**Post-traumatic Stress Disorder (PTSD)**

**Why is this relevant?**

Covid-19 workers are likely to witness a number of distressing scenes and be exposed to a range of potentially traumatic events. For some, this may contribute to the development of Post-traumatic Stress Disorder (PTSD).

**Core constructs/concepts**

PTSD is a disorder that may result when an individual lives through or witnesses an event in which he or she believes there is a threat to life or physical integrity and safety and experiences fear, terror, or helplessness. Exposure to the traumatic event may be vicarious if the event happens to a loved one/someone under person’s care or if there is repeated exposure to aversive details

People with PTSD, including complex PTSD, may present with a range of symptoms associated with functional impairment, including:

* Re-experiencing
* Avoidance
* Hyperarousal (including hypervigilance, anger and irritability)
* Negative alterations in mood and thinking
* Emotional numbing
* Dissociation
* Emotional dysregulation
* Interpersonal difficulties or problems in relationships
* Negative self-perception (including feeling diminished, defeated or worthless)

Risk factors for developing PTSD include:

* Living through dangerous events and traumas
* Getting hurt
* Seeing another person hurt, or seeing a dead body
* Childhood trauma
* Feeling horror, helplessness, or extreme fear
* Having little or no social support after the event
* Dealing with extra stress after the event, such as loss of a loved one, pain and injury, or loss of a job or home
* Having a history of mental illness or substance abuse

Reported incidence rates for PTSD development in emergency services personnel range from as low as 1% to greater than 20%.

There is little evidence that a trauma-focused debrief is helpful - in fact, research has consistently shown it is ineffective and can even be harmful. There is also no consistent evidence that any formal interventions within the first month of a traumatic incident are effective in preventing the onset of PTSD.

Social support and informal peer support programmes such as Trauma Risk Management (TRiM) and Psychological First Aid (PFA) appear to be effective, though there is limited long-term evidence to support any post-trauma interventions.

**Practical recommendations**

Best practice is to follow the NICE PTSD guidelines (<https://www.nice.org.uk/guidance/ng116>). Those providing support should be familiar with the guidelines.

Instead of immediate intervention, NICE recommend ‘active monitoring’ or ‘watchful waiting’ during the first month post-incident to see whether further intervention is needed. If after the first month an individual is showing signs of distress, further professional support is advised.

Informal peer support provided by trusted colleagues, family and friends is likely to be most helpful in the immediate aftermath of trauma. Try to prepare workers by encouraging them to think about their preferences for who they would want to speak to if they were struggling to cope with a traumatic event.

Leaders and those providing support should continue to monitor staff wellbeing in the aftermath of a traumatic event.

Efforts should be made to try and promote and enhance team cohesion amongst covid-19 workers.

**Relevant literature**

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Brooks, S. K., Rubin, G. J., & Greenberg, N. (2019). Traumatic stress within disaster-exposed occupations: overview of the literature and suggestions for the management of traumatic stress in the workplace. British medical bulletin.

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