AUSTRALIAN GUIDELINES FOR THE PREVENTION AND TREATMENT OF
Acute Stress Disorder, Posttraumatic Stress Disorder and Complex PTSD

Specific Populations and Trauma Types
Emergency services personnel

This *Emergency services personnel* information sheet addresses background issues and provides presentation, assessment and treatment recommendations for practitioners working with emergency services personnel.

Background issues

A recent national survey of emergency services personnel across Australia found a PTSD prevalence rate of 10 per cent amongst emergency services personnel. This ranged from six per cent in state emergency services workers to eight per cent in ambulance, nine per cent in fire and rescue, and 11 per cent in police.[1] The rates in those who have transitioned is likely to be significantly greater.[2] Also, there is a similar sized population of emergency services personnel who have significant distress manifest as subsyndromal symptoms of PTSD that are at significant risk of further escalation with ongoing traumatic exposures.[3]

The nature of the exposures experienced in emergency services personnel, like military personnel, is somewhat different to that in other trauma-exposed populations. Their operational role entails an expectation of trauma exposure. Further, it is not uncommon for emergency services personnel to work in more than one service type across their career, thus increasing their lifetime exposure to potentially traumatic events. For example, 65 per cent of South Australian Metropolitan Fire Service (MFS) personnel have work experience in other emergency services (police, ambulance, SES or ADF) either prior or concurrent with their employment in the MFS.[3]

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.[4] 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.[4] Thus, many individuals will experience significant subsyndromal distress, which can impair their resilience following future traumatic events and increase the risk of subsequently developing PTSD.[5]

While systems are in place within organisations to minimise the risks of injury, and personnel are specifically trained to deal with threat and danger, these strategies clearly have their limitations.

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.[6,7]

Organisational factors

The particular challenge with these groups of people is to implement treatment as early as possible. Using the principles of secondary prevention, this minimises the development of a series of secondary patterns of adaptation that in themselves can present a significant disadvantage. The systems of care that ensure early identification, such as screening and addressing stigmatisation in the workplace are of particular importance. Recognition of the value to an organisation of maintaining the skill base of highly trained officers is an important priority in encouraging a general attitudinal change within these organisations. Significant experience in dealing with these particular groups is also an important matter for clinicians because understanding the specific culture of these organisations can be central to the development of a positive therapeutic relationship with the ASD or PTSD sufferer.

Screening

Systematic screening potentially has an important role in identifying ASD or PTSD in emergency services personnel who are either engaged in repeated high risk exposures or have had a recent deployment or major event which carries a significant risk of PTSD. 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.[8,9] However, it should be recognised that the emergence of symptoms might be delayed, pointing to the value of an annual health assessment above and beyond an initial screening process.[10] The administration of screening questionnaires should only be seen as a guide to a more systematic diagnostic assessment by a trained clinician.

A range of psychometric instruments has been trialled in police, military, and fire services for monitoring the emergence of symptoms (for example,[7,8). Until these have been more thoroughly researched, however, the use of standard measures such as the Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5)[11] is recommended. Measures need to be flexibly applied in regards to the nature of the exposure, recognising the potential for cumulative trauma rather than focussing on exposure to a sole traumatic event.

Given the issues about under reporting, arising from concerns about disadvantage and discrimination, there is some evidence that lower thresholds should be used in determining referral for a clinical assessment.[12] Any screening process should also regularly interview a fixed proportion of people who are symptomatic, to remove the stigma of referral for follow-up.

Symptom presentation

The presentation of symptoms for this group tends to be somewhat different to other traumatic stress victims. The association between the trauma exposures and the workplace means PTSD often has an indirect presentation in these cases. For example, the individual's difficulties may become manifest as increasing conflict with senior personnel over a variety of operational and disciplinary issues. Furthermore, the individual may have had a prolonged period of symptomatic distress which they have attempted to minimise and deny. The general sense of camaraderie and collegial support in these organisations often

assists the individual in maintaining a façade of functioning. A failed promotion or a disciplinary charge often becomes the focal point around which an individual's distress is manifest and may itself be a consequence of the individual's increasingly disorganised behaviour. The indirect manifestation of the individual's distress can delay the appropriate assessment and diagnosis.

The clinical manifestation of an individual's distress in these situations can occur in a variety of ways, including the following.

- 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.[5]

- Comorbid alcohol abuse is not an uncommon presentation where the individual attempts to self-medicate. The associated interpersonal and work-related difficulties may lead to individuals, other than the person suffering from PTSD, being aware of the difficulties prior to the sufferer.

- Interpersonal conflict with family, and in particular, violent outbursts, is another indirect manifestation that may first be brought to the attention of welfare services from a secondary victim, such as the spouse.

- The individual may initially present with a prolonged period of numbing and increasing interpersonal insensitivity. This can be manifest as inappropriate management of junior personnel or conflict with superiors.

- An intense pattern of distress may emerge in response to a recent traumatic event. The recent event may have some particular similarity to a prior exposure which played an important role in the initial disruption of the individual's reactivity to stress. Hence, the longitudinal pattern of symptoms needs to be assessed, as well as the acute disorganisation in response to recent exposures.

- Individuals who leave an organisation may first present some time after their discharge. The loss of identity and support through the structure of the organisation which has provided the raison d'etre for the individual's functioning, can lead to the progressive emergence of PTSD symptoms, including increasing and distressing recollections and nightmares.

Assessment

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. This requires a high index of suspicion 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 to assist in a clinical assessment.

The clinical presentation of emergency services personnel infrequently occurs following the initial exposure to a single traumatic incident. The more typical scenario is where the individual breaks down after repeated experiences of a variety of traumatic incidents which entail varying degrees of a sense of personal threat often combined with the witnessing of harm or death to 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.[13] Major terrorist incidents, disasters with multiple losses of life, and exposure to gruesome or horrific accident scenes carry a particular risk for such individuals.

The available evidence suggests that prolonged exposure or repeated intense exposures over a period of time leads to an accumulated risk.[14] 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.[12]

Treatment

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. It is optimal that while an individual is receiving treatment, that he or she is not continuing to be exposed to traumatic events of the type that led to the onset of his/her disorder. Ideally, the person should not be given sick leave, but rather, kept in a meaningful role in the organisation that does not expose them to traumatic events that sustain their reactivity and disrupt the treatment process.[15]

Once PTSD has been identified, the standard evidence-based treatments apply to emergency services personnel. 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 methods of adaptation may have become engrained.

- The existence of comorbid substance abuse is a frequent therapeutic challenge. Evidence suggests this should be dealt with alongside the initial control of an individual's symptomatic distress. This approach takes account of the fact that frequent alcohol usage has been a form of self-medication which the individual has used to address their difficulties.

A particular challenge when working with currently serving emergency services personnel is the management of exposure to further stressors in the workplace during the immediate aftermath of 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 collegial 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.

The challenge of determining recommendations for future duties should be based on an individual's residual pattern of arousability 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 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.

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.[16] It is critical to note, however, that the most important predictor of successful return to work following a psychological injury is a positive and supportive response from the employer.[17]

Source and contributors

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