Intended for healthcare professionals

Career Focus

Post-traumatic stress disorder in doctors

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Abstract

Doctors have an increased risk of developing post-traumatic stress disorder. **Raj Persaud** considers the reasons why and describes the treatments available

Post-traumatic stress disorder (PTSD) is often elicited when a person has experienced, witnessed, or been confronted with an event which entailed actual or threatened death or injury or a threat to the physical integrity of themselves or others.

By the very nature of their profession, doctors, like firefighters and police officers, are much more likely to encounter traumatic events and experiences than most other professionals. While some doctors, such as those in the armed forces, accident and emergency medicine, or acute specialties, are even more likely to witness trauma, no branch of medicine will escape an encounter sooner or later with incidents of an emotional or shocking nature beyond the norm.

Doctors at high risk

Doctors witnessing a traumatic event in the casualty department, such as a patient brought in severely injured from a catastrophic industrial injury or a gun fight, usually have their professional role to fall back on to help them. They can thus temporarily distract themselves from the enormity of what they may be witnessing. Later, however, when they have done their job, feelings and thoughts can run the gamut of shock, denial, rage, anger, sadness, confusion, terror, shame, humiliation, grief, sorrow, or even suicidal or homicidal ideation.

Feelings of inadequacy

One doctor who arrived on the scene in the immediate aftermath of a bomb asked a young passer by to help with the injured. Afterwards he held the belief that he had “broken” this young person's life and had vivid, intrusive images of the “petrified young face.”

Another doctor felt intensely guilty because she had not stayed with a person who was severely injured in an explosion, despite the fact that not much could be done and she herself was under enemy fire. She appraised her role in a negative way and concluded that she was “an appalling, negligent doctor.”

A third doctor initially interpreted his PTSD symptoms as a “severe mental breakdown” and believed that he would never be able to work again. As his PTSD symptoms reduced he became preoccupied with the belief that he must be “weak” to have been affected in this way by his traumatic experience.

As PTSD is a common consequence of exposure to traumatic events such as assaults, natural disasters, severe accidents, and bombings, it is likely that doctors are at high risk for the development of these psychological symptoms. However, since doctors generally do not like to admit to emotional problems many in the medical profession may suffer from PTSD or related symptoms in silence or in secret.

Main symptoms

The main symptoms of PTSD are repeated and unwanted re-experiencing of the event, hyperarousal, emotional numbing, and avoidance of stimuli that could act as reminders of the event. Many of the people who develop PTSD recover without treatment over the next few months, but in a substantial subgroup (30-40%) the symptoms persist, often for many years

Of course, doctors have several advantages compared with most people who experience trauma. They may have a better sense of what is going on when they are witnessing a shocking event and are less likely to be acutely confused. Also, if the incident occurs in a hospital or casualty department the doctor is less likely to be disorientated or bewildered by finding themselves in a strange environment.

Despite this, it is clear from the limited research which has been conducted on medical teams that doctors are vulnerable to PTSD at levels of incidence that might be surprising to the profession.

Research on medical teams

Three years after caring for the victims of a terrorist attack in an auditorium of the Catholic University of Louvain, the 15 members of the emergency team who intervened within the framework of the disaster plan—doctors and nurses belonging to the emergency service of the Cliniques Universitaires Saint-Luc (which is only 500 metres away)—underwent a psychometric evaluation. Two of them (13%) showed key characteristics of PTSD. Five others (33.3%) had pronounced intrusive symptoms of PTSD three years later. These results highlight the considerable extent of the potential post-traumatic sequelae that can be suffered by a disaster medical team.

Risk factors

There have been only a few attempts to investigate high risk occupational groups who, by virtue of their routine work, may be susceptible to developing PTSD. Research has focused on firefighters and paramedics following natural disasters—for example, tornados and volunteer firefighters. There has been little formal research on doctors.

Work on these other professional groups has improved our understanding of the events and variables that may increase the risk of PTSD symptoms in emergency workers. For example, injuries or deaths in infants and children, exposure to gruesome injuries or death, and facing dangerous or unpredictable situations have greater impact. Previous trauma experiences can influence the development and degree of PTSD symptoms—for example, firefighters with chronic PTSD had experienced more negative life events before the trauma.⇓

Credit: SIPA/REX

Negative appraisals

Post-traumatic stress is strongly associated with multiple and recent critical incidents, particularly where professionals feel helpless in their inability to manage the physical or emotional trauma being suffered by the victim.

PTSD becomes persistent when individuals process the trauma in a way that leads to a sense of serious, current threat. The sense of threat arises as a consequence of excessively negative appraisals of the trauma and/or its sequelae and a disturbance of autobiographical memory characterised by poor elaboration and contextualisation, strong associative memory, and strong perceptual priming. Change in the negative appraisals and the trauma memory is prevented by a series of problematic behavioural and cognitive strategies.

So some key vulnerabilities of doctors are often their subsequent feelings of inadequacy when faced with overwhelming trauma, and medical helplessness only adds to the overwhelming frustration of frequently being able to do so little.⇓

Varied presentation of post-traumatic stress disorder

- Recurrent disturbed visitations to a specific geographical location
- Recurrent distressing visual and audible nightmares
- A sudden belief that the traumatic event was recurring—that is, illusions, hallucinations, and flashbacks

- Intense psychological distress at exposure to a specific event—such as anniversaries, location, and media coverage
- Persistent avoidance of aspects associated with the trauma—for example, efforts to avoid thoughts and feelings, activities, or situations that incur memories of the incident
- Psychogenic amnesia—an inability to recall an important aspect of the trauma
- Feelings of detachment and isolation, appreciable behavioural alterations, and suppression of emotions
- A change of mood and sleep pattern; increased irritability; anger; becoming inwardly concerned and less aware of surroundings, family, and work environment
- Possible increase in alcohol or drug misuse
- Physiological reactivity on exposure to events that symbolise or remind a person of the trauma—for example, intense fear of travel and of motor vehicles

Treatment

The treatment of PTSD in doctors entails an emphasis on psychotherapy, which starts by exploring issues of personal protection from danger. Doctors need to feel safe and secure in their job, and to recover from trauma they need to return to a feeling of safety at work.

The worry/rumination thinking style that is present in PTSD leads to constant threat monitoring and avoidant coping (for example, thought suppression). This state is known as “trauma lock.”

The problem with attentional strategies such as threat monitoring is that they fix attention on threat related information, which leads to a sense of recurrent threat and thereby maintains activation of the anxiety programme and strengthens cognitive strategies of threat detection. The individual becomes a skilled “threat detector,” tuning into unlikely threats and failing to retune to the normal threat-free environment.

Postponed worry exercises

To enhance disengagement from daily worry/rumination, postponed worry exercises can be introduced. The sufferer is instructed that whenever they experience intrusive phenomena they needed to acknowledge that the thought, flashback, or nightmare had occurred and then tell themselves that they are not going to worry about it or ruminate about the trauma now, but think about it later. They are therefore instructed to acknowledge the thought and to make a mental note of its content, tell themselves they will think about it later, and then let the thought fade away in its own time. Patients are asked to allot half an hour each evening as their designated worry time.

Ventilation and validation

Another important part of treatment for doctors is ventilation and validation, as in their own way they need to discuss their exposure, sensory experiences, thoughts, and feelings as tied to the event.

Exposure therapy

Exposure therapy has been found to be the most effective treatment for PTSD management. This technique uses imaginary exposure to the sufferer so as to recall the traumatic memories in the therapist's office or repeatedly confront realistically safe situations, places, or objects that are reminders of the trauma until they no longer elicit such strong emotions. The objective of this treatment is that the trauma should be emotionally processed to make it less painful.

While doctors are not usually recommended to attend funerals or other ceremonies linked to their patients, in cases of PTSD involvement in these may help achieve “closure.”

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What would be the most appropriate replacement for the term junior doctors in the UK?

- ○ Postgraduate doctors
- ○ Doctors
- ○ Doctors in training
- ○ The specific phase/year F1, CT1, ST3…
- ○ Non-consultant doctor
- ○ Attending/Resident
- ○ None -- junior doctors is the correct term
- ○ Other:

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