Posttraumatic Stress Disorder, Trauma and Burnout in the Workplace

Presentation to:
Canadian Federation of Nurses' Unions

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- “Trauma destroys the fabric of time… In normal time you move from one moment to the next, sunrise to sunset, birth to death. After trauma, you may move in circles, find yourslf being sucked backwards into an eddy or bouncing like a rubber ball from now to then to back again… In the traumatic universe the basic laws of matter are suspended; ceiling fans can be helicopters, car exhaust can be mustard gas.”

  David J. Morris, “The Evil Hours”

- “What’s going on in Iraq, in Syria, what’s going on in the Congo—it’s not a news item for me. I can hear them screaming. I can hear them hurting. I can hear the fighting. I can smell it.”

Romeo Dallaire

Canadian Mental Health Association Bottom Line Conference 2015

Probability of Trauma (Gen Pop)

- Lifetime risk for at least one event: 55-90%
  (25-50% experience more than one event)
- Women > men (sexual assault)
- Men > women (physical assault, accidents)
- Occupations at high risk: military, police, firefighters

- Lifetime prevalence PTSD in Canadian pop: 7-9%

How to prevent PTSD:

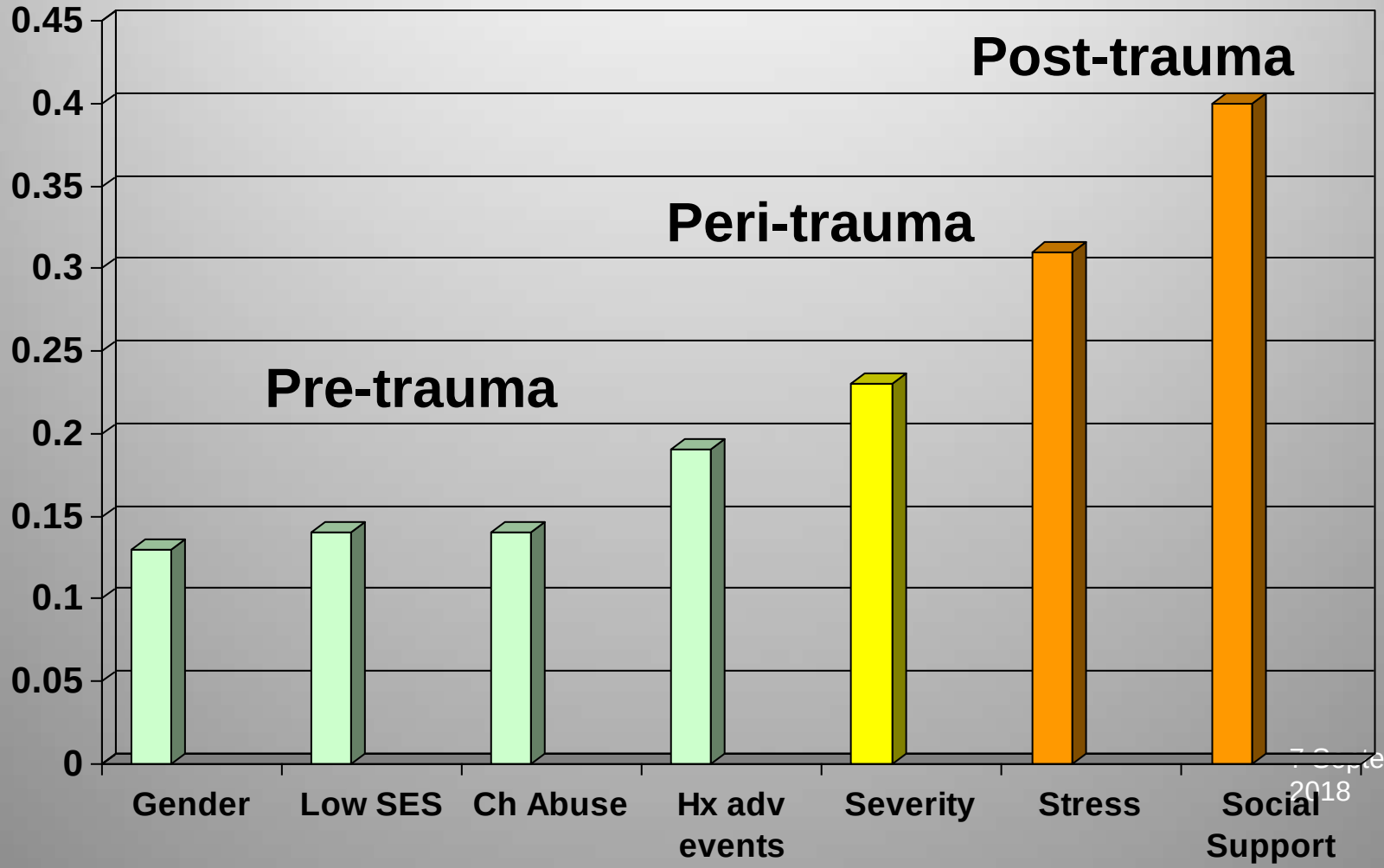
- Prevent exposure to traumatizing events!

Risk Factors for PTSD

- The reasons why one person develops PTSD, and another does not, are not fully understood
- **Pre-traumatic risk factors** (previous adverse events, psychological vulnerability)
- **Peri-traumatic risk factors** (severity of stressor, being injured)
- **Post-traumatic risk factors** (the amount of support received afterwards, further traumatizing events)

- Which factors have significance?

Journal of Consulting & Clinical Psychology - Brewin et al, 2000



What is PTSD?

- A diagnosis
- Psychological reaction following exposure to, or learning of death or threatened death, serious injury or sexual violence to self or loved one, or repeated exposure to aversive details of trauma (eg police viewing child pornography material)
- Four clusters of characteristic symptoms :

  Intrusions (intrusive memories, nightmares, flashbacks, physical/emotional reactions to triggers)

  Avoidance (of thoughts, people, places)

  Negative alterations in mood/cognitions (amnesia, distortions, fear, anger, detachment)

  Arousal (no sleep, irritability, hypervigilence, startle)

What is PTSD?

- To have PTSD, the symptoms must cause **significant distress** or **impaired functioning** in one of these areas:
  - Occupational
  - Family/ Social
  - Activities of Daily Living
- Other medical and psychiatric conditions ruled out

Comorbidity (Kessler, 1995)

- 88% of men with PTSD have at least one other lifetime MH diagnosis
- 60% have at least 3 other MH diagnoses

Alcohol Abuse	50%
Major depression	48%
Panic disorder	7%
GAD	16%
Agorophobia	19%
Social Phobia	28%

PTSD Treatment
(Three Phase Model)

Phase 1

Stabilization

Target: Understanding and Coping

Phase 2

Integration of Traumatic Memories

Target: Re-experiencing Symptoms

Phase 3

Re-integration/Maintenance

Target: Consolidation

Traumatic Stress Response (Acute Stress Disorder?)

- Very common to have psychological symptoms on exposure to war or other events that threaten our life or personal integrity
- Symptoms look like PTSD
  - State of "fight, flight or freeze" to life-threatening situation continues after event is over "threat sensitive"
  - Hard to **process new information** in this state
  - Symptoms:
    - Disturbed sleep, *ANGER*
    - Hypervigilance
    - Easily startled (reaching for weapon, duck & cover)
    - Panic

- **For most, these symptoms decrease and disappear without medical/psychological treatment**
- Members distressed, fear they're going crazy, or are weak
- An effective intervention at this point is to educate and support **"Leadership"** to support their people

Critical Incident Stress Debriefing: Why We Moved from CISD to Present Service Delivery Model - The Cochrane Review (2009):

"Psychological debriefing is either equivalent to, or worse than, control or educational interventions in preventing or reducing the severity of PTSD, depression, anxiety and general psychological morbidity.

There is some suggestion that it may increase the risk of PTSD and depression."

What We Learned From The Cochrane Review – continued

"The routine use of single session debriefing

given to non selected trauma victims is not supported. No evidence has been found that this procedure is effective."

The Impact of Caregiving on Ourselves and Our Relationships

Interchangeable Terms?

- Compassion Fatigue
- Secondary Stress/Secondary Traumatisation
- Vicarious Traumatization (VT)
- Burnout
- Indirect Trauma

What does VT/Compassion Fatigue look like?

- General Changes:
  - Disconnected from loved ones
  - Altered view of self, others and the world
  - Social withdrawal
  - Increased sensitivity to violence
  - Cynicism
  - Sleep disturbance (e.g., nightmares)
  - Feelings of despair and hopelessness

What does Burnout look like?

- Increased physical problems and illnesses (headaches)
- Increased negative thoughts and feelings about things and people previously enjoyed
- Increased unhealthy behaviours (eg poor eating)
- Inability to continue to push oneself

– Emotional Exhaustion: still work, “go through the motions”, appear normal, but have little or no reserve (interpersonal situations hardest) → nothing left at the end of the day

– Decreased Sense of Personal Accomplishments: no longer enjoy work, hard to recall what you liked about it in the first place

When to get professional help

- The feelings and behaviors continue for several weeks to months
- The feelings and behaviors increase over time
- These feelings and behaviors interfere with your day-to-day functioning (eg can’t get yourself out of bed in the morning)
- Overuse of alcohol or medications/drugs
- **Any** thoughts of suicide (or unremitting hopelessness)

Who is at risk?

- Short answer: Potentially all of us!

- Risk increases with:
  - High empathy/ low skill in boundary-setting
  - Unresolved personal trauma

  - Insufficient recovery time after potentially traumatic experiences
  - Working in isolation
  - Lack of systemic resources
  - Lack of training
  - Poor leadership!

Our Expectations

- Nurses come into the field out of a desire to help others
- Such motivation can be a powerful force for good
- We often come into this work with high self-expectations

Benefits and Risks of Caregiving

- To engage in caregiving, to empathize with another person, especially one who is suffering or traumatized, can be incredibly rewarding work

- However, it can sometimes be costly to the nurse, and to the nurse’s personal relationships

Pitfalls:

- Rescue Fantasies:
  - Who do you think you will have the most difficulty caring for?
  - Possible over-identification with our patient
  - Can result in a loss of objectivity
  - Excessive tolerance of abusive behavior

Impact on Relationships

- This work can take unique toll on personal relationships
- Can spend so much energy thinking about the problems of others that we have little left over for ourselves and our loved ones
- Overwhelming situations may lead to feelings of helplessness

Prevention and Resolution Strategies

- Training/Education “Inoculation”
  - Decrease or alter exposure
  - Decrease surprise
  - Increase sense of mastery

- Leadership/Mentoring/Supervision
  - Foster teamwork
  - Provide role models (eg boundary-setting)
  - Provide guidance
  - Provide meaning

- Personal Counseling/Therapy

Self Care Strategies (Professional)

- Talk to colleagues
- Use creative problem-solving
- Keep your sense of humour
- Accept feedback from colleagues, friends and family
- Talk about, write about, present on difficult patient cases with trusted others
- Accept limitations

Leadership is very important

Training/education, motivation, discipline and group cohesion are all factors in reducing burnout, VT and traumatic stress reactions

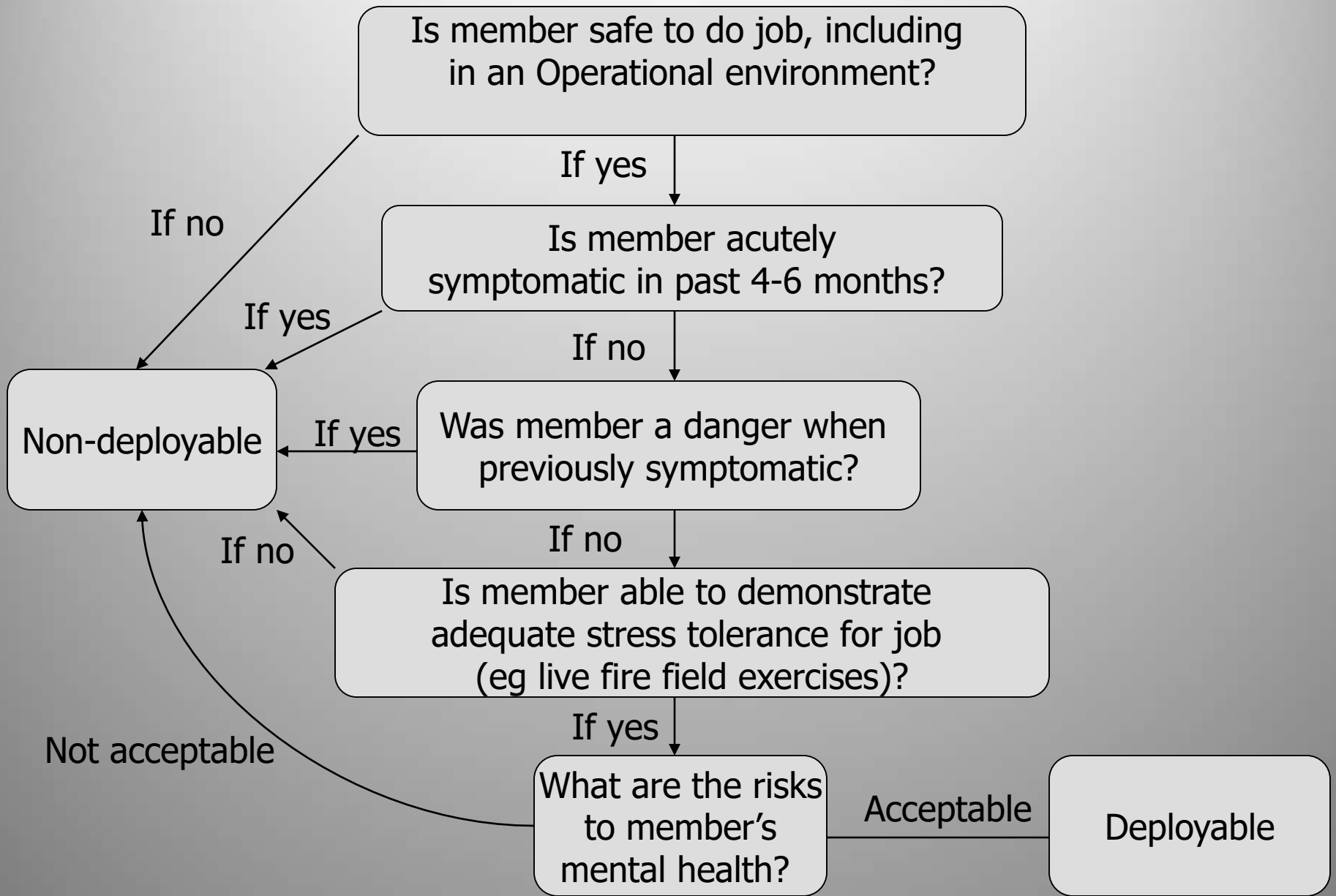
AD HOC INCIDENT REVIEW (AIR)
A FORMULA FOR LEADERS

- **Acknowledge and Listen**
  - Acknowledge what happened. Don't try to ignore it and carry on. Don't overemphasize it. Review the facts. Be calm and straightforward. Provide opportunity to discuss (if appropriate).
- **Inform**
  - Normalize TSR-type response. Remind them of self-care. Inform them of resources if needed. Then refocus on mission and their value to its success. Make commitment to check in on them again.
- **Respond**
  - Observe, follow-up, model healthy coping. Demonstrate genuine concern. Expect recovery. Good leadership strengthens cohesion, resilience and resolve.

PTSD, VT, Burnout and Fitness to Work

- Occupational Medicine issue

Risk to Operation vs Risk to Member



Summary

- Nurses, like CAF Members, they are often repeatedly exposed to traumatic events in the course of their careers
- Preparation for trauma, understanding common responses and engaging in a good self care regimen are integral to the maintenance of mental health
- Professional help may be called for if education, support and time does not provide comfort or relief from distress

Posttraumatic Stress Disorder: A Primer for Primary Care Physicians

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- **Recognizing, diagnosing and treating PTSD**
- Online course accredited for Mainpro credits
- Available in English, and in French

- Sponsored by the Mood Disorders Society of Canada

www.MDcme.ca

Thank-you

Questions?

Anonymous soldier
Rwanda 1994