisation

The debriefers should have continuous exposure and training in debriefing techniques in order to maintain a high standard of knowledge regarding the process and in order to be able to conduct a successful debriefing session.

- **Guideline Six**

Voluntary participation of all those involved should be the golden rule.

Operationalisation

It must be kept in mind that the debriefing process should be attended on a voluntary basis. No person involved should be forced to attend a debriefing session, nor any person be forced to be a debriefer if they feel that they do not have the qualities to be a successful debriefer.

- **Guideline Seven**

The debriefer should have community facility knowledge and awareness.

Operationalisation

It is also important that the debriefer should be aware of the available community facilities in order to be able to make a successful referral for further management. Before a debriefer can refer an individual for further management, they should be familiar with the facilities most appropriate to that individual.

- **Guideline Eight**

The debriefer must have a sensitive attitude.

Operationalisation

The debriefers should be sensitive of the situation and the feelings of the individuals who are debriefed.

- **Guideline Nine**

The debriefer must have confidence and appropriate life skills.

Operationalisation

The debriefers should be confident and be able to impart the necessary life skills when conducting a debriefing session. It is the debriefers' responsibility to ensure that they are equipped with the necessary knowledge and skills and have the necessary defusing tools, in order to be able to provide effective debriefing. They should also be able to convey stress management tools to the debriefed

who has to further manage stress after the debriefing session. These skills and tools include any skills and tools that are imparted to the debriefed with the aim of helping to reduce the stress caused by the critical incident.

- **Guideline Ten**

The debriefer must be from the same profession – peer debriefing.

Operationalisation

The study revealed that the debriefer should always be from the same profession and unit as those being debriefed. Peer debriefing is a key concept in these debriefing sessions. The participants in this study believed that if the debriefers are from the same profession and unit, they are more likely to have insight into the specific clinical situation. Another advantage of peer debriefing is that the debriefer is likely to better understand those being debriefed, by virtue of previously knowing them, thus making communication easier. The participants continued to say that the debriefing sessions might not be successful if an outsider, with limited understanding of the situation, were involved.

4.6 Conclusion

This study was positively received and perceived in the A&E unit involved. Nurses need to understand the importance of their own psychological well-being and that they cannot treat a patient optimally if they have not addressed the hazards to themselves, such as not being debriefed.

Every participant had the opportunity to attend a structured debriefing session in order to manage the psychological and critical incident stress that goes with working in an A&E unit. The Emergency Nurses Association in the USA supports

the development and utilisation of CISD to accelerate the recovery of emergency nurses from acute incidents (Mitchell & Everly 2001:89).

This study showed that mostly positive perceptions regarding debriefing programmes exist in the A&E unit, as explored by the researcher. The programme for structured debriefing can be implemented in the future in A&E units nationally and internationally and can improve the psychological well-being of all A&E nurses.

The recommendations in Chapter 3 should play a major role in making such a debriefing programme effective and successful. However, the negative aspects that were perceived and stated by the respondents should not be ignored. These negative aspects should be addressed and further research should be conducted in order to improve the debriefing programme in the future.

It is also important to recognise the risks associated with CISD. CISD participants could in fact become victims if, for example, debriefers were insufficiently trained, and therefore further research is still required in the area of CISD.

The researcher took the risk-benefit ratio into consideration and determined that the benefits outweighed the risks and no harm was done to any of the participants. Due to the fact that no debriefing was available at the time to the A&E nurses, they had nothing to lose and only the opportunity to gain from the debriefing programme, in the management of their stress related to critical incidents.

Nurses are exposed to critical incidents everyday. This will only escalate in the future and therefore they need to be able to manage this stress. This study has shown that the only way to do this successfully is to implement a programme in which the debriefing is conducted in a proper way. The general outcomes of this

study show that structured debriefing can have a positive effect in the A&E unit and that it could reduce A&E nurses' stress, related to critical incidents.

It should be noted that debriefing forms a part of the primary survey in managing a critically injured or ill patient. The H (Hazards) in the primary survey should be emphasised, and it should be considered that the A&E nurses, who are not debriefed after a critical incident, are a hazard to themselves and the patients (Dolan & Holt 2000:20). Only psychologically healthy nurses can provide adequate health care to their patients, but the question remains, to what extent are our nurses psychologically healthy?

We learn by doing and realizing what came of what we did.
John Dewey

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ANNEXURE A

APPROVAL FROM FACULTY OF HEALTH SCIENCES RESEARCH ETHICS COMMITTEE TO CONDUCT STUDY

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ANNEXURE B

PARTICIPANT INFORMATION LEAFLET AND INFORMED CONSENT DOCUMENT

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PARTICIPANT INFORMATION LEAFLET AND INFORMED CONSENT DOCUMENT

TITLE OF RESEARCH STUDY

The perceptions of accident and emergency nurses regarding a structured debriefing programme in a private hospital in Gauteng

INTRODUCTION

You are invited to volunteer for this research study. The researcher aims to determine accident and emergency nurses' perceptions of a structured debriefing programme to be implemented in a private hospital in Gauteng. This information leaflet will help you decide whether or not to participate. Before you agree to participate in this study, you should fully understand what is involved. If you need more information about the proposed study, please do not hesitate to approach the researcher. You should not agree to participate unless you are completely satisfied with the goal and nature of the proposed research.

PURPOSE OF THE STUDY

As an accident and emergency nurse working in an accident and emergency unit, you are exposed to multiple critical incidents and stressful traumatic events. The researcher has observed that there was no proper structured debriefing programme in place to help accident and emergency nurses cope with stressful situations. For the purpose of this study, three persons will be selected and trained as debriefers. A structured debriefing programme will be implemented in your accident and emergency unit. After successful implementation of this programme, volunteers will be interviewed to determine their perceptions of the newly implemented structured debriefing programme. Participants will also have the opportunity to discuss any problems associated

with the programme. Even after the research study has been completed, debriefing facilities will be in place and debriefers will be available to help nurses cope with stressful events and situations in the unit.

ETHICAL APPROVAL

The study protocol was submitted to the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria. The committee has granted written approval.

RIGHTS OF PARTICIPANTS

Your participation in this study will be voluntary, and you can refuse to participate or withdraw you participation at any time without stating a reason. Your withdrawal will not affect access to any future assistance you may need. However, the researcher reserves the right to withdraw a participant from the study if it is considered to be in his/her best interest.

CONFIDENTIALITY

All information obtained during the interviews will be strictly confidential. Data will be available to only the researcher and study leader. Results of the study will be anonymously processed into a study report. Data that might be reported in scientific journals would not include any information that could lead to the identification of a participant.

ADDITIONAL INFORMATION

If you need more information about the research study, please do not hesitate to contact the researcher, Marius van Heerden, at the following number:
+27 84 584 2253

Researcher: Marius van Heerden (Student no. 9810043)
Study leader: Dr ADH Botha

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INFORMED CONSENT DOCUMENT

I hereby confirm that I was informed by the researcher, Marius van Heerden, about the nature and expected benefits of the proposed study. I have received, read and understood the above participation leaflet about voluntary participation in the research study titled: Accident and emergency nurses' perceptions of a structured debriefing programme implemented in a private hospital in Gauteng.

I am aware that all data obtained will be kept confidential and that study results will be anonymously processed into a study report.

At any stage and without prejudice, I may withdraw my consent and participation in the study. I had sufficient opportunity to ask questions and, of my own free will, declare myself willing to participate in the study.

Participant's name _____ (Please print)
Participant's signature _____ Date _____

I, Marius van Heerden, hereby confirm that the above participant has been fully informed about the nature and benefits of the proposed study.

Researcher's name _____ (Please print)
Researcher's signature _____ Date _____

ANNEXURE C

TRANSCRIBED UNSTRUCTURED INTERVIEW

TRANSCRIBED UNSTRUCTURED INTERVIEW

M: Ok, Mr. A, uhm, you have done the debriefing training to become a debriefer and you attended a debriefing session where you were also a co-debriefer at one of the debriefing sessions that we held. So, I think you have a relatively good idea what the debriefing is all about, what we plan. I just want to know from you: What are your perceptions as an A&E unit nurse, what are your perceptions regarding the structured debriefing programme, what we planned and the training that you've had?

A: I think it is two in line, but, on the one hand, for me personally, is the structure, it is good, it is almost like your P 1 notes, it gives you a "recipe" *it guides your thinking,* and that you don't skip here and there, because I think in a crisis situation, and especially if you are under pressure, and you have a lot of people that are under pressure, and they do not "operate" their best, then you can easily start to focus on just one aspect and you can get lost therein. Whereas this is a complete process, in that way for me as co - debriefer, it was good, uhm, you have a way of thinking, and you go through certain steps which ensure you that you cover everything, and you make it easier for yourself, you know that you will not get lost somewhere. There is not a chance to miss things that are important. Uhm the perceptions that I also got from the peoples participation, is that they feel they also get the opportunity to address particularities about, uhm, is struggled with this or that, or this was a problem or that was a problem for me, that type of things, but they also get the opportunity to address the emotions towards it, and they also get direct and directive help from this and this is things you can do, not only from the debriefer but from other guys inputs.

M: OK

A: So my perception is that this is a complete process, uhm, if I can use an example comparing debriefing and defusing in different settings and or methods

and approaches. Others aren't direct, complete less structured; other methods are more something that will occur over multiple sessions by a therapist, and each session addresses a different aspect and then you tend to get stuck on certain aspects, but with these debriefing session you cover everything.

M: Ok, uhm, so would you say that the whole concept of peer debriefing is positive / negative aspect taking into consideration that you are an A & E nurse who debriefs other A & E nurses? Do you think that something, like this should rather be done by a registered therapist or in dependant outsider?

A: Because I was also I in the position of a qualified psychologist, many people have the perception that you sit in a glass palace, and that you don't have an idea about what happens in reality, uhm, I think about debriefings that I have done before at SASOL, when I left SASOL, when I wasn't co-debriefer anymore. People relate to you in a different manner, and you get a certain group of people that relate more difficult to therapist. Uh, it feels that because there is no one doing the job, they do not understand what its all about, in that regard the whole idea of peer debriefing is very important, people know that you were most probably also in such situations, and you understand what its all about, uhm you know the background, uhm you relate more easily to your, its not someone that is outside your reference framework, its not someone to which you must suck up to, if they feel they can say "bliksem" because you have also said "bliksem" in such circumstances, you know the proto, you know the setup, so I think that it is a very huge advantage.

M: Ok, Mr. A uhm, are there any suggestions, positive critique that you can highlight regarding the whole structured debriefing, you know you've said a few positive things, is there other suggestions you can make?

A: I think in terms of selling and marketing of the thing, we did not have the opportunity to do that. I think it is a shortcoming. We sit with a workable tool, and we don't apply it widely enough, we don't make it known enough. It can work in most situations. A short coming but it's not the goal of the structured debriefing or peer debriefing. Uhm, I think it can occasionally happen that where

you have someone with either a predisposition, someone that previously had a similar circumstances where they were more personally involved, for example someone that were raped before and now they are put into a similar situation where they need to help a rape victim, uhm I think there is a danger that that person can loose their head and that you can miss that someone may need long-term therapy, uhm the, short intervention sometimes mean that people who really have a long-term problem and have a long existing problem doesn't get picked up for referral for further therapy. Some people share more difficult with certain stuff and one session is not necessarily enough for them, and I think a person can miss those people, there is a place for peer debriefing it doesn't mean it can replace psychotherapy. You must be sensitive and also in your training of your debriefers must you look a bit wider and say that you must look out for this and this type of things, so that you know who must be referred further for psychotherapy.

A: I also think what you can do is sometimes.... You will say: " Yes I have given my participation in the session, I talked and all", and I think there will be persons who will choose to talk individually as well, because everyone does not "operate" well in a group and this is a group situation. Some people are better on the one to one basis, and I think you can loose some of those guys.

M: Ok thank you very much. I do not have a lot of questions, one central question.

A: There is an additional type of advantage, which I think you do not realize all the time. If you drive past an accident scene, and you drive past it bothers you. If you drive and you stop and do something, then it is a coping mechanism. Especially with emergency personal, you are trained, it is your nature to want to help, uhm, I think it is an additional advantage of the debriefing, is that even though you were not part of the particular incident, it still gives you tools to help and also what I have already said, it soothes you a bit personally, you get it a lot that you are frustrated, you see the other guys, how they react and you feel lazy you feel intemperate to do something, and it contributes to your frustration, if you help in this manner it is another way to get involved and it is also a bit of

self healing and self therapy as well, I think it is an additional advantage of such a thing.

M: I just want to come back to what you have said earlier, about one problem like the rape case and other people that were exposed. Will you say that you should look after your after care and that you will need to have a good referral framework with you, that you can suggest and advise to other persons?

A: You must know your community facilities well. If there is only one psychologist in your area, you must know who he is, but if there is 20 psychologist in your area and one of them are specialised in rape, then you must know he is in order to refer a person to him, so you must know your support systems very well and you must be sensitive and you must be able to pick it up in a session, and you are very busy in a session, your head is working overtime. I think there is a danger that you can miss these things.

M: *Can you enlighten some aspects that were significant to you?*

A: The last part, the teaching phase where you can say to people, you can go and walk with the dog, you can go and throw eggs on the road, you can shoot at bottles, you can walk the dog and those type of thing, uhm there I think the debriefer must almost give you like a library and say this is techniques, that guy already knows one or two techniques, or use even one or two techniques, the one guy will go and try but it won't work for everybody. And he will make a suggestion; go and run tonight, go to the gym and if someone tells me to go for a run or to the gym I will most probably send them to another place. Yes I think this way we can equip the debriefers better if we give them sort of an arsenal, and say this is the possibilities, things like your usual relaxation techniques that of the muscle group constrictions and those types of things that you yourself can use, demonstrate or do in a session. There is certain books that explain certain techniques very well, and you can use this as a handout, and say this is relaxation techniques that worked for me, and you can try this or that or how it works. There is lot of techniques and I think we are shortcoming in a big variety.

M: Thank you Mr. A, I think that you made remarkable comments regarding this debriefing programme and I thank you for that and really appreciate it.