

Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder

Specific Populations and Trauma Types Emergency services personnel and PTSD

This *Emergency services personnel and PTSD* information sheet addresses background issues and provides presentation, assessment and treatment recommendations for practitioners working with emergency services personnel. These recommendations are based on the systematic review of the international literature, and the expert opinion and advice presented in the Specific Populations and Trauma Types chapter of the *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder*. www.phoenixaustralia.org/resources/ptsd-guidelines/.

Background issues

Members of the emergency services are invariably exposed to multiple traumatic events, or 'critical incidents', over the course of their careers. Such events may include witnessing gruesome scenes, being unable to prevent another person's death or serious injury, and being at personal risk of injury or death. The clinical presentation of emergency services personnel infrequently occurs following the initial exposure to a single traumatic incident. More common is the process of sensitisation, where repeated experiences of traumatic incidents result in progressively more severe reactions over time.[1] A related construct is that of kindling, whereby repeated exposure to traumatic events results in an increased responsivity, such that events that would not previously have affected the individual begin to trigger mental health symptoms.[1] Given that cumulative trauma exposure is associated with increased risk of disorder, long-term emergency services employees may be more likely than new recruits to develop mental health problems such as posttraumatic stress disorder (PTSD).

Emergency services personnel are likely to be more affected by some incidents than others; the extent to which a specific incident is personalised through some identification with the event or the victim plays an important role in modifying the resilience and vulnerability of the individual.[2] Unlike members of other emergency services, police officers may also be required to injure or kill another person in the course of duty. As a precipitating event for mental health problems, that experience is more likely to lead to PTSD than other problems such as depression or alcohol use.[3]

In addition, emergency services personnel are exposed to significant routine workplace stressors such as long hours, physical exertion, interpersonal conflict, budgetary constraints, and so on. There is some evidence to suggest that daily, low-level stressors may be related more closely to the development of PTSD than the experience of isolated single critical incidents.[4, 5]

Approximately 10 per cent of first responders are estimated to have PTSD, although the prevalence may vary across services. Results of one meta-analysis suggest the disorder is most common among ambulance personnel (15%), with lower rates in firefighters (7%), police (5%), and other rescue workers (13%)[6]. However, police were only included in Berger et al's meta-analysis if they were exposed to a natural disaster; the prevalence of PTSD in studies with more representative police samples ranges from 7 to 19 per cent.[7]

Presentation

Emergency services personnel often respond to traumatic experiences differently to other trauma-exposed populations, reporting occupationally appropriate responses such as anger or guilt rather than emotions such as fear or horror commonly seen in civilian trauma survivors. Indeed, anger is a significant issue in this population. Pre-existing anger may influence the development of PTSD following a critical incident, while PTSD in turn is associated with an increase in anger.[8] Its visible nature and effect on work and interpersonal relationships mean anger may be more likely to bring attention to the individual than internal expressions of distress. Substance use is another common presenting problem, for similar reasons. In terms of PTSD symptoms, personnel who have experienced particularly frequent exposure to critical incidents may be more likely to present with prominent hyperarousal.[2]

Many individuals will experience significant subsyndromal distress, which can impair their resilience following future traumatic events and increase the risk of subsequently developing PTSD.[9] Subsyndromal PTSD symptoms can result in similar levels of disability to full-blown disorder, and are associated with other problematic behaviours such as binge drinking.[1]

Assessment

Systematic screening potentially has an important role in identifying PTSD in emergency services personnel. Pre-exposure screening has not been found to have much benefit in this population. Post-exposure screening may be more helpful, and should generally focus on personnel who display one or more risk factors, such as past psychiatric history, repeated exposure to fatal or grotesque incidents, performance deterioration, interpersonal conflict, or increased alcohol use.[10] However, screening in the immediate aftermath of trauma exposure may not identify individuals who experience a delayed onset of clinically significant symptoms, and routine annual screening is therefore recommended.[11]

A number of screening and assessment measures have been designed specifically for use with emergency services personnel (for example, 5, 12). Until these have been more thoroughly researched, however, the use of standard measures such as the Posttraumatic Stress Disorder Checklist for DSM-5 (PCL5; Weathers et al. 2013) is recommended. Underreporting of symptoms is common, due to concerns about disadvantage and discrimination, and as such there may be some value in using lower thresholds to determine referral for a clinical assessment.[10]

In assessing for the risk or presence of PTSD in emergency services personnel, practitioners should consider both the frequency and severity of trauma exposure. Research with police officers suggests that the less frequently a given event occurs (i.e., the less it is considered a normal part of the job), the more it is perceived as traumatic.[12, 13]

The available evidence suggests that prolonged exposure to trauma, or repeated intense exposures over time leads to an accumulated risk (see, for example, Smid et al.[9]). As a consequence, a comprehensive assessment of trauma history is required; the history obtained from emergency services personnel should focus on the lifetime exposure, as well as the immediate antecedent event that may have prompted the presentation for treatment.[10]

Individuals with a work-related disability are often placed in a difficult conflict about seeking assistance because this can lead to significant discrimination and disadvantage in the workplace. This is a recognised difficulty when presenting to occupational health services and has particular relevance for emergency services populations where an adverse health assessment may make the person unsuitable for front-line duties. This situation requires a high level of skill from the assessing clinician. It is important that supervisors who are familiar with the individual's normal disposition and capability have some awareness of the indirect manifestation of the effects of PTSD in the workplace so that appropriate referrals can occur. The health professional needs to have access to personnel records (which may, for example, highlight absences or disciplinary measures for aggression or substance abuse) to assist in a clinical assessment.

Treatment

Limited treatment research has been conducted with this population, although the available evidence supports the relevance of standard treatment guidelines for PTSD.[7] The key recommendations, graded A through D depending upon the strength of the evidence, are:

Psychological interventions for adults

- For adults exposed to a potentially traumatic event, a one-session, structured, psychological intervention in the acute phase, such as psychological debriefing, should not be offered on a routine basis for the prevention of PTSD.
Grade B
- For adults displaying symptoms consistent with acute stress disorder (ASD) or PTSD in the initial four weeks after a

potentially traumatic event, individual trauma-focussed cognitive behavioural therapy, including exposure and/or cognitive therapy, should be considered if indicated by a thorough clinical assessment. **Grade C**

- Adults with PTSD should be offered trauma-focussed cognitive behavioural interventions or eye movement desensitisation and reprocessing. **Grade A**

Pharmacological interventions for adults

- For adults exposed to a potentially traumatic event, drug treatments should not be used for all those exposed as a preventive intervention. **Grade D**
- The routine use of pharmacotherapy to treat ASD or early PTSD (i.e., within four weeks of symptom onset) in adults is not recommended. **Grade C**
- Drug treatments for PTSD should not be preferentially used as a routine first treatment for adults, over trauma-focussed cognitive behavioural therapy or eye movement desensitisation and reprocessing. **Grade B**
- Where medication is considered for the treatment of PTSD in adults, selective serotonin reuptake inhibitor antidepressants should be considered the first choice. **Grade C**

In the aftermath of a critical incident, the provision of peer support as a secondary prevention strategy is recommended. Several guidelines for the implementation of successful peer support programs have been identified, with the overarching principle being the need for such programs to be well planned, integrated, and tailored to the particular organisation, and available to both current and recently serving personnel.[14]

As for other populations who encounter potentially traumatic events on a regular basis, it is important to encourage treatment seeking as early as possible in emergency services personnel. Effective early intervention minimises the development of secondary problems, or the escalation of subthreshold symptoms into disorder, and increases the chances of a rapid return to full functioning. Thus, a supportive and enlightened workplace culture, along with strategies to facilitate early identification, such as screening and addressing stigmatisation in the workplace, are of particular importance.

Once PTSD has been identified, the general recommendations outlined earlier regarding treatment will apply. Specific consideration of the following points may be helpful.

- Treatment planning needs to take into consideration the multiplicity of traumatic exposures that emergency services personnel have had to deal with and the consequent multiple 'triggers' or trauma reminders.
- Many symptoms of PTSD, including hypervigilance, exaggerated startle response, anger, and emotional numbing, can be adaptive and even life-saving in some situations encountered by emergency services personnel. Addressing these issues can be of particular relevance to those individuals who have had a prolonged period of service where these responses may have become ingrained.

A particular challenge when working with emergency services personnel is the potential for further trauma exposure during treatment. In most circumstances, establishing a safe environment is an important precursor to commencement of trauma-focussed therapy, or indeed, any therapeutic intervention. However, it is rarely helpful to remove the person from the work situation altogether. Such an approach creates problems in terms of daily activity scheduling and makes rehabilitation and return to work harder. Rather, an opportunity to perform a different (non-front-line) role at work provides access to organisational and collegiate support, daily structure, and a sense of self-esteem that can greatly facilitate recovery. In circumstances where ongoing exposure cannot be avoided, some benefit may still be derived from trauma-focussed therapy. This should follow careful assessment of the person's coping resources and available support. A model of sensitisation and kindling is a valuable theoretical construct to inform any cognitive behavioural management.

Although empirical evidence is lacking, it is reasonable to assume that decisions regarding fitness for return to normal duties following treatment should be based on an individual's residual pattern of arousability, degree of recovery, and general adaptation. If a significant degree of triggered distress remains, it is probable that further exposures will exacerbate the individual's symptoms. In these instances, it is best to minimise the probability of such exposures and recommend alternative duties. Other factors to consider might include current circumstances (especially support networks within and outside the service), duration and severity of the most recent episode, and prior risk factors (such as adverse childhood, other traumatic exposures, prior psychiatric history). A key additional issue will be the person's wishes – do they want to go back to the same front-line role? It is reasonable to assume that relapse will be more likely if the person does not want to return to their former duties. In summary, for emergency services personnel on sick leave as a result of PTSD, return to work is an important goal of treatment. While avoidance behaviours may pose a barrier for many, research suggests that following a work-related traumatic experience, individuals who return to work are more likely to recover than those who do not. Workplace-based interventions may assist in improving both work and mental health outcomes.[15]

Source and contributors

This information was taken from the Emergency Services Personnel section (p.149-151) of the Special Populations and Trauma Types chapter of the *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder* www.phoenixaustralia.org/resources/ptsd-guidelines/. The Emergency Services Personnel section was developed by Phoenix Australia in collaboration with Andrew Coghlan, National Manager Emergency Services, Red Cross Australia and Professor Alexander McFarlane, Director Centre for Traumatic Stress Studies, University of Adelaide.

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