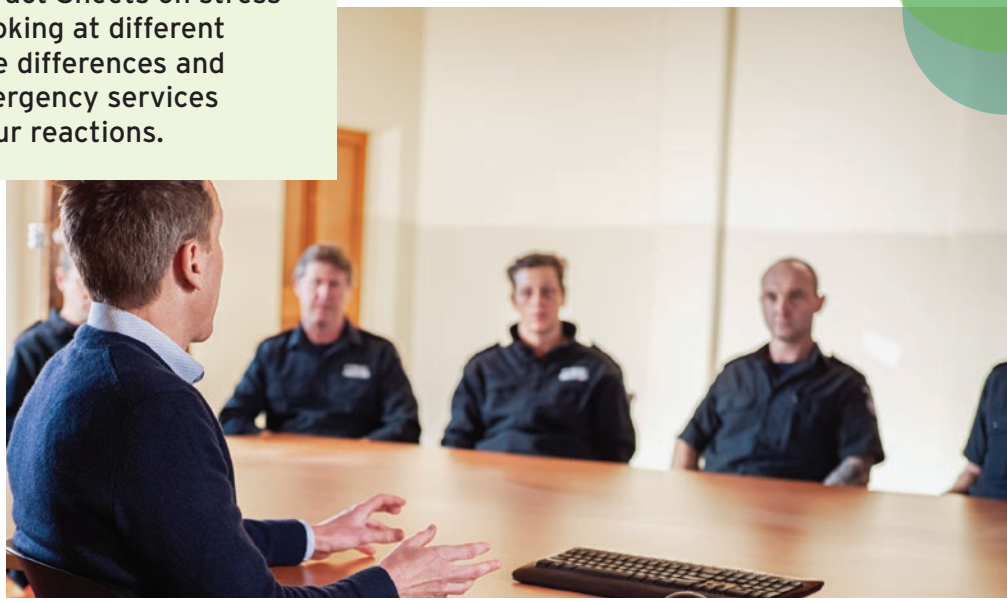
Wellbeing
SUPPORT

PART 4: STRESS, TRAUMA AND YOU

Trauma & PTSD

Welcome to a five part series of Fact Sheets on stress and trauma. The series will be looking at different aspects of stress and trauma, the differences and similarities, their impacts on emergency services workers, and ways to manage your reactions.



In this edition, we will learn more about trauma, trauma reactions and Post-Traumatic Stress Disorder (PTSD). In the last Fact Sheet, we looked at stress, burnout and trauma, their symptoms and differences. We also defined trauma and traumatic stress (or post-traumatic stress). To recap:

- A traumatic event is defined as one that involves experiencing or witnessing events that are typically (but not always), sudden and unexpected, where there is a real or perceived threat to life or physical integrity, and outside the range of normal human experiences.
- Traumatic stress (or posttraumatic stress) refers to the reactions that occur in response to a traumatic event/s.

For those in emergency services, the term "critical incident" is often used to refer to potentially traumatic events. In the Tasmanian emergency services, critical incidents include:

a. the death of, or serious injury to, an emergency service worker (including suicide);
b. any incident involving serious threat from firearms, or in which an emergency service worker is fired upon, or returns fire;
c. any other situation in which there is a serious threat to the life or safety of an emergency service worker;
d. situations involving serious injury to, or the death of, a child; and
e. any other situation that, in the opinion of the manager or supervisor, has the potential to produce, or has produced, a high level of immediate or delayed emotional reaction in one or more emergency service workers.

Post-Traumatic Stress (PTS) vs Post-Traumatic Stress Disorder (PTSD)

Given the events faced by emergency services responders, the terms are often used interchangeably, but they are in fact different.

There is a continuum of trauma reactions or responses, and a range of possible pathways following exposure. While all PTSD is trauma, not all trauma is PTSD. What this means is that PTSD by definition describes a particular pattern of trauma symptoms, however individuals can experience a range of responses to trauma but not meet the specific diagnosis of PTSD.

So how are PTS and PTSD different?

The Black Dog Institute notes that many people exposed to traumatic events commonly experience post-traumatic stress (PTS) reactions in the initial weeks following that event. For most people, these symptoms are temporary and subside over time.

Given the common trend for symptoms to occur following a traumatic event then decrease, having a trauma reaction can be considered a normal, adaptive process to the experience of a traumatic event – a ***normal*** reaction process to an ***abnormal*** event.

While the presence of a reaction is considered normal, the symptoms themselves can vary from mild to severe.

The following are common traumatic stress reactions. You will notice many of them are also general stress reactions, although there are some differences:

PHYSICAL
- Fatigue/lethargy
- Headaches
- Muscular tension/aches
- Sleep disturbance
- Upset stomach/ gastrointestinal symptoms
- Sweating
- Teeth grinding/jaw clenching
- Dizziness
- Agitated
- High blood pressure
- Changes in sex drive

EMOTIONAL
- Anxiety/worry
- Low mood
- Overwhelmed
- Disconnected or numb
- Shock
- Guilt
- Anger/Irritability
- Agitation
- Easily upset

COGNITIVE/MENTAL
- Changes in alertness
- Poor motivation
- Trouble remembering parts of the incident
- Time distortion
- Disturbed dreams
- Preoccupied with memories of the incident
- Intrusive thoughts
- Confusion
- Poor attention/concentration
- Easily distracted
- Self-doubt

BEHAVIOURAL
- Inability to rest
- Changes in interest/ participation in social activities
- Changes in appetite, activity, sleep, sex
- Increased alcohol, smoking, drugs or food intake
- Restlessness
- Falling behind or avoiding work

There are simple things that people can do to support themselves through this time (refer to Part 5 of the Stress Trauma and You Series – *Critical/traumatic Incidents: Managing Reactions*).

When does a trauma reaction, or PTS, become PTSD?

When symptoms have not resolved, have become worse, are persistent and cause distress, PTS has likely moved from being an adaptive response to becoming a syndrome.

Post-traumatic Stress Disorder (PTSD) refers to a condition only diagnosable by mental health clinicians. It refers to a ***persistent and chronic traumatic stress response*** that manifests in a particular way following a traumatic incident or series of incidents.

For a diagnosis to be made, there must have been exposure to a traumatic event that involved exposure to actual or threatened death, serious injury, or sexual violence. Exposure can be through experiencing the event personally, witnessing the event, learning that it happened to someone close to you, or through repeated exposure to the traumatic details of the event.

In addition, a person must be experiencing symptoms in each of the following four categories for at least one month, and symptoms must be associated with significant distress or impairment in social, occupational or other important areas of functioning (Black Dog Institute, Expert Guidelines).

1. **Re-experiencing symptoms –** including intrusive memories, flashbacks and nightmares
2. **Avoidance symptoms –** active avoidance of reminders (thoughts, situations, places) of the trauma
3. **Negative mood and thoughts –** similar to symptoms of depression and can include fear, guilt, numbness, or difficulty remembering important details of the event
4. **Arousal symptoms –** refers to a heightened physiological state and includes symptoms such as insomnia, exaggerated startle response, hypervigilance, irritability and concentration difficulties.

Research shows that about 5 to 10% of Australians will suffer from PTSD at some point in their lives. In comparison, the *Beyond Blue Answering the Call* study found that, Australia wide:

- 10% of employees had 'probable' PTSD. Rates ranged from 6% in the state emergency services sector, to 8% in ambulance, 9% in fire and rescue, and 11% in police.
- 4% of ambulance volunteers, 5% of fire and rescue volunteers, and 6% of state emergency services volunteers had probable PTSD.

It is important to note that these results are based on self-report on a screening questionnaire, and as such are not diagnostic, and do not take the place of a clinical assessment conducted by a mental health professional.

Trauma in Emergency Services

The Black Dog Institute notes that the presentation of symptoms in emergency services workers as a result of trauma is often different to those experienced in other populations. Routine and repeated exposure through the course of their work can more commonly cause reactions of guilt and anger in emergency services workers, as opposed to fear and horror that is more commonly described by the general population exposed to single incident trauma.

Consequently, emergency services workers may experience a build-up, or an accumulation of symptoms over time, or they may present with acute symptoms after a single event. Historically, as a result of cultures that minimise the impact of trauma, stigma about mental health, self-stigma, and fears about career impacts, many individuals are likely not to

seek help and receive appropriate assessment of their mental health. AT and DPFEM are committed to removing the stigma associated with help seeking ensuring people get access to the services they need.

PTSD is both over – and under-diagnosed in emergency services

Due to this downplaying of symptoms, more indirect symptoms or difficulties may present initially, such as alcohol issues, anger or relationship problems, meaning that PTSD may not be picked up or identified, resulting in under- or mis-diagnosis.

Conversely, due to the obvious exposure of emergency services work, many treaters may be too quick to diagnose PTSD and overlook other conditions.

It is also common for emergency services workers to experience symptoms of PTSD, but in such a way that the pattern of symptoms does not meet the diagnostic threshold, often referred to as "sub-syndromal". This does not mean that treatment and support are not needed.

Whilst PTSD has been the condition with the most focus in emergency services, it is important to remember:

- PTSD is not the most common mental health condition
- Exposure to trauma can result in other mental health conditions, such as depression and anxiety. It does not always lead to PTSD
- You can experience distressing symptoms of trauma that significantly impact your functioning, but not meet the criteria for PTSD
- All PTSD is trauma, but not all trauma is PTSD – so we need to recognise the broader spectrum of trauma symptoms in order to get better at identifying ALL of those who may be struggling with their mental health.

Other mental health conditions

It is common to experience other mental health conditions in addition to PTSD. Most frequently, those with PTSD will experience depression, anxiety, alcohol abuse or drug use.

Treatment for PTSD

Diagnosing PTSD is a complex task and requires time and thorough assessment. Thorough assessment typically includes clinical interviews, structured interview protocols, self-report measures, psychological testing and other collateral information. For more information about assessing PTSD access the Black Dog Expert Guidelines.

Once PTSD has been diagnosed, then evidence-based treatments should begin as soon as possible. There are a range of effective treatments for PTSD in emergency services that are available, which are detailed in the Black Dog Expert Guidelines.

Psychological Treatments:

Generally, effective treatments involve psychological treatment (talking therapy). The two most recommended psychological treatments for PTSD are Trauma-focussed Cognitive Behavioural Therapy (CBT) (you may hear this referred to as Exposure therapy) and Eye Movement Desensitisation and Reprocessing (EMDR). These treatments have been found to be effective for most people, however will not be effective for all people all the time.

Whilst different in their approach, the cornerstone of psychological treatment for PTSD is to help you address the memory of the traumatic event and the thoughts and feelings associated with it. Because it can provoke intense fear and distress, it is common for people to want to avoid anything that reminds them of the trauma. While this might feel good temporarily, it is one of the main reasons people do not recover. When people avoid what makes them distressed, they do not have the opportunity to address what occurred or develop strategies to help them feel safe and cope.

Treatment usually focuses on goals such as reducing the severity of symptoms, preventing or reducing other co-occurring conditions, improving social, personal and occupational functioning, and protecting against relapse.

Make sure you get recommendations to a registered Psychologist or qualified EMDR practitioner who has expertise in one of these approaches.

For information about what it's like to do exposure therapy watch the video of Victoria Police member Mark. It is available at https://www.phoenixaustralia.org/recovery/treatment-options/ptsd-counselling/

Medication:

Both the Black Dog Institute Expert Guidelines and the Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder (Phoenix Australia) note that while there is evidence for the use of anti-depressants, research suggests that greater clinical improvement could be gained from the psychological treatments. As such, medication is not recommended as a first line treatment for PTSD.

Like any health condition however, the need for medication will be determined by a range of individual factors and should be determined in consultation with your health providers. For medication for PTSD (or any mental health condition), it is important to see a Psychiatrist who has experience with PTSD, preferably in emergency services, and who is familiar with the Black Dog Expert Guidelines.

Other treatments

Counselling or programs that focus on other areas (e.g. lifestyle programs, stress inoculation, problem solving, mindfulness etc.) are considered as adjunct supports, not direct treatment of PTSD.

While group treatment demonstrates some efficacy for PTSD, and provides opportunity for peer support, normalisation, learning and motivation through the group process, the elements addressing the exposure to your particular trauma should not be conducted in a group setting unless approved by a psychologist. Recommendations primarily support individual treatment in the first instance. Any treatment protocol however, should be determined in consultation with your treating practitioners, and be based on your individual needs.

Where can I access treatment?

It is important that you find qualified practitioners who are experienced at providing psychological treatment, as well as medication. Wellbeing Support has a list of psychologists and psychiatrists who have experience in working with emergency service workers. **Wellbeing Support is contactable on 6173 2188 or wellbeing@dpfem.tas.gov.au.**

Want further help or resources?

Download a copy of the *Black Dog Expert Guidelines: Diagnosis and Treatment of Post-Traumatic Stress Disorder in Emergency Service Workers*. You can take a copy with you to your treating practitioner so they are aware of the recommendations.

PHOENIX AUSTRALIA
www.phoenixaustralia.org

- Download a copy of *Recovery after Trauma – A Guide for People with Posttraumatic Stress Disorder*
- Download a copy of the *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder*

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2019

GET HELP NOW

You can access a range of confidential services, which are designed specifically for the Tasmanian emergency services community from Wellbeing Support.

Ambulance Tasmania Peer Support 6166 1994

CISM 0427 181 207 | manager@cism.tas.gov.au

Wellbeing Support Psychological Services
Phone (office hours) 6173 2188 | wellbeing@dpfem.tas.gov.au

Wellbeing Support Officers:
South 0429 453 689 or 0436 800 604 **North** 0436 812 038 **North West** 0419 126 551

Further general information is available at **mypulse.com.au**

Printed fact sheets are available from **wellbeing@dpfem.tas.gov.au**