Bioethical Inquiry (2021) 18:573–587
https://doi.org/10.1007/s11673-021-10140-0

CRITICAL PERSPECTIVES

Reflecting Before, During, and After the Heat of the Moment: A Review of Four Approaches for Supporting Health Staff to Manage Stressful Events

C. Delany · S. Jones · J. Sokol · L. Gillam · T. Prentice

Received: 13 February 2021 / Accepted: 16 September 2021 / Published online: 6 November 2021

Abstract Being a healthcare professional in both paediatric and adult hospitals will mean being exposed to human tragedies and stressful events involving conflict, misunderstanding, and moral distress. There are a number of different structured approaches to reflection and discussion designed to support healthcare professionals process and make sense of their feelings and experiences and to mitigate against direct and vicarious trauma. In this paper, we draw from our experience in a large children's hospital and more broadly from the literature to identify and analyse four established approaches to facilitated reflective discussions. Each of the four approaches seeks to acknowledge the stressful nature of health professional work and to support clinicians from all healthcare professions to develop sustainable skills so they continue to grow and thrive as health professionals. Each approach also has the potential to open up feelings of uncertainty, frustration, sorrow, anguish, and moral distress for participants. We argue, therefore, that in order to avoid unintentionally causing harm, a facilitator should have specific skills required to safely lead the discussion and be able to explain the nature, scope, safe application, and limits

C. Delany (✉) · L. Gillam
Children's Bioethics Centre, Royal Children's Hospital, 50 Flemington Rd, Parkville, Victoria 3052, Australia
e-mail: c.delany@unimelb.edu.au

L. Gillam
e-mail: Lynn.gillam@rch.org.au

C. Delany
Department of Medical Education, Melbourne Medical School, The University of Melbourne, Parkville, Australia

S. Jones
Affiliate of Social Work Department, Royal Children's Hospital and Private Practice, 124 Jolimont Road, Victoria 3002 East Melbourne, Australia
e-mail: sjjones@melbpc.org.au

J. Sokol
Department of Medical Education, Head of Simulation, Royal Children's Hospital. , Department of Paediatrics, University of Melbourne , 50 Flemington Rd, Parkville, Victoria 3052, Australia
e-mail: Jenni.sokol@rch.org.au

L. Gillam
Children's Bioethics Centre, Royal Children's Hospital, Department of Paediatrics, The University of Melbourne, Parkville, Australia

T. Prentice
Newborn Intensive Care, Royal Children's Hospital, Dept of Paediatrics, University of Melbourne, Honorary Research Fellow, Murdoch Childrens Research Institute, 50 Flemington Rd, Parkville, Victoria 3052, Australia
e-mail: Trisha.Prentice@rch.org.au

of each approach. With reference to a hypothetical but realistic clinical case scenario, we discuss the application and key features of each approach, including the goals, underpinning theory, and methods of facilitation.

Keywords Clinical ethics · Supervision · Critical incident · Stress · Healthcare · Debriefs

Introduction

Being a healthcare professional in both paediatric and adult hospitals means potentially encountering tragedies and stressful events involving conflict, misunderstanding, and moral distress (Breen et al. 2014; Everly and Mitchell 2000; Kelly 2020; Boss, Geller, and Donohue 2015), despite the efforts of highly skilled and experienced health professional teams (McDougall, Delany, and Gillam (2016). The following hypothetical but realistic case scenario, based on our own professional experiences, provides a picture of the sort of tragic and stressful event that can occur.

> *Charlotte was a two-year-old toddler, the only child of her two parents, Amanda and David. She was born with biliary atresia—a serious congenital condition involving blockage of the ducts that carry bile from the liver to the gallbladder. At twelve months, Charlotte had surgery to remove the blocked ducts and replace them with a segment of her small intestine (Kasai procedure). However she experienced recurrent episodes of cholangitis (infection in the biliary tree) post the Kasai procedure. After only four months at home with her parents, she was back in hospital and required a living donor liver transplant, for which her father volunteered to be the donor. Charlotte developed a life-threatening infection one month after the transplant which required her to be readmitted to the Paediatric Intensive Care Unit (PICU) with gram negative septic shock, respiratory failure, and intractable coagulopathy. Her mother, Amanda, became increasingly distressed by her daughter's continued need for invasive procedures. She eventually said to staff that "enough is enough." However, Charlotte's father, David, stated that he "cannot give up on his child."*
>
> *There was an urgent need to come to a decision about life-sustaining interventions and their cessation. Although the PICU healthcare team and their palliative care colleagues had a number of discussions with Charlotte's parents on a day-to-day basis, Charlotte's parents had been unable to reach agreement about clear and specific advanced care directives and any treatment limitations due to their contrasting views. Hence there was ongoing uncertainty for the healthcare team about how they should respond in the event of an acute deterioration.*
>
> *Charlotte had a cardiac arrest after ten days in PICU. At the time, because of the uncertainty and lack of agreement about goals of care, the doctors felt they had no choice other than to begin CPR. They spent fifteen minutes providing chest compressions all the time thinking that this was futile and not in Charlotte's interests. This did not save Charlotte's frail life. Several team members were extremely distressed in witnessing what they regarded as an unnecessary resuscitation on such a sick child, and some believed that Charlotte and her parents were denied the opportunity for a "good death."*

The situation of two-year-old Charlotte was medically complex. It was also tragic for her family. For her parents, despite many discussions with doctors about the risks and benefits of the Kasai procedure and the liver transplant, and a supportive multidisciplinary team involved in providing psychosocial and mental health support for their difficult journey, Charlotte's short life involved grief, misunderstandings, and uncertainty. For the many health professionals caring for her in her final months of life, it was challenging and distressing. Our focus in this paper is on the stressful event experienced by the health professionals. Our use of the term "stressful event" is similar to the notion of a critical incident and refers to an event typically outside the usual range of experiences which challenges or overwhelms a clinician's ability to cope (Everly and Mitchell 2000; Lützén and Ewalds-Kvist 2013). When not adequately addressed, the effects of these events may accumulate for clinicians and can manifest as fatigue, demotivation, job dissatisfaction, feelings of isolation, burnout

(Mihailescu and Neiterman 2019) PTSD, (Alden, Regambal, and Laposa 2008; Panagioti et al. 2018), and depression (Jennings and Slavin 2015; Rushton et al. 2021). Ultimately if clinicians are stressed and inadequately supported, their capacity to provide timely, competent, and compassionate healthcare diminishes (Liselotte N Dyrbye and Shanafelt 2011).

Many different approaches to supporting healthcare professionals after stressful events have developed over time. They include suggestions for self-care such as "mindfulness," relaxation and exercise, cognitive behavioural therapy (Atallah et al. 2016), strategies to build emotional and moral resilience (Chaukos et al. 2018), and interventions to improve workplace systems such as demanding rosters, administrative burdens, and organizational culture (Dyrbye et al. 2017). Other approaches include facilitated reflective discussions aimed at supporting and educating health professionals to support their psychological safety and assist them to develop skills and self-awareness to sustainably manage workplace stressors and continue to develop as health professionals (Everly and Mitchell 2000; Heffron, Reynolds, and Talbot 2016; Udo, Melin-Johansson, and Danielson 2011; Edwards, McClement, and Read 2013). In recent systematic reviews of published approaches to address moral distress—a common component of stressful events (Morley et al. 2021; Imbulana, Davis, and Prentice 2021; Prentice et al. 2016)—educational programmes which included communication techniques, role play, formulation of action plans, and structured reflection were found to be the most prevalent and effective (Morley et al. 2021).

In this paper, we focus on four types of facilitated structured reflective approaches which aim to assist health staff to be psychologically safe and to develop skills to reflect on and process stressful events, including those involving experiences of moral distress. A common goal of each of the four approaches is to enable health professionals to make sense of stressful workplace experiences and ultimately to grow professionally. We draw from our collective experiences in a large children's hospital and from the literature more generally to delineate the practical processes followed (table 1) and the goals, underpinning theoretical concepts, and facilitation methods used (table 2) in four established reflective discussion approaches. We then discuss how each model might respond to a case such as Charlotte's to broadly illustrate the types of processes followed and possible outcomes of these reflective discussions. Reflective discussions do not necessarily involve a review of clinical decision-making but rather focus on the different responses, needs, and experiences of the health professionals involved. So our hypothetical scenario of Charlotte is framed to portray an emotionally charged and distressing situation involving a gravely ill child, complicated by disagreement between her parents and conflict and uncertainty amongst health professionals, and does not provide clinical details.

Each of the four approaches we review has the potential to open up feelings of uncertainty, frustration, sorrow, anguish, and moral distress for participants. We argue, therefore, that it is crucial a facilitator has the specific skills and training (Edwards, McClement, and Read 2013) required to safely lead the discussion and is clear about the nature, scope, safe application, and limits of each approach.

Psychological First Aid

Psychological first aid (PFA), also known as mental health first aid, specifically focuses on providing support to a person to ensure they are psychologically safe after witnessing or being involved in a traumatic or stressful situation (primary exposure). It may also be applied to those who have experienced secondary (family, colleagues) or tertiary (other patients and community) exposure. Originally developed to assist people following significantly traumatic events such as terrorism and natural disasters (World Health Organization 2011), it has increasingly been used in work environments following a critical or stressful event in the workplace (Cotton 2014), in particular, in the authors' own hospital environment.

In health settings, the focus of PFA is to assist a clinician to consider what he or she needs to feel safe and supported. This is often achieved by validating a person's emotional responses through reassurance and practical and immediate support. PFA intentionally does not review the clinical details of a traumatic event and discourages early analysis of what occurred (Rose et al. 2002). This recognizes that the facts may not be immediately clear after an event and that the clinician may not be emotionally ready or

Table 1 Four reflective discussion models

Approaches to reflective thinking	Timing	Who attends?	Who leads the discussion?
Psychological First Aid	Ideally immediately after but can be at any time and repeated as many times as required	One-on-one discussion. Initially, clinicians who experience primary exposure but may subsequently involve those who experience secondary or tertiary exposure	Any person trained to deliver PFA (colleague, peer or manager)
Critical Incident Stress Debrief (CISD)	Usually occurs from 1-3 weeks after an event	Group discussion. Any clinician who has had either direct or indirect involvement or knowledge of the event.	Trained professional in CISD, alongside a clinical content expert.
Clinical Ethics De-brief	Less immediate. May occur weeks to months after an event	Can be one-on-one but more usually a group comprising clinicians involved in the event, and/or wider pool of people interested in the ethical topic raised by the event	A clinical ethicist (internal or external to the hospital)
Clinical Supervision	Regular scheduled weekly, fortnightly or monthly (maybepre/post critical event): part of ongoing professional development process	Individual or group. Supervision generally aimed to at all members of the team	Experienced clinician, commonly but not exclusively with mental health training—preferably with a background in working in hospital environment.

Table 2 Underpinning theory and goals

Formal reflective thinking approach	Theoretical basis	Goals:
Psychological First Aid	Theories of mental health, safety and attachment	• Provide support, which does not intrude • Protect people from further harm • Normalizes the emotional response • Help people connect to information, services, and social supports
Critical Incident Stress Debrief	Based on trauma de-brief models	• Brings all involved together to develop a narrative about a clinical event • Normalizes the emotional response • Support clinicians by building confidence to step back, reflect, and provide resources to enable return to work • Enables reflection to improve future performance
Clinical Ethics De-brief	Analytic and philosophical reasoning	• Unpack ethical concerns underlying emotional responses • Review ethical decision points, ethical values being balanced/traded- off, constraints on decision-makers • Distinguish moral distress vs moral regret • Identify insights to take forward
Clinical Supervision	Varied theoretical models depending on the clinical supervisors' background and training	• Assist in critical reflection on clinical experience, teamwork and interactions with patients and families to promote improved clinical care • Develop clinician capacity to make thoughtful and considered clinical decisions • Raise awareness of feelings of burnout • Build a supportive, trusting, and ongoing relationship with team members

psychologically equipped to safely discuss the event (Couper and Perkins 2013; Vaithilingam, Jain, and Davies 2008).

Personnel facilitating PFA do not require expertise in counselling or debriefing but should have training in the scope and limits of PFA. The expertise necessary to facilitate a psychological first aid includes active listening and an ability to assist a person to share their particular concerns and express what they need to feel safe. Not all clinicians will require or desire PFA, but it is important for clinicians to know that this form of support is available and readily accessible (Kessler, Cheng, and Mullan 2015).

In Charlotte's case:

PFA would likely occur immediately after, or potentially in the days following, her death, as PFA can be safely delivered at any time after a challenging event. A clinician trained in facilitation of PFA (medical, nursing, or allied health) would approach any identified vulnerable clinical and non-clinical staff who had been involved in or who had observed Charlotte's resuscitation and offer an optional individual "time-out" to support their psychosocial well-being. Using the "Look, Listen, Link" framework for PFA (World Health Organization 2011) (figure 1), a safe environment in which to engage in conversation, would first be identified. The facilitator would then listen to the clinician's feelings and concerns about Charlotte's deterioration and death whilst intentionally avoiding going into significant details about what happened. Support for a person's psychological safety may require a period of leave from work and/or linking the clinician to internal (hospital) and external support services. Ideally, clinicians who have participated in PFA would receive follow-ups by colleagues over a period of time to check their psychosocial well-being, and additional support and ongoing referral to

LOOK	Supervisor check-in for those who may need support:
	Assess safety, urgency, & severity of reactions immediately post incident
	Introductions and establish the safe environment
LISTEN	Listen to them talk; leave extensive review of details until they are emotionally ready
	Help them feel calm
	Establish their safety & check for stress reactions
	Ascertain their priorities
	Check need for urgent basic needs
LINK	Suggest link up with family/friends/ follow-up
	Limit advice to safety and well-being
	Provide information & resources for help, whilst encouraging people to meet their own needs
	Validate their feelings and concerns

Fig 1 Look, listen, link framework. Adapted from World Health Organization (2011)

1. Introduction
2. The facts
3. Thoughts and impressions
4. Emotional Reactions – use defusing to allow for the ventilation of thoughts emotions and experiences
5. Symptoms and normalisation – prediction natural responses
6. Teaching and planning for the future
7. Disengagement or re-entry

Fig 2 Adapted from Mitchell's (1983) 7 stages of CISD

professional services would be provided when and if necessary.

Critical Incident Stress Debriefing (CISD)

Critical incident stress debriefing, as defined by Mitchell (Mitchell 1983) (figure 2) and Mitchell and Everly (Mitchell and Everly 1995), was initially developed as a group intervention for emergency first responder personnel and as part of a multistep process for critical incident stress management. It has a broader focus than PFA, encouraging clinicians to reflect on a range of factors which may have influenced an event, such as medical facts, management decisions, and professional roles. CISD also allows room for clinicians to think about their emotional responses to an event with the aim of facilitating psychological closure and enabling a team to return to or continue with their work.

The reflective process follows seven formalized stages originally outlined by Mitchell (1983). The incorporation of emotional and psychological response (stage 4) in a CISD is a key difference from other types of stress debriefing such as "hot," "technical," or "clinical," debriefs. In these latter approaches, the focus is limited to a discussion of the technical aspects of a clinical event, including the flow of events, clinical decisions made, and outcomes for the patient (Couper and Perkins 2013; Kessler, Cheng, and Mullan 2015; Mullan, Kessler, and Cheng 2014). It is also different from psychological first aid as the emphasis is on review and analysis of technical and psychological thoughts, requiring an expert to facilitate this method of debriefing.

In CISD, in order to safely and effectively move attendees through reflection about clinical as well as emotional aspects of an incident, a CISD facilitator needs skills to lead a clinical and factual review with all members of the multidisciplinary team

who were involved in a case, whilst at the same time cultivating a safe environment that allows each health professional to contribute their feelings and personal responses about an event. Important facilitation skills include a non-judgmental approach, a capacity to draw out specific facts and management responses that occurred, and to notice, acknowledge and validate personal reflections and emotional reactions experienced. In the final steps, participants are prompted to analyse implications for future practice including team interactions and ensure the participants are safe and able to return to clinical practice. Although CISD or a similar form of debrief is anecdotally commonly sought out by health professionals involved in the event, CISD should not be a compulsory process as research suggests it may increase post-traumatic stress disorder (Bledsoe 2003; Rose, Bisson, and Wessely 2002). It is ideally provided one to two weeks after the challenging event, to allow attending staff time to process the emotional aspects of the event and be able to discuss their feelings in a group setting.

In Charlotte's case:

Ideally around one week after her death, a formal group CISD would be arranged. A trained facilitator or psychologist would lead the discussion. In addition, a clinical content expert would provide insights or answers to questions raised in regard to the clinical aspects of the event. Any member of the treating team involved in Charlotte's care would be invited to attend, although participating is entirely voluntary. Following an introduction that sets out the ground rules of engagement and intent of the CISD (figure 2), an outline of the clinical facts of the case and timeline of events would be presented as background context for the review. Then attendees would be invited to share the nature of their involvement and any emotional reactions or thoughts associated with the event (Lane 1994). In Charlotte's case, topics may include acknowledging clinicians' feelings and concerns about the resuscitation, whether there were opportunities to address parental conflict or disagreements earlier, and the challenges of advanced care planning when family members disagree between themselves or with clinicians. According to the CISD approach, the discussion would also include the clinical facts and seek understanding about whether Charlotte's outcome could have been anticipated or planned for as part of her clinical trajectory.

Discussion points arising during a CISD about Charlotte's case may include the need for more clarity about legal and ethical positions related to Charlotte's advance care directives and how staff might seek support from senior leadership leading up to resuscitation. A brief summary of the discussion and key outcomes would be provided to participants with reminders of avenues for further support and contact should further questions arise.

Clinical Ethics Review

A clinical ethics review begins from the premise that ethical knowledge and skills already permeate healthcare. Clinicians do not need an ethicist to provide epistemic access to norms that guide their practice (McCullough 2020; Verkerk and Lindemann 2012). However, common features of stressful events in healthcare are that they involve misunderstandings, conflicting or unarticulated goals of care, and differing perspectives about harms or burdens associated with clinical care. The goals of a clinical ethics review are to provide an opportunity for participants to discuss and unpack ethical concerns underlying their emotional responses. The process of unpacking often begins with identifying and reviewing decision points along the way to the outcome, identifying what options were open at each point, what ethical values were being promoted, balanced, or traded off, and what constraints were placed on decision-makers.

Some of these decision points may represent what Komesaroff (1995) describes as micro-ethical decisions. These include moments such as interactions aimed at establishing trust, probing a patient's or parent's fears and hopes, or introducing changes to treatment goals. These micro-points in communication and delivery of care do not have the obvious trade-off between ethical values that are characteristic of the more classic ethical dilemmas. However, they are still ethically important and may be experienced as incremental forms of moral loss or distress by clinicians.

An important goal in clinical ethics reviews is to enable clinicians to name and process these experiences by providing an opportunity and some appropriate, shared language. The idea is to move participants

from feelings of moral distress or unresolved moral tension about a past event towards greater moral clarity about what could or should have been done in the circumstances (Guidry-Grimes et al. 2019; Newson 2015; Nussbaum 1994; Morley and Horsburgh 2021).

As part of this process, the facilitator may introduce ethics concepts and ways of identifying and weighing up different values and moral perspectives about decision points and experiences (McDougall, Shadbolt, and Gillam 2020; McMillan 2018). The central idea is to "bring moral reasoning to bear" on a clinical event or experience (Battin 2013). One important task of moral reasoning in relation to stressful events is to help participants distinguish between moral distress (emotion arising from a belief that they were involved in an event that was morally wrong due to some form of constraint) (Jameton 1984; Epstein and Harmric 2009; Prentice et al. 2016) and moral regret (emotion arising from recognition that in a trade-off between values, something of value is lost even when appropriate moral balancing informed the decision) (Gasdaglis 2019). Clinical ethics reviews are usually conducted by a clinician with clinical ethics expertise (obtained via formal bioethics or medical ethics study) or a clinical ethicist with a background in philosophy, bioethics, or medical ethics (Agich 1995).

An ethics review may be conducted as a one-on-one discussion, with a group of health professionals from the same discipline or as part of an interprofessional team discussion. The topics are determined by the participants, in a similar vein to the methodology of a semi-structured qualitative interview, where there is an overriding area of interest but the participant determines the specific focus (DiCicco-Bloom and Crabtree 2006). The five steps and accompanying questions listed in figure 3 show how a facilitator might begin with participants' feelings and perspectives about a situation, then through a series of questions, assist them to identify ethical concerns or values underling these responses and articulate or specify the nature of the ethical concern (Gillam et al. 2014). From there, the facilitator encourages reflection on what decisions were made, what other decisions could have been made, and what the ethical considerations (possibly competing with each other) were. The facilitator encourages participants to reflect on their ethical thinking and understand how others could see things differently and how to manage situations where there are different ethical views.

A group discussion is particularly conducive to raising awareness of how colleagues are identifying, considering, and balancing values (McDougall, Shadbolt, and Gillam 2020). This has the effect of highlighting the presence of differing moral perspectives within the team (Burbules and Rice 1991), providing insight into why moral complexity may not easily be resolved, and acknowledging that ethical reviews are not an indication that someone is unethical or uncaring. A further effect of ethical reviews for health professional teams is to reinforce the notion that individual health professionals should not feel they must review and process morally complex experiences on their own (McDougall et al. 2014).

In Charlotte's case:

Participants would first be encouraged to discuss what they had found to be upsetting, distressing, or morally challenging about the situation, with the aim of unpacking what ethical or moral concerns might be involved. Participants may report feeling distressed about the way Charlotte died. Asked to be more specific, and think about values, they may explain that the effort to resuscitate Charlotte was futile, harmful for Charlotte, traumatic for the clinicians involved, and/or unfair for Charlotte's mother who did not want this type of ending. These ethical concerns would be acknowledged then further unpacked to get a sense of the ethical weight or significance of each. The facilitator may introduce ethical concepts to assist in this. For example, "futility" is a complex and contested concept (Gillon 1997); understanding its different meanings may help participants to clarify their thoughts. Resuscitation may have been futile in relation to the goal of keeping Charlotte alive but not futile in relation to a parent's goal of doing everything possible to save their child.

The next step is for participants to work through what happened in the lead-up to the stressful event, seeking to identify decision-points (places where an ethically important decision was made) and think about whether different decisions could have been made at those points. This leads participants into a guided discussion of weighing up the ethical pros and cons of those possible decisions, taking into account uncertainty and subjectivity in this process. The

Fig 3 Questions to guide clinical ethics review

1. What was ethically concerning to you?
    a. What has stayed with you about 'the clinical experience/event?
    b. What ethical concerns underlie your emotional responses to this event? Were there some aspects that you found ethically concerning or challenging in some way? Was there something you felt was wrong or unethical?

2. What were the particular ethical concern/s or question/s?
    a. Can you say more about this ethical concern?
    b. Does your concern relate to a particular treatment decision?
    c. Does it relate to burdens or harms to the patient, or family members?
    d. Does it relate to someone's wishes not being respected?
    e. Does it relate to interactions between team members?
    f. Does it relate to protocols or systems of care?
    g. Does it relate to style of communication between staff, families or patients?

3. Identify possible decision-points and options.
    a. Can you see any points at which a different decision could have been made?
    b. What other options available at that time, with what was known then?
    c. What would have to be in place for alternative options to have worked?

4. Analyse the ethical pros and cons of each option.
    a. For each of the other options identified:
    b. What would have been the effect on all those involved?
    c. What ethical values would that option have served or promoted?
    d. How do the other options compare ethically with the one that actually happened?
    e. Were there some areas that uncertainty (eg about outcome or people's emotional responses) that made it harder to compare options?
    f. Based on all this, what do you think should have been done? (What decisions should have been made at the key points?)

5. Reflection.
    a. Can you see how someone else (also well-intentioned and having the same information) could have a different view about what should have been done?
    b. Was this a situation where more than one pathway would have been ethically justifiable?
    c. Do you now think that a wrong was done (the response being moral distress), or that what was done was the "least worse" option, where any option chosen would have involved some moral loss or compromise (moral regret at unavoidable but justifiable moral loss?)

facilitator would encourage participants to reflect on whether their understanding of the ethical situation had shifted or expanded—for example, moving from moral distress to moral regret.

The aim of a clinical ethics review is not to reach a decision about what should have been done or to blame individuals for doing something wrong. Rather, the aim is for participants to make moral sense for themselves out of what happened and their initial moral reactions (McMillan 2018). This will enable development of nuanced ethical understanding and build capacity to work collaboratively and

effectively in a context where people sometimes have different values and come to different ethical views.

Clinical Supervision

Clinical supervision is a specific approach to supporting staff to learn from everyday practice. It is also called reflective supervision and needs to be distinguished from supervision as a form of monitoring, assessing, or credentialing staff (Bond and Holland 2011). The overarching goal of reflective clinical supervision is to provide a sanctioned context to learn to think about challenging work with patients, families, and colleagues, and through that reflection, to develop compassionate and safe clinical practice. Participants are encouraged to explore openly what may have been missed in close and detailed work with families, to learn about their own capacities, and to make sense of and give meaning to their own and others' behaviours, emotions, beliefs, and intentions. This type of reflection is described as reflective functioning—a process where a person or a group of people are invited to step back from the immediate and intense experience of their work and to make sense of and then learn from such events (Fonagy, Gergely, and Jurist 2018; Heffron, Reynolds, and Talbot 2016).

Developing out of the disciplines of psychology, social work, and psychiatry, and informed by theories of psychoanalysis (Obholzer and Roberts 2003) and reflective functioning (Fonagy and Target 2005), clinical supervision works to acknowledge, affirm, and at times bear witness to clinicians' experiences. Ideally, the facilitator should not have a day-to-day role in the team's work and can therefore be interested but not invested in an outcome. Clinical supervisors may be originally trained in any of the medical or allied health disciplines, and most would have undertaken considerable supervision themselves. Through open and facilitated discussion, supervision aims to promote collegial support, team building (Heffron, Reynolds, and Talbot 2016), and mutual respect (Pawl 1995) and to increase resilience of individual clinicians (Fonagy, Gergely, and Jurist 2018; Terry et al. 2020). A clinical supervisor supports participants to focus, explore, and make sense of their experiences, thoughts, and feelings directly connected with their work. Figure 4 provides an example of the types of steps involved in clinical supervision.

The process of clinical supervision offers and encourages participants to develop new or alternative skills for working with patients or colleagues. Often a staff member will put into words a dilemma a whole team has experienced, and a new understanding arises for the group. As Gilkerson (Gilkerson 2004) argues, clinicians already know a lot about what to do, and the challenge is to carry out the approaches given the complexity within the families for whom they care.

Menzies (1960) from her pioneering observational studies in NHS hospital wards, similarly noted the emergence of "social defence systems" within hospital systems, which had the effect of sometimes detaching staff from feelings (Bloom 2004). To address this inherent complexity which patients and families bring and the impact of institutional systems of care, Obholzer and Roberts (2003) highlight the advantage of supervisors being informed by psychoanalytic/systemic frameworks because they can increase participants' understanding of how group effectiveness and morale can be undermined within institutions.

Questions brought to supervision may be existential in nature—for example, the experience of witnessing cumulative deaths or loss of compassion or gender/power problems in a unit. The experienced supervisor might respond by using a reflective mode to address the needs of the staff members at the time. The supervisor may also structure and guide the discussions by offering pertinent hypotheses to explore the issue.

At a group level, clinical supervision enables a team to develop their own "reflective functioning," which, in turn, increases the group's capacity for thinking together to navigate a path through complex and emotionally charged experiences (Heffron, Reynolds, and Talbot 2016). Building this type of reflective capacity, competence, confidence, and effective working (Costello 2020) is best fostered by organizational support for building a culture that values staff confidence in the exploration of everyday practice. Over time this facilitates a supervision context of safety and trust and a spirit of mutual respect and openness to be challenged.

In Charlotte's case:

Supervision for those working with Charlotte would most likely acknowledge the long relationships staff might have had with the family and explore the

Fig 4 Structure and facilitation approaches for a clinical supervision session

Structure

1. The clinical supervisor begins by providing guidance about the function, time boundaries and process to be followed within the supervision session:
    a. *Eg. "In general, the goal of your supervision sessions is for you to feel comfortable enough to raise difficult clinical encounters, or the impact of ongoing exposure of demanding work and to explore what might be learnt from this exploration*

2. Participants might then be encouraged to bring the work that concerns, delights or deeply troubles them. The staff member who presents the work for the session is encouraged to indicate to the group what she most wants help with, or if that is not yet clear, then say something about "why now with this issue".
3. Participants are encouraged to articulate the 'issue', guided by the supervisor to go beneath the surface of the initial description of the problem. The whole group is encouraged to offer reflections, comments, parallel experiences, and to try to refrain at this stage from "solutions / problem solving' responses.

Facilitation Approaches

Clinical supervisors rely on clinical wisdom about what would most benefit the needs of the group. This guidance aims to cultivate a thinking space for participants.

a. Participants are invited to ask questions, or to recall, similar experiences and in so doing, use their own practice wisdom to make sense of experiences. The facilitator encourages reflection about what might be acknowledged as a strength and about what remains as ongoing concerns
b. Hypotheses are co-created amongst the participants as to what might be happening in a particular situation; with the patient and family members, within the clinician or within the team.
c. If there are opportunities for teaching/offering different ways to work - team members are seen as having valuable contributions to bring to the discussion.
d. Supervisors might summarise the salient aspects of the discussion, raise suggestions for the clinician/s and based on the discussion within the group, and ideas posed, discuss alternative approaches to the patient/family.

impact of witnessing Charlotte's parents' differing desires about her treatment and death. The group may be encouraged to discuss how divergent points of view between very distressed parents over a gravely unwell little child commonly creates unhelpful splits in teams, where some staff become more sympathetic to one parent, or their baby, and clinicians within a team are pulled in divergent positions which mirror those in the family (Foster 2001). The discussion may highlight the impact of the death of child, when the death is unforeseen or where there has been an inability to plan and agree, including how this leaves not only the parents but also staff unprepared, often leading to feeling powerless and angry. Other feelings and responses that may be drawn out may include that some clinicians felt upset with themselves and/or others for not advocating more strongly for Charlotte. The supervisor would be curious about and specifically address why it was so difficult to raise a palliative care referral.

These types of discussion areas aim to both learn from the experience with Charlotte and support clinicians dealing with the difficulties at the time. How this may be undertaken in supervision is to acknowledge and to gain a deep understanding of clinicians' responses to make room for the least appreciated perspective and to grow compassion and empathy where it previously may not have been possible.

One of the central tenets of clinical supervision is to help hospital staff recognize and accept the state of

"not knowing"—not knowing all the facts, not understanding the parents' differences or their motivations. Helping to provide clarity about salient aspects of the experience of Charlotte's care and ultimate traumatic death enables the development of a coherent narrative (Siegel 2007). Developing more coherence about an experience serves three purposes. It can bring a sense of relief or closure to the experience. Secondly, it can leave practitioners feeling validated or supported. Thirdly, members of the team may have more confidence to be emboldened with future parents in similar situations.

The process of supervision may offer a shared space to mourn and honour Charlotte and her mother and father. The supervision might conclude with affirming the work and kindness of the team. It would aim to make sense of the life and premature death of Charlotte and the loss for her family—that it was Charlotte's illness not "the hospital" that took her life. By talking collectively about what can feel unbearable, clinical supervision discussions assist teams and individuals to learn to bear more of the emotions that arise and to help others bear the limits of medical science.

Discussion

Each of the four reflective approaches discussed in this paper starts from the premise that each individual health professional potentially has emotional, psychological, and intellectual resources to think and act ethically, humanely, and reflectively (Lützén and Ewalds-Kvist 2013; Scher and Kozlowska 2018; Verkerk and Lindemann 2012). In each approach, the overall role of the facilitator is to orient participants towards their intrinsic resources so they can access and use them effectively. Each of the four approaches either implicitly (PFA, CISD, Clinical Ethics Review) or explicitly (Clinical Supervision) draw from psychotherapeutic techniques which can have adverse as well as beneficial effects (Shultz and Forbes 2014). Basic ground rules of the four models are that participation is voluntary, that discussions are to be mutually respectful and never intended as a performance appraisal, and that the facilitator understands their role and the potential beneficial and adverse impacts of their facilitation approach. The facilitation process involves purposefully creating a scaffold for participants' thinking and reflection. The goals are to assist them to step back from an experience and identify their feelings, thoughts, and assumptions in order to make sense of and learn from their experience (Parlakian 2002). The effectiveness of reflective discussions within health profession teams relies on facilitators ensuring participants feel safe to reflect, share, and be open to exploring alternative perspectives that may sit in tension, allowing for a more nuanced discussion (Prentice et al. 2018). Coming together as a team enables validation of experience (Meziane, Ramirez-Garcia, and Fortin 2018), builds understanding, and promotes acceptance of moral discomfort (Imbulana, Davis, and Prentice 2021). This creates a space where specific ethical challenges, team dynamics, and specific unit-based environmental factors can be respectfully and constructively addressed (Morley et al. 2021).

This paper also highlights important differences in the guiding focus, timing, intended outcomes, and underpinning methodologies employed within these models. For example, the focus of PFA is constrained by what is needed for a person to move to a psychologically safe space. It purposefully does not seek to analyse the trauma or the events leading up to an event. The focus expands in CISD. Clinicians are encouraged to discuss and reflect upon, but also move beyond, a position of immediate safety so they can begin processing how the event has affected, or might later affect, their personal and professional functioning. Supported CISD discussions encourage participants to think about how they might effectively return to and work within the health teams and institution in which they experienced the critical incident (Schmutz et al. 2018).

In contrast, in both clinical ethics review and clinical supervision, the structure and purpose of the reflective discussion is less prescriptive. In both approaches, the aim is to open up and at times unsettle existing clinical, moral, and professional role frameworks (Newson 2015), offering the possibility of transformative learning (Mezirow 1991), where perspectives are challenged and new or revised understandings which might better explain a phenomenon are encouraged (Hartwell 2004). Given that the goal is to explore and challenge clinicians, the relationship between the facilitator and the group, or more accurately the level of trust a participant has in the facilitator, is central. Clinicians, as participants, need

to trust the process and feel safe to contribute. Asking participants to bring their concerns and to identify what makes them feel anxious or worried in their work and then not having a framework or skills to acknowledge and support clinicians to process such feelings is potentially harmful (Emmerich, Gormley, and McCullough 2018; Rudolph et al. 2007). The onus is therefore on the facilitator to not only know what they are doing but also to recognize the scope and limitations of their specific approach within their skillset and anticipate what could go wrong.

All five authors work in a health institution where each reflective discussion approach is available some of the time. However, as with many large organizations, they are not yet offered in a coordinated, complementary, or systematic way (Boss, Geller, and Donohue 2015). For example, in a case such as Charlotte's, requests from individual clinicians for PFA may occur. Others may organize a CISD and/or a clinical ethics review. In some clinical teams, where there is established clinical supervision support, Charlotte and her family may be discussed during a regular meeting.

This variation in what is offered to support clinicians following stressful events is common (Panagioti et al. 2017). In addition, whilst there is emerging evidence about the efficacy of such interventions, (Nordentoft 2008; O'Keeffe, and Shelton 2007; Shultz and Forbes 2014; West et al. 2016; Morleyet al 2021; Imbulana, Davis, and Prentice 2021) measuring the impact is notoriously challenging (Guidry-Grimes et al. 2019; Morley et al. 2021). The task of making an informed decision about which reflective discussion intervention to provide in a workplace or which approach to select for specific stressful events requires more empirical research about the effectiveness of interventions (Morley et al. 2021). It also requires clinicians, clinical leaders, and administrators to have a thorough understanding of the purpose of the discussion, who is best able to facilitate such a discussion, and what it is likely to achieve.

Conclusion

Being a health professional in an adult or paediatric health setting means inevitably encountering tragic situations. Every day, hospital clinicians face the reality of confronting the limits of medical science, as well as human tragedies and stressful events involving conflict, misunderstanding, and moral distress. Each of the four models of facilitated reflective discussion reviewed in this paper give clinicians, individually or collectively, a supportive experience so they know that they don't have to bear the load alone. Each approach has the potential to provide clinicians with the critical thinking and reflection they require for processing and analysing ethically challenging clinical experiences, enabling them to flourish and grow professionally. Using these approaches wisely and safely benefits clinician growth and ultimately benefits patients and families such as Charlotte and her family.

References

Agich, G.J. 1995. Authority in ethics consultation. *The Journal of Law, Medicine & Ethics* 23(3): 273–283.

Alden, L.E., M. Regambal, and J. Laposa. 2008. The effects of direct versus witnessed threat on emergency department healthcare workers: implications for PTSD criterion A. *Journal of Anxiety Disorders* 22(8): 1337–1346.

Atallah, F., A. McCalla., S. Karakash, and H. Minkoff. 2016. Please put on your own oxygen mask before assisting others: A call to arms to battle burnout. *American Journal of Obstetrics and Gynecology* 215(6): 731.e1–731.e6.

Battin, M. 2013. Bioethics. *International Encyclopedia of Ethics*.

Bledsoe, B. 2003. Critical incident stress management: Benefit or risk for emergency services? *Prehospital Emergency Care* 7(2): 272–279.

Bloom, S. L. 2004. Neither liberty nor safety: The impact of fear on individuals, institutions, and societies, Part I. *Psychotherapy and Politics International* 2(2): 78–98.

Bond, M., and S. Holland. 2011. *Skills of clinical supervision for nurses: A practical guide for supervisees, clinical supervisors and managers*. McGraw-Hill Education.

Boss, R.D., G. Geller, and P. Donohue. 2015. Conflicts in learning to care for critically ill newborns: It makes me question my own morals. *Journal of Bioethical Inquiry* 12(3): 437–448.

Breen, L.J., M. O'Connor, L. Hewitt, and E. Lobb. 2014. The "specter" of cancer: Exploring secondary trauma for health professionals providing cancer support and counseling. *Psychological Services* 11(1): 60.

Burbules, N., and S. Rice. 1991. Dialogue across differences: Continuing the conversation. *Harvard Educational Review* 61(4): 393–417.

Chaukos, D., H. Vestal, C. Bernstein, et al. 2018. An ounce of prevention: A public health approach to improving physician well-being. *Academic Psychiatry* 42(1): 150–154.

Costello, S. 2020. Review of *Supporting vulnerable babies and young children: Interventions for working with trauma, mental health, illness and other complex challenges*, edited by W. Bunston and S. Jones. *The British Journal of Social Work* 51(6): 2264–2266.

Cotton, P. 2014. Workplace psychological health and wellbeing: An overview of key trends. *InPsych* 36(6): 9.

Couper, K., and G. Perkins. 2013. Debriefing after resuscitation. *Current Opinion in Critical Care* 19(3): 188–194.

DiCicco-Bloom, B. and B. Crabtree. 2006. The qualitative research interview. *Medical Education* 40(4): 314–321.

Dyrbye, L.N., and T. Shanafelt. 2011. Physician burnout: A potential threat to successful health care reform. *JAMA* 305(19): 2009–2010.

Dyrbye, L.N., T. Shanafelt, C. Sinsky, et al. 2017. Burnout among health care professionals: A call to explore and address this underrecognized threat to safe, high-quality care. Discussion Paper, National Academy of Medicine, Washington. *NAM Perspectives*, July 5.

Edwards, M.P., S. McClement, and L. Read. 2013. Nurses' responses to initial moral distress in long-term care. *Journal of Bioethical Inquiry* 10(3): 325–336.

Emmerich, N., G. Gormley, and M. McCullough. 2018. Ethics of healthcare simulation. In *Healthcare simulation education: Evidence, theory and practice*, edited by D. Nestel, M. Kelly, B. Jolly and M. Watson, 119–126. John Wiley and Sons.

Epstein, E.G., and A.B. Hamric. 2009. Moral distress, moral residue, and the crescendo effect. *Journal of Clinical Ethics* 20(4): 330–342.

Everly, G.S., and J. Mitchell. 2000. The debriefing "controversy" and crisis intervention: A review of lexical and substantive issues. *International Journal of Emergency Mental Health* 2(4): 211–226.

Fonagy, P., G. Gergely, and E. Jurist. 2018. *Affect regulation, mentalization and the development of the self*. Routledge.

Fonagy, P., and M. Target. 2005. Bridging the transmission gap: An end to an important mystery of attachment research? *Attachment & Human Development* 7(3): 333-343.

Foster, A. 2001. The duty to care and the need to split. *Journal of Social Work Practice*15(1): 81–90.

Gasdaglis, K. 2019. Moral regret and moral feeling(s). *Inquiry* 64(4) 424–452.

Gilkerson, L. 2004. Reflective supervision in infant-family programs: Adding clinical process to nonclinical settings. Irving B. Harris Distinguished Lecture. *Infant Mental Health Journal* 25(5): 424–439.

Gillam, L., C. Delany, M. Guillemin, and S. Warmington. 2014. The role of emotions in health professional ethics teaching. *Journal of Medical Ethics* 40(5): 331–335.

Gillon, R. 1997. "Futility"—too ambiguous and pejorative a term? *Journal of Medical Ethics* 23(6): 339.

Guidry-Grimes, L., M. Warren, H. Lipman, et al. 2019. Clarifying a clinical ethics service's value, the visible and the hidden. *Journal of Clinical Ethics* 30(3): 251–261.

Hartwell, S. 2004. Moral growth or moral angst? A clinical approach. *Clinical Law Review* 11: 115.

Heffron, M.C., D. Reynolds, and B. Talbot. 2016. Reflecting together: Reflective functioning as a focus for deepening group supervision. *Infant Mental Health Journal* 37(6): 628–639.

Imbulana, D.I., P.G. Davis, and T.M. Prentice. 2021. Interventions to reduce moral distress in clinicians working in intensive care: A systematic review. *Intensive and Critical Care Nursing* 66: 103092.

Jameton, A. 1984. *Nursing practice: The ethical issues*. Englewood Cliffs, New Jersey: Prentice-Hall.

Jennings, M.L., and S. Slavin. 2015. Resident wellness matters: Optimizing resident education and wellness through the learning environment. *Academic Medicine* 90(9): 1246–1250.

Kelly, L. 2020. Burnout, compassion fatigue, and secondary trauma in nurses: Recognizing the occupational phenomenon and personal consequences of caregiving. *Critical Care Nursing Quarterly* 43(1): 73–80.

Kessler, D.O., A. Cheng, and P. Mullan. 2015. Debriefing in the emergency department after clinical events: A practical guide. *Annals of Emergency Medicine* 65(6): 690–698.

Komesaroff, P. 1995. Troubled bodies: Critical perspectives on postmodernism. In *From bioethics to microethics: Ethical debate and clinical medicine*, edited by P. Komesaroff, 62–86. Melbourne: Melbourne University Press.

Lane, P.S. 1994. Critical incident stress debriefing for health care workers. *OMEGA: Journal of Death and Dying* 28(4): 301–315.

Lützén, K., and B. Ewalds-Kvist. 2013. Moral distress and its interconnection with moral sensitivity and moral resilience: Viewed from the philosophy of Viktor E. Frankl. *Journal of Bioethical Inquiry* 10(3): 317–324.

McCullough, L.B. 2020. In response to COVID-19 pandemic physicians already know what to do. *The American Journal of Bioethics* 20(7): 9–12.

McDougall, R., C. Delany, and L. Gillam, eds. 2016. *When doctors and parents disagree: Paediatrics, ethics and the zone of parental discretion.* New South Wales: Federation Press.

McDougall, R., C. Delany, M. Spriggs, and L. Gillam. 2014. Collaboration in clinical ethics consultation: A method for achieving "balanced accountability." *American Journal of Bioethics* 14(6): 47–48.

McDougall, R., C. Shadbolt, and L. Gillam. 2020. The practice of balancing in clinical ethics case consultation. *Clinical Ethics* 15(1): 49–55.

McMillan, J. 2018. *The methods of bioethics: An essay in meta-bioethics*. Oxford University Press.

Menzies, I.E.P. 1960. A case-study in the functioning of social systems as a defence against anxiety: A Report of a Study on the Nursing Service of a General Hospital. *Human Relations* 13(2): 95–121.

Meziane, D., M.P. Ramirez-Garcia, and M.L. Fortin. 2018. A reflective practice intervention to act on the moral distress of nurses providing end-of-life care on acute care units. *International Journal of Palliative Nursing* 24(9): 444–451.

Mezirow, J. 1991. *Transformative dimensions of adult learning*. ERIC.

Mihailescu, M., and E. Neiterman. 2019. A scoping review of the literature on the current mental health status of physicians and physicians-in-training in North America. *BMC Public Health* 19(1): 1363.

Mitchell, J. T. 1983. When disaster strikes … the critical incident stress debriefing process. *JEMS* 8(1): 36–39.

Mitchell, J. T, and G. Everly. 1995. Critical incident stress debriefing (CISD) and the prevention of work-related traumatic stress among high risk occupational groups. In *Psychotraumatology*: *Key papers and core concepts in post-traumatic stress*, edited by G.S. Everly, Jr. and J.M. Lating, 267–280. Plenum Press.

Mullan, P.C., D. Kessler, and A. Cheng. 2014. Educational opportunities with postevent debriefing. *JAMA* 312(22): 2333–2334.

Morley, G., R. Field, C. Horsburgh, and C. Burchill. 2021. Interventions to mitigate moral distress: A systematic review of the literature. *International Journal of Nursing Studies* 121: 103984.

Morley, G., and C. Horsburgh. 2021. Reflective debriefs as a response to moral distress: Two case study examples. *HEC Forum*. ePub ahead of print, Januart 26. doi: https://doi.org/10.1007/s10730-021-09441-z

Newson, A.J. 2015. The value of clinical ethics support in Australian health care. *Medical Journal of Australia* 202(11): 568–569.

Nordentoft, H.M. 2008. Changes in emotion work at interdisciplinary conferences following clinical supervision in a palliative outpatient ward. *Qualitative Health Research* 18(7): 913–927.

Nussbaum, M.C. 1994. *The therapy of desire: Theory and practice in Hellenistic ethics*. Princeton University Press.

O'Keeffe, M.J., and D. Shelton. 2007. Personal supervision for paediatricians. *Journal of Paediatrics and Child Health* 43(3): 103–106.

Obholzer, A. and V. Zagier Roberts. 2003. *The unconscious at work: Individual and organizational stress in the human services*. Routledge.

Panagioti, M., K. Geraghty, J. Johnson, et al. 2018. Association between physician burnout and patient safety, professionalism, and patient satisfaction: A systematic review and meta-analysis. *JAMA Internal Medicine* 178(10): 1317–1331.

Panagioti, M., E. Panagopoulou, P. Bower, et al. 2017. Controlled interventions to reduce burnout in physicians: A systematic review and meta-analysis. *JAMA Internal Medicine* 177(2): 195–205.

Parlakian, R. 2002. *Reflective supervision in practice: Stories from the field*. Zero to Three Center for Program Excellence.

Pawl, J.H. 1995. Educating and supporting the infant/family work force: Models, methods and materials. *Zero to Three* 15(3): 21–29.

Prentice, T., A. Janvier, L. Gillam and P.G. Davis. 2016. Moral distress within neonatal and paediatric intensive care units: A systematic review. *Archives of Disease in Childhood* 101(8): 701–708.

Prentice, T., L. Gillam, P. Davis, and A. Janvier. 2018. The use and misuse of moral distress in neonatology. *Seminars in Fetal and Neonatal Medicine* 23(1): 39–43.

Rose, S., J. Bisson, R. Churchill, and S. Wessely. 2002. Psychological debriefing for preventing post traumatic stress disorder (PTSD). *Cochrane Database of Systematic Reviews* 2: CD000560.

Rudolph, J.W., R. Simon, P. Rivard, R. Dufresne, and D. Raemer. 2007. Debriefing with good judgment: Combining rigorous feedback with genuine inquiry. *Anesthesiology Clinics* 25(2): 361–376.

Rushton, C.H., S. Swoboda, N. Reller, et al. 2021. Mindful ethical practice and resilience academy: Equipping nurses to address ethical challenges. *American Journal of Critical Care* 30(1): e1–e11.

Scher, S., and K. Kozlowska. 2018. *Rethinking health care ethics*. Springer Nature.

Schmutz, J. B., Z. Lei, W. Eppich, and T. Manser. 2018. Reflection in the heat of the moment: The role of in-action team reflexivity in health care emergency teams. *Journal of Organizational Behavior* 39(6): 749–765.

Shultz, J.M., and Forbes, D. 2014.Psychological first aid: Rapid proliferation and the search for evidence. *Disaster Health* 2(1): 3–12.

Siegel, D. J. 2007. Mindfulness training and neural integration: Differentiation of distinct streams of awareness and the cultivation of well-being. *Social Cognitive and Affective Neuroscience* 2(4): 259–263.

Terry, D., H. Nguyen, A. Perkins, and B. Peck. 2020. Supervision in healthcare: A critical review of the role, function and capacity for training. *Universal Journal of Public Health* 8(1): 1–14.

Udo, C., C. Melin-Johansson, and E. Danielson. 2011. Existential issues among health care staff in surgical cancer care—discussions in supervision sessions. *European Journal of Oncology Nursing* 15(5): 447–453.

Vaithilingam, N., S. Jain, and D. Davies. 2008. Helping the helpers: Debriefing following an adverse incident. *The Obstetrician & Gynaecologist* 10(4): 251–256.

Verkerk, M., and H. Lindemann. 2012. Toward a naturalized clinical ethics. *Kennedy Institute of Ethics Journal* 22(4): 289–306.

West, C.P., L. Dyrbye, P. Erwin, and T.Shanafelt. 2016. Interventions to prevent and reduce physician burnout: A systematic review and meta-analysis. *The Lancet* 388(10057): 2272–2281.

World Health Organization, War Trauma Foundation, and World Vision International. 2011. *Psychological first aid: Guide for field workers*. World Health Organization. https://www.who.int/publications/i/item/9789241548205. Accessed 3/11/21.