The Aftermath of Trauma – Post-Traumatic Stress Disorder

Most of us build our lives around the belief that we will be relatively safe. Granted, normal daily life involves many stressors, especially in these hectic times, but we expect these pressures to happen and we become accustomed to handling them. The more flexible we are and the more we know ourselves and are in touch with our abilities, the easier it is to deal with normal everyday stress.

Sometimes, however, any of us could be subjected to catastrophic stress. Our feeling of safety in these circumstances can vanish. We could experience terror and a complete inability to know how to handle these situations that are outside of the ordinary realm of experience. These catastrophic events can include rape, physical or sexual abuse, physical attack, mugging, car-jacking, natural disasters (earthquakes, hurricanes, tornados, floods, etc.), fires, car accidents, plane crashes, hostage situations, school shootings, military combat, or the sudden death of a loved one. It is not only the victims of these events, but also witnesses, families of victims, and helping professionals who can develop severe stress symptoms which can last for months or even years after the event.

Post-Traumatic Stress Disorder (PTSD) is the term used to characterize people who have endured highly stressful and frightening experiences and who are undergoing distress caused by memories of that event. It is as if the person just cannot let go of the experience. The event comes back to haunt them. The anxiety experienced during or immediately after a catastrophic event is called traumatic stress. When the symptoms last several months after the event, it is called post-traumatic stress. PTSD can last for years after the original trauma and may not become evident initially. For example, an individual may witness a murder as a child, but not experience the associated stress until mid-life.

Some people are more likely to develop PTSD than others. Experts are not sure why some people develop PTSD after a relatively minor trauma while others exposed to great trauma do not. Those who are very young or very old are more vulnerable. PTSD is also associated with intelligence (those with a higher level of intelligence are less likely to suffer from PTSD). Individuals who already suffer from anxiety disorders, some personality disorders or depression seem more likely to get PTSD after extreme trauma. It seems that the more vulnerable one feels in dealing with the world, the more likely one is to develop PTSD.
Trauma of great severity is more likely to produce PTSD than lesser traumas. For example, it was found with Vietnam War veterans that prolonged combat with sniping and air bombardment produced PTSD more often than brief exposure to combat with few weapons. It has also been found that traumas between people (such as sexual assault and muggings) are more likely to produce PTSD than natural disasters like earthquakes or floods.

**Symptoms of PTSD**

People can be considered to have PTSD when they have been exposed to an extreme trauma, the symptoms last at least a month in duration, and the symptoms cause excessive distress so that social functioning and job performance are impaired. One sign of PTSD is that the traumatic event is relived repeatedly in the person’s mind – and this appears in the form of “flashbacks,” recurrent images, thoughts or dreams about the event...and even nightmares. Reminders of the event can cause distress – so many people go out of their way to avoid places and events that remind them of the catastrophic occurrence. Many people experience anxiety, restlessness, concentration difficulties, decreased memory, irritability, sleeplessness, hypervigilance, or an exaggerated startle response. Some people even experience what is called “survivor’s guilt” – because they survived and others did not or because of certain things they may have had to do in order to survive.

There are three main clusters of PTSD symptoms, and all three of these groupings must be present for a diagnosis of PTSD.

**Intrusive Symptoms:** Intrusive and repetitive memories which stir up negative feelings experienced during the trauma can overwhelm a person. These memories can appear in the form of:

- flashbacks (a feeling of reliving the trauma)
- frequent, distressing memories of the trauma
- nightmares
- emotional and physical distress when traumatic memories are triggered.

**Arousal Symptoms:** PTSD sufferers experience physiological reactions, which indicate that they don’t feel safe and they are physically on the alert to deal with danger. These can include:

- being easily startled or feeling jumpy
- hypervigilance (feeling “on guard” even when the situation is safe)
- concentration difficulties
- outbursts of anger and irritability
- problems in falling asleep or staying asleep.

**Avoidance Symptoms:** People suffering from PTSD go out of their way to escape the overpowering memories and arousal symptoms. This pattern of behavior can include:

- avoiding places, people or situations that serve as reminders of the trauma
avoiding thoughts or feelings associated with the trauma
memory loss about some aspects of the traumatic event
feeling emotionally numb
feeling estranged or detached from other people
feelings of hopelessness and helplessness about the future
decreased interest in pleasurable activities.

There are other emotional and physical problems that may accompany PTSD. Unfortunately, some people seek relief from these symptoms without dealing with the root cause so that the symptoms persist. These problems may precede PTSD, in which case they become exacerbated, or they might develop after the onset of PTSD. The emotional problems include panic disorder, agoraphobia (fear of being out in public), social anxiety (speaking in public), depression, obsessive-compulsive disorder, sleep disorders, suicidal thoughts and substance abuse (drug or alcohol abuse). The physical problems can include skin problems, pain, gastrointestinal disorders, fatigue, respiratory problems, low back pain, muscle cramps, headaches, and cardiovascular problems.

It is important to remember that PTSD is a normal reaction to a very abnormal situation. There is no shame in experiencing these symptoms, nor is having these symptoms a sign of weakness. Help is available from trained professionals so that in most cases, with the appropriate effort and courage, the symptoms can disappear completely, or at least substantially decrease and become more manageable.

Getting Help for PTSD
We live in a world of relative safety most of the time – but it is a world in which people often lack support for dealing with calamities. In these times we may not have the extended families, long-term friendships, sense of neighborhood, feeling of community or the support from religion that have historically helped people endure times of crisis. We usually get along without difficulty as long as things go smoothly. But when a crisis occurs, we sometimes simply do not know what to do or where to turn.

Traumatic events can leave us stranded. We may lack not only social support when a crisis occurs, but also the language for understanding the place of tragedy in our lives. We may not know how to conceptualize it – how to use words that can describe a disaster and make it real. We may not know how to react emotionally when crisis comes into our lives – these are feelings that we may have never experienced before and they may frighten us. So we refuse to accept the crisis or to deal with it. We think we are strong and able to endure anything. Denial comes easily. Refusing or not knowing how to deal with the thoughts and feelings that accompany a major catastrophe, unfortunately, sets us up for PTSD. And it is not our fault.

PTSD is highly treatable, especially if it is caught early. The idea behind the treatment is to process or work through the traumatic event, as well as to manage the immediate troublesome symptoms the person is experiencing. A trained therapist can help the PTSD sufferer to find the words, in a safe and gentle way, to talk about the event and to confront the feelings that accompany the experience. This is not an easy step, but it is a necessary one. While it might seem natural to avoid reliving a painful memory, it is important to face the memories, feel the emotions and try to work through them. When this happens, the trauma no longer controls the person – the person is now in control of the memory of the trauma to the extent that he or she can approach it objectively and flexibly.

A person who has survived a traumatic event will probably never feel as if the event never happened, but the distressing and disruptive effects of PTSD can be alleviated. In therapy, a person can learn to describe a
coherent account of his or her life. People who are able to do this are much less susceptible to the effects of trauma. Therapists use a number of techniques to help a person work through traumatic events, some involving talking and some involving more physical interventions. Sometimes medication can help to lessen the anxiety, depression and sleep difficulties, as well as the physical symptoms, which go along with PTSD. Social agencies now use highly effective techniques, such as critical incident debriefing, to help people process their way through a trauma immediately after a disaster occurs in a community. Victims of violence are often now given support to talk about the event soon after it has occurred.

The old way of thinking was that the strongest people were those who could hold in their emotions and face tragedy stoically. Unfortunately, this is precisely the pattern which leads to PTSD. Real strength comes from knowing oneself and expressing that sense of self in the world with openness, honesty, integrity – and courage.

Some PTSD Statistics
Most people who are exposed to extreme stress are able to process their way through their reactions and never develop PTSD.

It has been estimated that 70 percent of people will be exposed to a traumatic event in their lifetime.

Of those people, 20 percent will go on to develop PTSD.

At any given time, an estimated 5 percent of people have PTSD.

Approximately 8 percent of the population will develop PTSD during their lifetime.

Women are about twice as likely to develop PTSD as men, mostly because women are more susceptible to experience interpersonal violence, including rape and physical beatings.

Victims of domestic violence and childhood abuse are at tremendous risk for PTSD.

Rape is the leading cause of PTSD.

Do You Have PTSD?
Do you have any of the following problems? If you check at least seven of the following items and it is several months after you have experienced a catastrophic event, it is advisable to have a professional consultation to determine if therapy for PTSD is indicated.

____ 1. I have strong physical sensations (e.g., sweating, rapid heart beat) when I think about the event.

____ 2. I try to avoid having upsetting thoughts or having contact with things or places associated with the event.

____ 3. My feelings are numb and I have difficulty experiencing normal pleasure and happiness.

____ 4. I am always watchful to make sure I don’t experience the same event again.

____ 5. I have feelings of guilt associated with the traumatic event.

____ 6. I have the feeling of being unreal or that the world is unreal.

____ 7. I feel alienated or isolated from others.

____ 8. I get irritated or angry a lot.

____ 9. I have flashbacks of the event (feeling like the past event is happening all over again in the present).

____ 10. I have trouble falling asleep or staying asleep because memories of the event come into my mind.
11. I have memory difficulties and trouble concentrating these days.

12. I am easily startled when I hear a loud noise or when danger seems imminent.

13. I have been relying increasingly on alcohol or drugs to get through the day.

Disease of Loneliness
by an Anonymous Physician

I had a patient experience that was profound for me. I was asked by the ICU to meet the parents of a 39 year old man who dying of liver and kidney failure from alcoholism. The ICU doctors were asking me to talk to his 70 year old parents about taking him off life support to die, because he was not going to improve.

I looked in the room, and saw him in the ICU bed, intubated, and his parents sitting against the wall, about 6 feet from the bed. It struck me that they were not holding his hand. I told my social worker I would be back. I had to take a walk because I was thinking to myself, “coulda been me.”

This is one of the youngest patients I have seen in the hospital dying from organ failure from drinking, as opposed to trauma. I met his parents and talked to them about what their son was like as a person. Dad spoke more than mom. They both seemed broken. Dad just couldn’t understand why he couldn’t stop drinking, and just wanted to help. He recalled when his son worked as a chef ... [he] eventually lost his job from too many screw ups. He drove him to AA meetings and his son told him they didn’t work. He drove him to his next job when he lost his license until they fired him for smelling like alcohol.

His mother wore a necklace with his baby picture. When I asked her what he likes to do, she said with tears in her eyes, “he likes to sleep, drink, and stay in his room.”

We talked about how he was dying and we could not fix his organs. His dad said, “even if you could fix him, it wouldn’t matter.” I could feel the helplessness in the room. They had tried for so long, and they truly understood we couldn’t help him. They have been trying for years. We talked about who needed to come to say goodbye to him. They could think of no one. He and his sister no longer spoke and they said she wouldn’t want to come. He did not have any friends.

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Despite all the conversations I have had with patients and families about dying, I was surprised at how ready they were for it to be over (which is different from letting him go). I wanted to let them go home for the night and come back the next morning to spend the day with him after taking him off of life support. They looked at each other, and his dad said, “go ahead and take him off now. We are going home. The son we know died a long time ago.” He also said “we will carry this for the rest of our lives.”

When they left, I felt saddened by how little they understood about their son’s addiction, at least from my own perspective of recovery. I thought about how...[the PHP] program does work, and that they are a couple who could use Al-Anon (which I mentioned to them), but they have the perception that this program doesn’t work, and therefore they won’t seek out the help they can receive from Al-Anon. I also thought about the leaps and bounds I have made with my family. The changes that have happened with the relationships with my family are huge and cannot be measured.

The next day, when we extubated him, I saw a good looking young man with a lot of potential. He died alone in the ICU 12 hours later.

This disease is truly a disease of loneliness. If I go back out, it will only be a matter of time until I am alone again. I don’t want to die that way.

Written by a PHP alum from another state.

**Editor’s Note:**

This article was made available to us by Dr. P Bradley Hall, Executive Medical Director for the West Virginia Medical Professionals Health Program and published by the Targeted News Service 5/7/13. We are re-printing it to show developments that may impact all hospitals in the future.

**All Hospitals Should Require Drug, Alcohol Tests for Physicians**

BALTIMORE, MAY 7 --Johns Hopkins Medicine issued the following news release: To improve patient safety, hospitals should randomly test physicians for drug and alcohol use in much the same way other major industries in the United States do to protect their customers. The recommendation comes from two Johns Hopkins physicians and patient safety experts in a commentary published online April 29 in The Journal of the American Medical Association. In addition, the experts say, medical institutions should take a cue from other high-risk industries, like airlines, railways and nuclear power plants, and mandate that doctors be tested for drug or alcohol impairment immediately following an unexpected patient death or other significant event.

“Patients might be better protected from preventable harm. Physicians and employers may experience reduced absenteeism, unintentional adverse events, injuries, and turnover, and early identification of a debilitating problems,” writes authors Julius Cuong Pham, M.D., Ph.D., an emergency medicine physician at the Johns Hopkins Hospital, and Peter J. Pronovost, M.D., Ph.D., director of the Johns Hopkins Armstrong Institute for Patient Safety and Quality. Gregory E. Skipper, M.D. of the drug and alcohol treatment center, Promises, in Santa Monica, CA, also contributed.

Pham, Pronovost and Skipper note that “mandatory alcohol-drug testing for clinicians involved with unexpected deaths or sentinel events is not conducted in medicine,” even though physicians are as susceptible
to alcohol, narcotic and sedative addiction as the general public. (A sentinel event is an incident which results in death or serious physical harm.)

The authors recommend in their commentary that hospitals take a number of steps as a model to address this overlooked patient safety issue. They are:

- Mandatory physician examination, drug testing or both, before a medical staff appointment to a hospital. This already occurs in some hospitals and has been successful in other industries.
- A policy for routine drug-alcohol testing for all physicians involved with a sentinel events leading to patient death.
- Establishment of testing standards by a national hospital regulatory or accrediting body. The steps could be limited to hospitals and their affiliated physicians at this time, since hospitals have the infrastructure to conduct adverse event analysis and drug testing, note the authors. Hospitals also have the governing bylaws to guide physician conduct and an existing national accrediting body, The Joint Commission, the authors add.

In cases in which a physician is found to be impaired, a hospital could “suspend or revoke privileges and, in some cases, report this to the state licensing board,” the authors write. Impaired physicians would undergo treatment and routine monitoring as a condition for continued licensure and hospital privileges.

“Patients and their family members have a right to be protected from impaired physicians,” argue the authors in the JAMA commentary. “In other high-risk industries, this right is supported by regulations and surveillance. Shouldn’t medicine be the same? A robust system to identify impaired physicians may enhance the professionalism that peer review seeks to protect.”

See the *Journal of the American Medical Association (JAMA)* April 29, 2013 for full article cited herein.
A Colleague Writes

Editor’s Note:
A colleague of a participant in the MPHP was moved to express appreciation for our work by writing the following note:

....On a personal note, I appreciate all you do for the physicians who would have fallen by the wayside if the MPHP wasn’t there to help them back. You’ve saved lives, relationships and made it possible for good physicians to be better ones. There was a Pogo cartoon some years back in which one of the characters asked Pogo why he looked glum to which he explained “Just realized I’m too old for camp and too young to retire.” Me too! Maybe medical staffs and the MPHP should consider sending some of us to personal insight camp for a couple of weeks every few years.

Anonymous Physician

Warning Sounded on Demoralized Health Care Work Force

A report from the National Patient Safety Foundation’s Lucien Leape Institute finds that many medical environments are growing more taxing for those who work in them, creating a greater risk for those treated in them. The organization said increasing occupational injury rates, more verbal and physical assaults among colleagues, and a drive to deliver more care in less time is setting back the effort to increase quality of care. The institute has some suggestions on how to reverse this trend, including creating an environment that values civility and transparency.

Read article (http://www.amednews.com/article/20130318/profession/130319941/1/)

Preventing Physician Flight Risk

Cejka Search reports that the “loss of just one full-time physician and then recruiting a new one over a one-year time period adds up to approximately $1.2 million.” In 2012, medical groups reported a turnover rate of 6.8%, the highest in their survey’s history. Physicians Practice suggests the following steps that practices can take to avert these losses: 1) Put extra effort to ensure physicians new to the practice are comfortable and get the resources they need during critical early weeks and months to avoid flight risk. 2) Develop a clear and thorough orientation and practice development plan for the new physician before he/she begins work. Groups that provide a year-long orientation process experienced lower turnover rates. 3) Pair new physicians with more established physician mentors.