



Post-Traumatic Stress Disorder

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COPD, CAD, PRN... the last thing nurses need is another abbreviation! This article is about **PTSD**—Post-Traumatic Stress Disorder, a psychiatric condition likely more common than you think. PTSD is the second most common anxiety disorder in the community, very common in this article as 100 percent of the writers suffer from it. OK, the *only* writer, and *that's me!* You may recall my March 2005 *Alberta RN* article entitled *To Bee or Not To Bee* where I described my near-death experience from wasp-induced acute anaphylaxis. I was diagnosed with PTSD shortly thereafter, received professional help and spent several years recovering. My mission here is to familiarize other nurses with PTSD information so they may recognize PTSD symptoms in patients and each other, so they may be instrumental in encouraging those at risk to seek professional help.

Almost everyone who has an acutely traumatic experience reacts to it by re-experiencing thoughts or dreams or intense emotions of fear, bewilderment, anger, helplessness or despair. Usually the person adjusts and improves over a period of weeks or months. Symptoms that last less than three months can be deemed an **Acute Stress Reaction**, a 'normal' response to a horrible experience. PTSD occurs when symptoms persist longer than three months and include the symptomatology discussed later in this article.

About PTSD

PTSD has been around for a long time. You might remember psychiatrist Dr. Sidney Freidman of television's *M*A*S*H* series who was often called upon to treat emotionally traumatized soldiers suffering from battle fatigue, shell shock syndrome, and combat neurosis—all old names for PTSD.

Causative factors of PTSD have expanded from purely war or mass casualty incidents to include 'broadly defined trauma which is not necessarily outside the range of normal human experience' (Oakander 2005), such as a horrible accident, assault or even a bug bite in my case!

I'd been stung on my arm and I thought nothing of it. But when I came to (not realizing I had been unconscious), as an ER nurse, I knew that if medics didn't intervene STAT there could only be a suboptimal result.

Core Definitions of PTSD

The DSM IV has very specific inclusion criteria for the diagnosis of PTSD:

- intense fear, helplessness or horror after experiencing or witnessing actual or threatened death or injury to self or to others

With a blood pressure of 38/0, I know I 'circled the drain'. It doesn't get more horrifying than that.

- recurrent and intrusive distressing recollections and dreams of the event, acting or feeling as if the trauma was re-occurring, psychological distress and/or physiological reactivity when exposed to cues that resemble an aspect of the traumatic event

I knew every time I went outside that I ran the risk of death from a BUG! I became leery of my bathroom; the site of my collapse where I would have been found days after my demise had my new roommate not been home to call 911.

- numbing and avoidance of stimuli associated with trauma and a general numbing of responsiveness as indicated by three or more of the following:

- avoidance of thoughts, feelings or conversations associated with the trauma

It was hard not to see myself lying on that trauma room stretcher. How could I nurse someone else lying there now?

- avoidance of activities that will arouse recollection of the trauma

I couldn't tolerate the sensations of tachycardia and tachypnea associated with exercise as they reminded me of the anaphylaxis which immediately brought on feelings of sudden irrational fear and anxiety.

- inability to recall an important aspect of the event

I am still missing at least 12 hours of my overnight stay in hospital. I don't recall having a chest X-ray or the trip home from hospital.

- markedly diminished interest in significant activities

Instead of interest in the latest ER goings-on, I could only focus on my real fears returning to work.

- feelings of detachment
I felt like no one really wanted to talk to me about my spiritual experience. Only later did I realize that my coworkers didn't want to face their own fears of being in my shoes (as the patient instead of the nurse) and my family understandably had trouble facing the fact that I'd come close to not being here at all.
- restricted range of mood
Hmm, I could easily describe my moods: crabby or crying.
- sense of foreshortened future
I had a very heightened sense of having survived. Why? Why me? My allergist explained that less than .5 of one per cent of allergic persons have as severe anaphylaxis as I do.
- Hyperarousal lasting more than a month indicated by two or more of the following:
 - difficulty falling or staying asleep
The elusive sleep moth only appeared after several cocktails. I never realized just how long nights could be.
 - irritability or outbursts of anger
Menopause will have no surprises for me!
 - difficulty concentrating
I could hardly read a book and had trouble following the plots of simple television programs. I seemed to have the concentration abilities of a gnat.
 - hypervigilance
I noticed wasps everywhere. I became obsessed with checking little wasp faces to see if I could identify another white-faced hornet, an insect I previously was totally unaware of, and that now had the power to kill me.
 - exaggerated startle response
You think YOU go crazy driving with a bee in your car?

Don't forget about the physical effects of PTSD and the power of the psychological over the physiological. Anxiety can present itself as chest pain, shortness of breath, nausea, tremulousness, and panic attacks.

Whenever I came in contact with 'screaming ambulances', I had to pull over, bawl, then return home a useless mess (I quit wearing mascara). Who ever heard of an emergency nurse who was afraid of ambulances?

Pre-Trauma Risk Factors

Those most at risk are female, under 25 years of age, have had multiple losses, experienced child abuse or developed early substance abuse, have been previously traumatized or suffer from a pre-existing psychiatric disorder (or family history). Those with poor coping styles, lower socio-economics and weak support systems are at risk, too. The severity of illness and functional impairment is increased if the person already suffers from depression or other anxiety disorder. Those who have experienced an intentional, man-made threat often have more severe symptoms.

In 1994, I was restless and unhappy in a job I thought was making me crazy. Our hospital was slated for demolition leaving many jobs (maybe mine) in the balance. In May of 1994, our team dealt with several particularly horrible deaths and cared for a popular medic

brought to ER, post overdose. By June I was a festering mass of frustration. The wasp simply incised the pressurized wound, spraying a layer of chaos over the rest of my life.

Treatment of PTSD

The good news is that mental health professionals report a high level of success treating PTSD. **Behaviour and psychodynamic psychotherapies** encourage the patient to explore feelings and behaviour patterns. **Family therapy** can be helpful for the entire family group who may be affected by one member's experience and resultant behaviours. **Peer-counseling groups** meet to allow PTSD survivors to discuss and share their experiences. Sometimes **medication** is required to help to control intrusion and anxiety (usually Paroxetine) which can hinder the patient's ability to focus and relax (benzodiazepines can be prescribed for sleeping).

I chose to forego medication to concentrate on counseling from a registered psychologist. Employee assistance programs weren't available yet where I worked. Only \$500 of counseling fees was covered through regular health benefits. However expensive, the counseling was instrumental in my recovery.

Front-line nurses are in the unique position of being able to assess for signs and symptoms of PTSD including sleep disturbances, somatic complaints and on-going affect. The physician should be notified of these as well as changes in physical status. Nurses can be instrumental in offering comfort and connecting the patient to professional counseling services.

Nurses Are Not Immune

Secondary traumatization may affect those who treat PTSD sufferers. For example, think of health-care professionals and social workers specializing in severe child abuse cases. They could be greatly disturbed by the victims and their stories, but are not in danger of becoming child abuse victims themselves.

Nurses, as they care for traumatized patients, are at risk for vicarious traumatization. Research by McCan, Pearlman and Saakvitne (1990, 1995, 1996) found that it is, "...a natural response to a very specialized, highly demanding work where empathetic engagement is required." They explain that nurses develop cumulative feelings of grief, powerlessness and outrage as they are repeatedly exposed to human suffering, pain and loss. Often those nurses use 'black humour', develop a 'thick skin', or 'a veneer of cynicism' (Sarah Little 2002) or a generalized numbness to deal with their feelings. ER nurses are especially vulnerable due to their volatile and dangerous work environment, and where patient outcomes remain largely unknown.

Returning to the ER, I was increasingly disturbed by the continuing parade of suffering. I obsessed over possible horrible ER scenarios and could not normalize my thought processes. Any additional stress sent me into an increasingly anxiety-ridden orbit.

Is Your Co-worker Suffering?

How can you tell if your co-worker is suffering from PTSD or vicarious traumatization? Besides the symptoms above, be on the lookout for:

- increased alcohol or chemical use

- depression, suicidal ideation

While caring for the overdosed medic, I thought to myself, "Gee, that could have been me." I was definitely losing my grip.

- psychosomatic complaints
- change in behaviour and/or demeanour such as tardiness, mood swings, flat affect or pronounced emotions dealing with work situations, apathy

Prior to my Sting Thing, I thrived on the rush of traumas and emergency room chaos. Now I dreaded it because the sum of my mental energy was funneled toward my own emotional survival... and I felt guilty for it. The most obvious change in my personality, however, was the fact that I had lost my sense of humour.

- increased sick time or other absences from work

I desperately wanted to call in sick so I could stay cocooned in my away-from-work world, but I didn't dare. I couldn't afford to lose my job.

What Can You Do?

- Allow the victim to tell you their story repeatedly.

I must have told my story a million times. I felt comforted by compassionate ears and a few well-chosen words.

- Treat traumatized individuals with kid gloves. They are indeed fragile creatures who need gentle care.

After only three weeks, I returned to my challenging duties as a nurse clinician, but turned out to be psychologically unable to handle the job. Staff complained about my performance. I felt embarrassed, unable to think clearly or protect my emotional self.

- Realize that the sufferer may lack confidence and may need guidance to make important decisions.

Eventually, my assistant manager (also a friend who knew me well) told me, "Go home. Can't you see that this place is making you sicker? We will be fine. Leave now and don't come back until you're really ready." That was the permission to leave that I needed. I helped no one by staying.

- Express that you care. Remaining silent, although perhaps easier, just reinforces feelings of isolation and leaves the impression that you don't care.

When co-workers avoided the subject, I felt invisible and unimportant. Worse than silence was someone asking how I was, then hurriedly escaping before I could answer!

- Show your compassion.

A colleague remarked, "I don't know what the big deal is. It wasn't like you were intubated or anything", an excellent example of what not to say.

- Realize and promote good mental health as a 'Check Up from the Neck Up'. Many health regions offer free and confidential employee assistance programs, some of which are available for family members, too.

Try to be supportive in all your interactions. If you see someone, anyone, struggling emotionally, please **say something** (preferably something nice). If you reach out to express your concern, you encourage disclosure, the first step towards effective treatment. **RN**

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Post-Traumatic Stress Disorder Checklist

To meet the criteria for post-traumatic stress disorder, the patient has either experienced or witnessed an unusually traumatic event that:

- involved actual or threatened death or serious physical injury to the patient or to others and
- the patient responded to the event with intense fear, horror or helplessness.

Following exposure to the event, the patient relives the event in one (or more) of the following ways:

- intrusive distressing recollections
- repeated distressing dreams
- flashbacks, hallucinations or illusions
- feeling or acting as if the event were recurring
- marked mental distress in reaction to internal or external cues that symbolize the event
- physiological reactions in response to these cues

In addition, the patient avoids trauma-related stimuli and shows numbing of general responsiveness, as evidenced by three or more of the following actions:

- tries to avoid feelings, thoughts or conversations about the event
- tries to avoid activities, people or places that recall the event
- cannot recall an important feature of the event
- experiences marked loss of interest or participation in activities important to the patient
- feels detached or isolated from other people
- feels life will be brief or unfulfilling.

In addition, the patient has at least two of the following symptoms of hyperarousal that were not present before the event and which have lasted longer than one month:

- insomnia
- angry outbursts or irritability
- poor concentration
- excessive vigilance
- increased startle response

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