

of one Liverpool hospital casualty may be of interest.

Broadgreen Hospital is one of the three major hospitals providing acute care for Liverpool. Although the disaster itself occurred in Sheffield, in the first two weeks after the event Broadgreen Casualty saw 46 people who had been present on the terraces at Hillsborough on 15 April 1989.

The majority (27) presented at the weekend (15 and 16 April). Twenty patients presented because of crush injuries to their chest, for which they were given either ibuprofen or paracetamol. There were two patients with broken fingers, one with a broken foot and one case of broken ribs.

In their notes casualty officers described ten cases with co-existing anxiety, two with tension headaches, two cases of an acute panic attack and five cases presenting with co-existing low mood. Only two cases presented with low mood alone. Both these were referred to psychiatry and given out-patient appointments. The two cases referred subsequently conformed to the DSM-III-R criteria for post-traumatic stress disorder (309.80).

The psychological manifestations of distress in these casualty attenders were largely dealt with by sympathetic reassurance and by giving out the number of an emergency social services help line. Two patients received two-day courses of benzodiazepines. A referral to a psychiatrist occurred only in a small minority of cases.

The proportion of patients with psychological distress increased with time after the event, and it is likely that with this elapse of time the number of psychiatric referrals of post-traumatic stress disorder (PTSD) from GPs and social services will also increase.

With the prevailing current opinion among psychiatrists that the disabling PTSD is a 'physio-neurosis' with a possible imbalance between noradrenaline and opioid release in the area of the locus coeruleus (Burgess Watson, Hoffman & Wilson, 1988), there is a case for even earlier psychiatric referral of these victims, who may be participants in the disaster or indeed their rescuers (Taylor & Frazer, 1982).

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DEAR SIRS

The day after the Hillsborough disaster of 15 April 1989, 23 of 31 survivors in the Royal Hallamshire Hospital were seen and counselled by a team of volunteer social workers. One patient had returned to Liverpool before the social worker arrived on the ward, and seven were too seriously ill to be seen so soon.

The age range of the patients seen was 16–47, average age 24. All were male. Most of the (crush) injuries were minor, ten patients being discharged on Sunday 16 April 1989, and a further nine patients the following day. The patients were dispersed throughout the hospital in seven different wards.

The seven workers were hospital-based, familiar with the hospital, and familiar with seeing patients in an in-patient setting, as most had worked on the overdose team. They were working a shift system organised by the principal social worker who was coordinating social work activities at the Hallamshire, but liaised directly with the duty registrar in psychiatry (myself) when they had seen their allocated patients.

All the survivors were willing to talk to the social worker. The duration of the interviews ranged from ten minutes to one and a half hours. In some instances, counselling was awkward – for example, one teenager had spent most of the morning (very productively) with a clergyman, had then been interviewed extensively by the media, had been visited by Margaret Thatcher, and was surrounded by members of his family; going through the story again seemed unhelpful. Other individuals found counselling more constructive; some were able to cry for the first time, some found it useful to describe their experiences in detailed chronological order (when previously they had just described snatches of events with other survivors, and medical and nursing staff). Most had thought they were going to die, several described near-death experiences. All had witnessed others dying and dead, and several had lost friends or relatives.

Each was encouraged to express his emotions, and told of some of the reactions they might expect. Each was given the telephone number of Liverpool Social Services or the Helpline Number, and encouraged to contact it as necessary. Twelve had no further specific follow-up, though nine were seen subsequently on one or more occasions by the same social worker. Two who had identifiable problems but were returning to Liverpool shortly were referred direct to Liverpool Social Services for further counselling.

'Counselling' is a non-specific term reviled by the two consultant psychiatrists concerned with the aftermath of the Lockerbie disaster (McCreadie, 1989; Pearson, 1989) (though there local people and bereaved relatives were offered counselling, not survivors). Further, there is no evidence that counselling

survivors following a disaster reduces post-traumatic stress disorder (PTSD) or other psychological morbidity, estimated to be 20–50% at one year (Raphael, 1986a). This is perhaps because follow-up research has considerable practical and ethical difficulties. However, Raphael (1986b), in her book on disaster management, strongly advocates counselling, and points to analogies with the phases of bereavement, and her own work suggesting that bereavement counselling reduces subsequent abnormal grief and psychiatric morbidity (Singh & Raphael, 1981).

There has been a succession of 'man-made' disasters in Britain in recent years – Bradford, Clapham, Hungerford, Kegworth, Kings Cross, Lockerbie, Manchester Airport, Piper Alpha, Zeebrugge – brought sharply into focus by media attention. The unique nature of each event makes planning for counselling in Major Accident Schemes an impossibility. However, all doctors and health professionals should be aware of the psychological impact and possible psychiatric sequelae of such traumatic events. From the Sheffield experience, and a review of the literature, I will draw the following conclusions:

- (a) Early counselling for survivors is probably useful for some individuals.
- (b) It is impossible to predict which survivors are going to be most deeply affected by their experience. In the extensive American literature on PTSD, it remains controversial whether the intensity of the experience or pre-morbid adjustments is more important in the subsequent development of PTSD (Breslau & Davis, 1987). Counselling should therefore be offered to all.
- (c) In the chaos prevailing after a disaster, mental health professionals should target specific groups to be offered counselling. For hospital in-patients, counselling should be organised rapidly, as patients admitted for observation during triage are likely to be discharged early. The degree of physical injury does not correlate with the degree of psychological injury.
- (d) Counselling is best carried out by social workers (though clergy may be more helpful for some individuals). Social workers have experience of crisis work and bereavement counselling, and in addition are best placed to offer practical help (e.g. in Sheffield, offers of accommodation for relatives or lifts back to Liverpool). The specific skills of psychiatrists and psychologists in assessing and treating mental illness (as opposed to mental distress) are not necessary in initial counselling, though may be relevant in con-

sultation, staff support, or later psychiatric morbidity.

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Research attachments

DEAR SIRS

May I offer support for the benefits of a research option for trainee psychiatrists as concluded by Foerster & Meadows (*Psychiatric Bulletin*, June 1989, **13**, 301–302), and describe a possible alternative to a full time 'intercalated' post.

I was able to negotiate a three day per week research attachment for five months immediately after successful completion of the MRCPsych examination. The remaining two days per week were spent in continuing an existing general adult psychiatry out-patient clinic and developing a newly established community clinic, working from a general practice medical centre.

The research project was to expand and consolidate a long-standing interest in the emotional and cognitive consequences of excessive alcohol consumption (Hambidge & Johnstone, 1986; 1987). I found the opportunity to spend time critically examining the literature and experimenting with clinical research possibilities a welcome and very beneficial change from the intensive acquisition of knowledge required for the examination. The time was in no way a 'holiday' but gave a valued opportunity to study subjects that could not otherwise be effectively looked at with the daily demands of general professional training in psychiatry.

The manpower implications of this half time absence need to be considered. However, in my opinion, the benefits to the trainee of such an intensive period to consolidate an ongoing research