Podcast Transcript

Post-Traumatic Stress in Healthcare Workers

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Content Warnings: Mentions of suicide, depression, death, self-harm

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Transcript

Episode 1 – What Does Post-Traumatic Stress Look Like in Healthcare Workers?

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MARIA MORALES (HOST): Hello. And thank you for taking time to join us today. I am Maria Morales with Colibri Healthcare. Our goal for this podcast is to better understand the very real phenomena of how post-traumatic stress affects healthcare workers. We all know that the healthcare system brings its own unique challenges for delivering quality, safe, and cost-effective healthcare. However, what happens when deliverers of healthcare, the healthcare workers themselves, exhibit symptoms of stress, post-traumatic stress, or even post-traumatic stress disorder? What do these symptoms look like? Do we feel we could accurately identify signs or symptoms that colleagues display? How frequent or common is post-traumatic stress in our very own healthcare team members?

I am joined by an expert in behavioral health and improving healthcare for underserved and diverse populations, Dr. Daphne Essex. Dr. Daphne Essex is a dual certified psychiatric mental health and family nurse practitioner with a doctoral degree with an emphasis on improving healthcare for underserved and diverse populations.

She treats clients with various behavioral and medical disorders. She is a 33-year military veteran and is a member of the Nurse Practitioner Alliance of Alabama, the American Psychiatric Nurses Association, the American Association of Nurse Practitioners, and the Advanced Practitioners for the River Region. What are some other experiences or interests that you would like to tell us about yourself that you bring to the table for this topic?

DR. DAPHNE ESSEX (GUEST): Thanks, Maria. So, greetings to all who are listening to this podcast on what does post-traumatic stress look like in healthcare workers. In addition to the said bio, I have a master's in nursing and adult education as well as psychiatric nursing. I have worked in various settings throughout my career as a nurse practitioner to include emergency and correctional medicine, family practice, as well as with the active military and veterans. Currently, I am a contributing faculty teaching prospective psychiatric nurse practitioner students.

MORALES: Well, you certainly have much experience to help explain more about this topic for us and help us to spread awareness about these matters.

ESSEX: Well, I have certainly enjoyed, and I'm continuing to enjoy my professional journey in behavioral health. The field of behavioral health is so diverse and varies on this wide continuum spectrum that goes from mental wellness to mental illness. I firmly believe if the mind can function at its fullest potential on the wellness end of the spectrum, we would have less psychological stress and negative behaviors, less pain and violence as well.

So, our overall physical health would be great. We could improve our resilience and just have a better outlook on life as it relates to self and others.

What we do know is that the mind can go from wellness to illness in a matter of seconds. The mind is very powerful, and the way we think is so interesting. I'm delighted to have chosen this career path.

MORALES: Oh, that's great. And what a great point you made: the mind can change quickly. So, we know health is not a static thing or a static condition. We have to continually interact and respond to the changing world with

a physical body and an intangible mind that changes too. So, this reminds us even more how we should monitor and maintain our mental and physical well-being.

Thank you, Dr. Essex, for sharing with us and being here today. Let's go ahead and jump more into this conversation. So, we're going to start off with a discussion of symptoms and characteristics of stress, post-traumatic stress, and post-traumatic stress disorder. Please tell us about post-traumatic stress symptoms known as PTSS and post-traumatic stress disorder known as PTSD.

ESSEX: I want to start by simply defining PTSD according to the Diagnostic and Statistical Manual of Mental Disorders, also known as DSM, which is now the DSM-5-TR, which is a text revision. So, in order to be diagnosed with PTSD, the adult, child, adolescent, or the healthcare workers in this case, must develop symptoms after being exposed to one or more traumatic events.

It's so important to know that each individual responds differently to PTSD, and the response is normally provoked by situations, the past coping strategies, support systems. Although our focus here is on healthcare workers, we know that healthcare workers must meet the same criteria as any other individual, as outlined by the DSM criteria for PTSD. We do realize that the PTSD onset can be considered acute, chronic, or delayed in these individuals.

MORALES: Please tell us more about that, the differences between acute, chronic, or delayed.

ESSEX: So, in the acute phase of symptoms normally lasts less than three months. Then, you have your chronic PTSD symptoms which are usually greater than three months. And with a delayed onset of PTSD, those symptoms are at least six months after the occurred stressor. So, identifying which phase the healthcare workers is in very significant, because the longer the individual goes without treatment, the longer and more intense the treatment or the therapy may be for that healthcare worker.

MORALES: Okay, so there could be a stressful, traumatic event, and some people may not experience symptoms until possibly months and months later?

ESSEX: Yes, this is true. Not only months, it can be years; so, often when delayed to this extent, the individual might have suppressed a lot of the symptoms and has some type of trigger that exacerbated the signs or the symptoms of the PTSD. Now, PTSD doesn't look any different in healthcare workers than it does in non-healthcare workers.

PTSD is PTSD regardless of the individual. So, the symptoms will either look the same or have some similarity. We use the DSM as a guide to assist with diagnosing the PTSD. Now, there are diagnostic criteria outlined in the DSM. However, you have to assess and evaluate the presentation of the individual. Not everyone's symptoms will be identical as laid out in the textbook.

However, it is our diagnosis Bible guide. So, to have the diagnosis of PTSD, for at least one month, the adult must have the following or some responses to validate the symptoms. And some of these responses include having at least one re-experiencing symptom like flashbacks, bad dreams, memories, or those frightening thoughts. Also, there must be at least one avoidance symptom, which that person may stay away from places that remind them of the experience, or they might avoid the thoughts or the feelings related to the situation.

There must be at least two arousal or reactivity symptoms when the individual is easily startled or feeling intense and on edge, they might have outbursts or have difficulty sleeping as well. In addition to all of these, there must be at least two cognition and mood symptoms, such as having trouble remembering key events, having those negative thoughts of self and of the world, guilty feelings, blame. There's loss of interest in things that are or were normally enjoyed at one point in that person's life.

MORALES: Wow. Okay. Well, now that you have told us about PTSD, let's step aside for a moment to mention post-traumatic stress syndrome and post-traumatic stress. What is the difference between these two? Is post-traumatic stress more like a layman's term for stress, or does it have a more psychological or medical definition?

ESSEX: Now, some may use these terms interchangeably. However, there are some slight differences in each one, when we use the word syndrome, we're looking for signs and symptoms of a pattern or occurrence that the illness might follow. In addition, a syndrome might have a pathological or disease-causing source. So, when we use the term post-traumatic stress, you often think of an event or situation that has happened or caused the individual to respond or react in a way that doesn't appear normal. So, the person's coping abilities are usually altered in some way. PTSD, which is the disorder ... encompasses the syndrome, the stress, the mood, thinking abilities, and behaviors of the person. So, in other words, it covers a multitude of signs and symptoms related to the issue. So, we have talked about the criteria for PTSD and provided some examples and descriptors for each to assist with making the diagnosis.

So please understand that the DSM is only a guide. The most important thing to be evaluated is the presentation of the healthcare worker. Being, the other disorders may be a factor with the healthcare worker presentation; so therefore, the subjective and objective component of the interview is very important, and it might take several visits to make the diagnosis.

MORALES: Are there some other differential diagnoses or situations that a person could be experiencing that look like PTSS or PTSD? ... or, that might also be a concern when a person is suffering with PTSS or PTSD?

ESSEX: So, in behavioral health, some of some diagnoses actually overlap. However, some symptoms are more pronounced than others. For example, clients with PTSD are most likely to present with mild to severe forms of anxiety or depression. Both the anxiety and depression would need to be treated. But with the assistance of the client, if that is possible, a determination should be made regarding which one of these symptoms are most destructive or traumatic to the client. So as a provider, we have to be mindful of other disorders that might exacerbate symptoms that resemble PTSS or PTSD.

MORALES: You've made some clarifying statements and good points to keep in mind. A couple things stick out to me. So, one, people, patients, clients, they might not present a textbook presentation, just like patients don't always have the exact same symptoms or the exact same severity of various symptoms when they have a disease or an illness. People can present within a range of symptoms when experiencing issues of a mental or behavioral health nature, just like physical conditions.

So, for example, I was thinking everyone with appendicitis may not present with the same description of pain or the same body temperature or otherwise. But there's a common range of signs and symptoms for which a healthcare provider might consider appendicitis as part of the differential diagnosis. So, with psychologically-related diagnoses, a range of different presentations is possible as well. So in general, I'm just curious, do you find practitioners more concerned with missing a psychiatric diagnosis or over-identifying one?

ESSEX: So in general, practitioners are more concerned about self-injuries or self-harm of the client that may lead to death by suicide. However, it is our intent to get the most accurate data from the client or significant other so an effective treatment plan can be generated as soon as possible. This is when the interview skills and behavior screenings become very important, because there are other psychiatric diagnoses that mimic PTSD.

This may be because PTSD is an umbrella to anxiety and depression, which, if left untreated, can lead to or mimic other syndromes or other disorders. It's awesome to have treatment regimens that can simultaneously tackle both the anxiety and the depression.

MORALES: Okay, the second point that stuck out to me as I was listening was about isolating or discerning the most destructive or traumatic symptoms. Ideally, I guess we would want to address all issues, all concerns, and help people increase their level of health and well-being. But, treatment takes time. It's a process. Sometimes a starting point has to be decided.

ESSEX: Yes, we must start somewhere. So, this is not always an easy process. You must first build that relationship with the client and approach the client in a way so they will open up to you. Sometimes you only have that one opportunity to make a difference. We only know what is being told, and we try to put that with an observation.

So, sometimes the subjective information and objective match up, and sometimes it doesn't. So, this is why it's important to provide patient-centered care. Ask the client, "What would you like to accomplish at this visit? How do you want to feel? What changes do you think you can make to get your highest level of functioning?" It's surprising how some clients don't go deep into the foundation of their problems.

This is often, this is when psychotherapy becomes an important aspect of the treatment plan. Psychosocial assessments become an important key to the treatment process as well. So, the ultimate goal is stabilize the individual in efforts to get the individual back to the wellness end of the continuum. So, in the DSM, there are at least nine differential diagnoses that are listed to rule out before being diagnosed with PTSD.

We look at acute stress disorder. This occurs like three days after the traumatic event, but only lasts 30 days or less following the event. You have your adjustment disorder, which may or may not meet a part of the PTSD criteria. Examples: divorces, the loss of jobs, lost loved ones. Then you have anxiety disorder and also your OCD, which is obsessive compulsive disorder. They're repetitive, intrusive thoughts that are not related to any type of trauma. You have major depression. Depression may or may not be a result of trauma. You have personality disorder. These internal difficulties may be exacerbated by PTSD, but the symptoms were present prior to the traumatic event. Then, you have your dissociative disorders. These may or may not be a result of trauma.

ESSEX: Sometimes this could be a result of a major depressive episode. You also have your conversion disorders, which is like a neurological function issue. Then we have your psychotic disorders such as your bipolar and your schizophrenic disorders, and you also have your traumatic brain injury. So, the client may also present with sleep issues such as insomnia, have nightmares they that may be a result of PTSD or one of the differentials. Again, it is important that we be as detailed as possible when obtaining subjective and objective data from the client.

MORALES: Is there a way to give a concise overview of when a person might cross over from exhibiting symptoms of stress in general to a more complex, serious issue? Can you discuss differences for us between potentially traumatic events and PTSD?

ESSEX: To answer this question, we never know what experience an individual may encounter that would cause them to convert from being able to cope with daily stressors to having PTSD. So however, what we do know is that unresolved stressors such as the repetitive stress that healthcare workers encounter during the height of COVID-19, which lasted more than 30 days, were factors that may have been a cause for the healthcare worker to cross over from just having an acute stress reaction or disorder, which is a result of a 3 to 30 day post-exposure, to having PTSD, which is a result of symptoms lasting greater than a month.

So, there are several protective factors that may prevent the healthcare worker from having a moderate to severe form of PTSD. Some of the protective factors could be a result of genetics or having that great support system. Their age could be a factor. Having children, being married. Some identified potentially causative

factors of PTSD are a result of symptoms lasting more than a month, causing significant distress and interrupting the daily function of the individual. These can be a result of natural disasters, serious accidents, terrorist acts, war, combat, rape, being threatened with death or sexual violence or serious injuries.

Now, these events can potentially cause PTSD. However, we would not know if the healthcare worker would develop PTSD from the causative factors until they present with some or all of the symptoms as identified in the DSM, as we discussed earlier. So, if a client had experience with one of the causative factors, then the client is most certainly a high-risk candidate for PTSD.

MORALES: That is very interesting to see there are commonalities, but there's so much that's so individualized from person to person. Could you describe a scenario for us illustrating how a healthcare team member might be progressing down the road of post-traumatic stress? How might they come across to others or interact with others?

ESSEX: So, what we do know is our experiences helped to shape us, whether it's in a positive or negative way. The healthcare worker might mention during a conversation that they might have been experiencing nightmares or unable to get certain memories off of their minds, continuing to talk about the death of clients or the scene of the trauma and having or expressing that feeling of guilt. The healthcare worker may also attempt to avoid taking care of a dying client.

Their thoughts might become distorted, and the healthcare worker might start making medical errors, providing substandard care, or being unable to remember situations. So, the client or the person's hygiene might also become a factor. The high energy coworker personality may no longer be. They may no longer be positive, or the worker is no longer experiencing that happiness that you normally see.

They look tired all the time and irritable. So, a coworker being able to know that there has been a change is a start in the right direction.

MORALES: Okay. If you can, please paint a picture for us of how this kind of stress in a team member might go unrecognized until symptoms were undeniable or obvious.

ESSEX: Okay. So, what we know is that PTSD has many faces. It may be difficult to immediately identify signs of PTSD in your peer being that you may only be with them during certain shifts or workdays. However, if you are able to identify a change in the peer's behavior or their mood, their job performance, and their social stance, from what you do know, there's a possibility that the team member may have PTSD, especially if you know they have experienced some type of traumatic event or have one of the previously identified positive factors.

So, some individual symptoms are less noticeable than others. Some symptoms are more progressive. Some have constant symptoms that may range from mild to severe. Again, the symptoms will vary from person to person and may be acute. They could be chronic or delayed like we previously talked about. Therefore, healthcare workers should be educated on symptoms of PTSD and maintain surveillance on each other.

Generally, they may fall into the re-experiencing symptoms such as having those flashbacks or the physical sensations, such as sweating, feeling sick or numb, and that pain. They could have hyperarousal, being anxious and can't relax, just easily startled, always on edge, and having those avoidance issues.

MORALES: Well, thank you for telling us so much about the symptomatology and related factors. At this point, why don't we go ahead and transition to talking about prevalence now? So, do you have any statistics or other data for us to help us understand the prevalence of post-traumatic stress, specifically in healthcare workers? Is there data like that out there specifically for healthcare workers?

ESSEX: So, PTSD is one of the most commonly reported psychological health conditions, reported approximately like 21.7% in healthcare workers. The majority are females under the age of 60, in urban areas. These numbers vary, according to the study in the location. So, the report of PTSD was like 14% versus 21% in healthcare workers versus those non-healthcare workers.

Anxiety disorders are reported to be 13% versus 20% in healthcare workers versus your non-healthcare workers. And major depressive disorder was reported to be at 9% in healthcare workers versus 15% in your non-medical personnel. So, the highest prevalence of anxiety and PTSD were found among those under 40 years of age and having the lower educational status.

So, please keep in mind that these numbers will vary depending on the part of the world that you're in and the size of the sample that actually participated in the study. So, some of the studies that were done were based on work areas in the hospital, those who worked with COVID patients versus those who did not were reported to have PTSD or some type of psychological disorder at a rate of like 28.7% versus 13% respectively.

So the intensive care healthcare workers would differ from the frontline workers versus the medical-surgical workers. Again, there are so many variations in these percentages based on psychosocial circumstances.

MORALES: Wow, I did not know that PTSD was the most commonly reported psychological health condition. I mean, a number in the 20% range is indeed significant. How does that compare to burnout or suicide statistics for healthcare workers?

ESSEX: As we continue to look at burnout and suicide statistics, we must not forget that the healthcare industry was already facing a shortage of workers. Healthcare workers were experiencing burnout, stress, and unreported psychological challenges prior to the pandemic. What the pandemic did was exacerbate these symptoms. If there were system failures related to leadership support, it worsened. Burnout … increased. Your stress increased, and more injury was more pronounced. … having to choose who would get that last ventilator. Which client or patient may need the most care at this moment? What we do know is that new symptoms either developed or were exacerbated by the pandemic. Now, there was a study from nine intensive care units in the UK which indicated that 13% of healthcare workers had contemplated suicide or some type of self-harm during the pandemic.

The suicide ideation rate among healthcare workers in Europe and Asia were estimated to be from 3.6 to 11%. In Australia, an online study was done on like 10,000 frontline healthcare workers and one out of ten healthcare workers reported thoughts of suicide or self-harm over a two-week period during the second pandemic wave that we had. Healthcare workers were identified to have more psychological stressors as compared to the general population.

So, prior to the pandemic, depression, anxiety, traumatic stress conditions, suicidal thoughts, and self-harm had increased as compared to the general population. There was a pre-pandemic study called Beyond the Blue in Australia that indicated 10.4% of doctors had suicidal ideations over a 12-month period. A study done nationally indicated that female healthcare professionals, male nurses, and midwives have higher suicide deaths than other healthcare workers.

Causative factors were high work demands, the long hours, the workplace violence exposure, and there was lack of organizational support. We do have to keep in mind that there were other pandemics and incidents that had already caused psychological stress in healthcare workers previously. So, stigma related to having these psychological stressors and the stress had a great hinderance to the needed care and prevented healthcare workers from coming forth for assistance.

MORALES: I feel like we need to take a moment to respectfully think about this. That's some serious information. Those frontline healthcare workers, those in the trenches, so to speak, those who assumed more risk than usual to care for others during a pandemic. Not only was there a risk of working with a virus we didn't fully understand at the time, but there was also the exacerbated stress which could open the door for psychological distress. This really makes the situation that much more complex and more of a risk to our fellow healthcare workers. We certainly do need to keep in mind the need to take care of our own as we take care of others. But let's go ahead and continue discussing some more topics along this path.

It seems like there are many that have left their jobs or even healthcare altogether. There's still plenty of still practicing professionals, but it seems like many have left.

ESSEX: Okay, so burnout along with moral distress have been factors in healthcare workers actually leaving the profession or their area of specialty. For instance, so you have ICU nurses reporting an extreme amount of stress in the work area. You had clients on ventilators with multi-organ failure for long periods of time. The mortality rates in one study were reported to be as high as 97%.

There were barriers in the system that limited the healthcare workers' ability to provide that safe and effective care. There were the lack of your PPE, which is your personal protective equipment, ventilators, family visitation was limited, or there was no visitation at all. There were concerns about the safety of yourself, fear of contracting COVID, or even giving the virus to loved ones and causing death.

Now, keep in mind that there have been previous infections, outbreaks, such as your MERS, SARS, Ebola, terrorist attacks, Hurricane Katrina, and the day-to-day operations that contributed to anxiety, depression, PTSD, burnout, and what we call moral injury or moral distress. I would like to provide the statistics from a study that was done in China, where it was said that the virus responsible for COVID-19 originated.

So, the statistics are the before and after mental health challenges that critical care nurses faced prior to and during the pandemic. Remember, we're still in the pandemic, so the stressors are still with us. So, you had anxiety, there was 11% before ... reported cases of anxiety versus 45% now with mental health challenges. With depression, there was like 13% versus 50% now with mental health challenges. Then you have 71% report distress, there was no report pre-pandemic on moral distress. PTSD, which was 33%. There was no report of the pre-pandemic PTSD in this study.

MORALES: So, based on what you just said as a ballpark way of looking at things, anxiety more than tripled, depression skyrocketed. And it seems fair to say distress and PTSD rose considerably. That's serious. You mentioned moral distress. Can you describe that some?

ESSEX: Um sure, so moral distress is based on ethical decisions or choices, not knowing if the right decision was made during that time. Moral distress is mental confusion with not knowing what is right or wrong at the time. During this time of the pandemic, there were a lot of decisions that had to be made that were uncharacteristic of that provider or the caretaker based on the circumstances.

So, this could be as simple as not spending enough time with the client or not being able to spend adequate time with the critically ill or the dying client. Who would get that treatment first? If you have several who are critically ill, do I spend more time working on this 20-year-old versus the 34-year-old that has a spouse with kids? Who's going to get this last ventilator that's left? These types of decisions are difficult to triage when there is a mass amount of people presenting at one time.

MORALES: Yes, very difficult, very serious. With the info discussed so far, do you think the pandemic has contributed to an increase in post-traumatic stress?

ESSEX: So, based on research, yes, post-traumatic stress has increased and will increase due to the pandemic. Remember, some PTSD symptoms are delayed and may take the individual years to acknowledge that they are experiencing post-traumatic stress symptoms.

MORALES: Great point, Dr. Essex. All may not have been revealed or come to light yet as far as the toll on psychological or mental health that the pandemic has taken.

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MORALES: Well, it's time to wrap up for now. We discussed symptomatology and prevalence information about post-traumatic stress with a focus on healthcare workers. Thank you for joining us, and I hope you will come back as we continue with topics such as COVID-19, contributing factors for post-traumatic stress, and interventions. A sincere thank you to Dr. Daphne Essex. This is Maria Morales for Colibri Healthcare.

SOUNDBITE OF MUSIC

Episode 2 – Doing Something about Post-Traumatic Stress in Healthcare Workers

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MORALES: Welcome back for Post-Traumatic Stress in Healthcare Workers. I am Maria Morales with Colibri Healthcare. And back with me is Dr. Daphne Essex. We are going to continue the conversation about the influence of the COVID-19 pandemic. We will also talk about contributing factors, interventions, and strategies for how the healthcare team can facilitate conversation about this topic and possibly work together to address it. So, let's talk about some of the things we can do about post-traumatic stress. So, Dr. Essex, do you have any stories you would be able to share about some of the experiences of healthcare workers and maybe the additional stress or emotional toll of caring for patients or clients during the pandemic?

ESSEX: So, on a personal note, caring for clients during the pandemic was highly stressful. I was working with a younger, healthy adult population. The attempt to strategize preventive processes, prevent cross-contamination, manage those who were positive in isolation, those who were quarantined as a result of being in close contact, having to make those daily calls to ensure they were physically and mentally okay during the entire process was very demanding and stressful, knowing that individuals were in isolation or quarantine for 10 to 14 days or longer, depending on the symptoms.

I was the subject matter expert for the mission. I lost sleep, worked considerably long hours, worried about the safety and the health of others, trying to assure no one's health declined under my surveillance. I had over approximately 200 clients rotating in and out every couple of weeks. I was literally traumatized and felt ill mentally as well as physically.

I was asked to return to assist with the mission again the next year, and I remember tears coming to my eyes for just being asked. I asked myself, "How do I survive?" I recall feeling ill, because I was so tired mentally and physically. I remember when the mission was over, I literally could not move. It was this like a temporary conversion issue.

My stress was affecting my family members. Talk about an experience! I dealt with supposedly healthy individuals. However, having to deal with their fears, my fears, and trying to educate myself and those around me …. The anxiety was high, and we know too much anxiety can cause mental distortion. On another note, I did

have an interview with an OBGYN provider who provided care and reported the stresses of having pregnant women on ventilators and working long hours to ensure the safety of the mother and baby.

Having to limit exposure and keep the conversation to a minimum were stressful. The constant calls that she remembers, the postponed surgeries, caused surgical cases to be backlogged. The provider was fortunate to not have any loss of any clients. However, the provider did work with a diverse population group and feared for her safety with having to go back and forth between healthcare settings.

She reported having trouble sleeping, having anxiety and having, as I, to this day. So again, not only is there a management of work issues, there are those personal and family issues that have to be managed as well.

MORALES: Well, I'm sorry, Dr. Essex. I mean, that's a lot. My heart goes out to you. I want to thank you for your dedication. And I would imagine there are so many healthcare workers listening who empathize and understand in some way with what you've described in your personal experience and what you described from this other provider's experience.

There were so many additional responsibilities outside of the usual when it comes to the pandemic. And that is a lot. That's a lot of weight to carry. Do you think healthcare in general is just an environment where healthcare workers are at increased risk for this kind of stress anyway?

ESSEX: From research, we can see that healthcare workers are at risk for PTSD. However, some symptoms are presumed mild, or the resilience factor is high. A routine day to day operations with a few bad days are considered normal and tolerable experiences. However, there are workers who may work in the ICU or E.R. or hospital setting for a brief period and realize the hospital setting, or that specific specialty area, was not for them because of different internal or external reasons. For whatever the reason may be, it might not have been reported.

So, do we really know if it was because of a previous traumatic experience or the stress of the job? In some cases, I'm sure we could say both.

MORALES: You mentioned the word resilience. Personally, I find resilience a fascinating topic. Thresholds for when a stressful or traumatic event crosses that line from stressful to traumatizing, from something we can cope with to something that exhausts our coping mechanisms, from an unpleasant experience to a truly, majorly life-changing experience …. It depends on so many factors. How do you describe resilience?

ESSEX: So, resilience is important. It is how you overcome an obstacle or situation in a positive way. It's a bounce back to normal or even more greatness. So, resilience reveals your courage, your strength, and abilities to continue to move forward.

MORALES: That's good. What are some more examples of the way COVID-19 seemed to increase psychological distress for healthcare teams and teammates?

ESSEX: So associated occupational stressors from the pandemic represented some major issues. The healthcare workers posed a risk to clients when they are mentally distressed. Possibilities are medication errors, lowered standard of care, compassion fatigue, there could be decreased productivity and an overall lower quality of care. It has been indicated that from 21 to 94% of hospital personnel with PTSD have co-morbid depression, which might have preceded the PTSD. Sometimes comorbid conditions may worsen the PTSD symptoms.

MORALES: Wow, everything is so connected. Anything else you would like to share with us about the impact of COVID-19?

ESSEX: There was one study that resulted how healthcare workers were infected with COVID-19 and recover. They had a higher rate of psychological symptoms versus those who were not infected. So, this was related to the fear of reinfection. So, would there be survival the next time I get infected? Infection of the family, being isolated. These findings revealed that the healthcare workers have more depression, anxiety, stress, avoidance, and those PTSD symptoms. We also know there are cases of what we call long haul symptoms related to having had COVID. Long haulers can have both physical and mental challenges related to having had COVID-19.

MORALES: What you're saying reminds me of the resilience discussion earlier and something else too. Once we have experienced something, sometimes it's easier to believe it can happen again versus someone who maybe has never gone through something before. Sometimes realizing a negative experience could be repeated can cross the line from just knowing about something to actual like fear, worry, and anxiety that it could happen again. Do you think that's a fair statement?

ESSEX: I would have to agree. In addition, if the individual is not effectively coping with the fears, worry, or anxiety, this will lead them to being diagnosed with a disorder which could become a chronic condition that will require ongoing interventions and treatment.

MORALES: Hmm. I see. How practical are resources for healthcare workers? There was a physician, a psychologist, and a nurse who were discussing the topic of this podcast, and the topic of resources came up. Some organizations might have better resources for staff than others, of course, and sometimes it seems like there's signs displayed where healthcare workers work, you know, maybe break rooms or public areas, to help increase awareness about stress and wellness. Sometimes there's pamphlets that are provided. If a healthcare worker just sees flyers or pamphlets, what would be a good next step to seek for more information?

ESSEX: The worker would need to look into the support their organization is offering. Hopefully, the larger organizations have already implemented a process to prevent or assist the healthcare worker to return to normalcy. Some of the small organizations might not have a process but should have co-joined with some of the large organizations to aid in treatment for their staff.

Otherwise, there are 1-800 numbers to call such as the National Alliance on Mental Illness, which is also called NAMI, or at 1-800-950-NAMI or 1-800-950-6264. They have available resources. There's also the suicide crisis hotline at 1-800-273-TALK or 1-800-273-8255. There is also a three-digit number that can connect an individual to the lifeline by dialing just 988, and there are several reading materials and therapeutic podcasts or media sessions that individuals could listen to or read based on preferences as well. There is also online resource support available.

MORALES: What about other people resources? It seems sometimes that healthcare workers may not use people resources that are available to them, like chaplains, therapists, counselors. Many organizations or hospitals have some kind of employee assistance program or employee assistance benefit through their employers. Do you recommend these sources of help early on?

ESSEX: So, any type of support that's considered positive will be a great help. What we do know is early intervention is the key to prevention.

ESSEX: I would definitely say that healthcare administrators and the healthcare workers share responsibility in the development of a program that could best support workers during crises such as the COVID-19 pandemic. The program should be available or operational to assist those healthcare workers who may have encountered psychological stress from day-to-day operations as a worker. There will always be some type of traumatic event periodically, such as death while working in healthcare. However, the magnitude may not be as great as it was with the pandemic. So, as we move forward in a day-to-day routine, a traumatic event might be a PTSD trigger

that may cause the healthcare worker to spiral down quicker than usual. Therefore, organizations should be moving quickly to have supportive services, implement it, or be in the process of being operational to handle these type of situations.

MORALES: In your opinion, do you think these services in people which are willing to help are underused?

ESSEX: Certainly, I do. We know that there are adequate personnel on staff to develop a crisis intervention team or behavioral health team to support their own or neighboring employees, such as psychiatrists, psychologists, social workers, chaplains, behavior specialists, counselors. There are many approaches that can ... that a team could work together to form that cohesiveness, to improve or to increase or improve resilience in the healthcare worker. In order for an organization to be a success, it would need a large percentage, if not all of the staff, to be on the end of the continuum called mental wellness.

MORALES: That is interesting. Let's shift right now and talk about contributing factors. Can you describe for us some more that may contribute to post-traumatic stress?

ESSEX: I would have to say, in addition to the burnout and stress, moral injury related to a feeling of guilt based on decisions that had to be made to sustain life, the healthcare worker's inability to respond adequately, and the violation of the healthcare worker's values. Another mental health challenge would be compassion fatigue, in which the healthcare worker is too tired to care or have the usual compassion due to mental and physical exhaustion.

So, this can cause one to feel overwhelmed, which in turn can lead to major depressive episodes and anxiety. So, both of these disorders can fall under PTSD.

ESSEX: It has been determined that older adults have been found to have better mental health coping strategies than younger adults. This may be a result of their learned abilities to cope or adapt to life-changing events from a professional and psychological standpoint. The lack of PPE was a major concern during the COVID-19 pandemic. Factories had to close down, and this seriously slowed production, and resources became scarce.

ESSEX: So, burnout increased among our healthcare workers. One study indicated stress levels started to decrease when PPE resources increased. So, the burnout risk factor was a result of physical and mental exhaustion. So, this was definitely a major concern that would require organizational support, because as there is a higher probability of a decrease in quality of care as well as opportunity for the worker to make detrimental errors or mistakes under these type of circumstances. The long work hours, working short staffed, or not having not having enough PPE were definitely stress-inducing concerns. There were issues with ethical dilemma, which is the moral injury ... and the compassion fatigue that we talked about already.

ESSEX: There was one meta-analysis study that indicated sociodemographic risk factors, such as being a female and young in age, having that prior mental illness such as depression and anxiety and mood disorder and lack of or not enough social support. Also included the worry, burnout (which has been previously mentioned), the interpersonal problems, and the individual's belief system.

MORALES: Hmm. If those factors you mentioned can increase risk, are there any characteristics that are more protective in nature to help a person lessen their risk for post-traumatic stress?

ESSEX: Again, being married with that good support system or just having a good support system regardless of marital status, health, having seniority, whether it's career or age in organization, having that resilience and a history of having effective ways to cope with issues or crises. These are factors that can help a person. Having that organizational support is also a great protective factor.

MORALES: Let's shift the discussion to interventions. So we know the power of evidence-based practice. Please tell us some of what the evidence and research say about non-pharmacological interventions.

ESSEX: I will briefly talk about a few of the non-pharmacological interventions that can be used to minimize trauma, and noninvasive treatment is almost always considered the preferred treatment. Evidence-based treatment programs that have shown therapeutic promise are your cognitive processing therapy, which is CPT, your prolonged exposure therapy, cognitive therapy for PTSD. You have your eye movement desensitization and reprocessing. Then you have your therapy pet and your family support.

MORALES: I would think therapy pets and family support would be really well known or more familiar. But can you tell us briefly or give us a light overview about some of the others you mentioned?

ESSEX: So, your cognitive processing therapy, clients are good at self-blaming. So, thinking if you had only done this differently, that person would still be alive. So, CPT assists with altering the mind to accommodate new belief or way of thinking. CPT is a trauma-focused psychotherapy protocol and is the most frequently researched therapy. It has been shown to be effective in complex PTSD cases and has been highly recommended for use in clinical practice.

You have your prolonged exposure, which is based on emotional response related to the fear. It encourages the individual to talk about the fear, situation, or place that has been avoided in the past that caused distress. This is done in real time or using an imaginary approach. The goal of PE is to distort erroneous information and help the individual confront the fear.

You have cognitive therapy for PTSD. Now this therapy includes CPT and your PE, which is your prolonged exposure, which is based on cognition and behaviors. So, the goals are to modify the negative behaviors and thinking and the trauma memory and remove the problematic behavior and the thinking. So, then you have your eye movement and reprocessing therapy.

So, the patient, their acute engagement may include a short image exposure of the incident using the imagination with back-and-forth eye movements for processing the traumatic event or there can be use of hand taps with the use of a stim machine. So, the bilateral stimulation keeps the left hemisphere of the brain engaged while processing the emotional memory that is stuck over in the right hemisphere of the brain.

So, the goal is for self-mastery of the experience processed in the memories and triggers and teaching the client appropriate social interaction skills. So, you want these clients to be able to respond appropriately to situations that are triggers and to effectively adapt to the challenging situation.

MORALES: That's interesting. I think I'd like to read more about that. When would you recommend someone take advantage of some of the non-pharmacological interventions? I'm going to assume earlier is better than later, as you mentioned previously.

ESSEX: Yes, wellness recovery interventions should be started sooner than later. Early identification and intervention usually promote a better outcome for the individual.

MORALES: Why don't we talk about screening? What kind of screening tools are available for post-traumatic stress or PTSD?

ESSEX: So, there are several screening tools that are available. Screening tools provide opportunities for clinicians to develop a picture of clients to adequately diagnose and determine the treatment options. These tools are also available online and can be self-administered. Utilizing different screening tools by different

clinicians could sometimes lead to bias with diagnoses, because the client experience may or may not fit into one screening category.

However, the purpose of the assessment is to assist with symptom recognition, frequency, your timeframe, and the severity of the issue. So, treatments based on symptom assessment and the presentation of the client. There is a list of diverse screening questionnaires for mental health assessment that may include, but they're not limited to, some of the ones that I will mention.

One of the most common ones that's used is your patient health questionnaire, which we call the PHQ-9, which measures depressive symptoms over the past two weeks on a scale of zero, which is not at all having issues, to three, which is your having the issues nearly every day. Then you have your PTSD checklist for the DSM, which is a PCL-5, which is rated on a scale of 0 to 4.

So, the PCL evaluates the severity of the symptoms using like a 20-item self-report of the issue. You have the trauma history questionnaire, which is the THQ. This is a 21-item to self-report measure to evaluate trauma over a lifetime of when the event occurred. You have Posttraumatic Cognitions Inventory (PTCI) which measures thoughts and beliefs about self and others post-exposure.

There's a 33-item self-report scale for this one with a rating of 1 to 7 in which you could totally agree or you can totally disagree. You also have the Alcohol Use Disorder Identification Test (AUDIT). You might have heard the word AUDIT-C, which is a three-item version of the full AUDIT 10-item screening tool to identify those with excessive alcohol use.

There's the Drug Abuse Screening Test, the DAST, which identifies nonspecific use of drugs. And also there's the Michigan Alcohol Screening Test, which is called the MAST screening tool, which also measures the severity of alcohol use. We use the CAGE questionnaire, which is a brief screen to detect alcohol use. And also you have the Columbia Suicide Severity Rating Scale (CSSRS), which measures suicidal ideations and those suicidal behaviors among individuals.

MORALES: That was a lot of information. Thank you for putting that together for us. So, since we've discussed non-pharmacological interventions and screening, let's move over to pharmacological interventions.

ESSEX: Sometimes non-pharmacological interventions are not as effective as we want them to be as the sole therapy. In addition, depending on the therapeutic intervention being used, therapy may take weeks, months, or even years. So, as the healthcare worker continues with non-pharmacological interventions, there may be a need for sooner relief to help target some of those symptoms. This is when a pharmacological intervention can be beneficial. Keep in mind that pharmacological interventions could be an initial choice as well and can be the sole therapeutic intervention for the moment.

There are several pharmacological medications that can be used for treatment. I would list some name variations with some of these medications. With that being said, please keep in mind that pharmacological medications are not for prophylactic use of trauma or disasters. So, we have the selective serotonin inhibitors such as fluoxetine, citalopram, escitalopram, your paroxetine, your fluvoxamine, and your sertraline, which can be your first line medication, first line medication treatment for PTSD. Now, these medications have a pretty good safety and side effect profile. If your desired outcomes are not met with one of these SSRI medications, they're still some of your second and third generation medications such as your tricyclic antidepressants such as your Tofranil®, or your (Elavil®) amitriptyline, your Anafranil®. Some of them you know by trade names or their generic names.

You have your monoamine oxidase inhibitors such as your Marplan®, the Parnate®, or Nardil®. However, some of the side effects are more greater with these medications. Suicidal precautions should be assessed in all clients starting any type of antidepressant, regardless of the class of the medication.

There is another medication that has been studied and has been shown to reduce those PTSD symptoms, and it can be used as a monotherapy drug. And this is prazosin or Minipress®. It has been shown to reduce nightmares. It's a central acting antagonist blood pressure medication that is used to help with those PTSD symptoms. We also have your benzodiazepines, which are also helpful but should be used as a short-term treatment and should not be a monotherapy drug. An example: this drug can be used with an SSRI until the efficacy of the drug starts to take effect, which is usually about 2 to 4 weeks.

MORALES: Well, thank you so much for all of this great and very practical information. It really does help to put all the little pieces together about how treatments work for PTSD. If we notice a colleague who seems to be struggling with post-traumatic stress, or we notice that we need some help coping through certain times in our lives, sometimes it's hard to know how to best start talking about it. So how would you recommend starting the conversation when we need to seek help for ourselves?

ESSEX: As healthcare workers, we often don't prioritize self-care. There is often fear of being stigmatized by others for providing self-care needs. However, there are some positives with self-care. Self-care is highly recommended as a way for individuals to cope and balance their physical and mental well-being. So often, when one decides on the importance of healthcare, they will often seek out the help that they that they need.

MORALES: Mm hmm. Any strategies for facilitating respectful discussion with a coworker?

ESSEX: The initiator of that conversation should feel comfortable with the approach. There is a chance this is possible if they have a close working relationship and interact often with each other, both formally and informally. Otherwise, it should be reported to a supervisor or a manager to approach this as they interact with the coworker on a different level as it relates to incidents, counseling, and performance evaluations.

So another good approach and strategy for the supervisor is to incorporate a screening tool to assess the staff at intervals, post pamphlets in break rooms, have a chaplain or counselor to give a brief at meetings, form a peer to peer support group, or form a buddy system for surveillance. There can also be use of all this digital technology for support and training that's available.

MORALES: Are there any preferred words or language choices that are better when discussing PTS? How can we lessen stigma with our word choices and make sure that we're using respectful approaches in conversation?

ESSEX: One thing to do is learn to listen before speaking! For example, you should get a feel for a client if you're comfortable with your approach. Sometimes telling the person about an experience that you had could open the door to a conversation. There is no perfect way to answer this question. However, when asking questions, be sure to ask open-ended questions that require the client to elaborate a little bit more.

Try to avoid those closed-ended questions, such as that will give you a yes or no answer.

MORALES: We are going to prepare to wrap up the podcast conversation. Healthcare workers can place the needs of others before themselves on many occasions in their quest to heal and to care. And it's important to remember that we must take care of ourselves so that we can continue to help others. Let's help increase awareness and make a difference for those who need some additional care so that they can also help us when or if it's our turn as well.

ESSEX: And before we wrap up the conversation, let's talk about a scenario to discuss how the healthcare team members can play a role in working together to help our own in this post-traumatic stress conversation.

MORALES: Oh, I like that! Yes, please do that.

ESSEX: Okay. So with this case study, we have Derek, who is a physical therapy assistant presenting to the emergency department of the healthcare system who employed him with signs and symptoms of vomiting, low grade fever, nausea, and having abdominal pain. He ended up having an emergency surgery where his appendix was removed, and he was admitted for antibiotics and further observation on the surgical floor. While completing rounds, the hospitalist was inquiring about Derek's pain level. Derek said he had some mild pain, three out of ten, but said it didn't bother him too much, since he hasn't been sleeping well anyway, since after a scary car accident six weeks ago that he fortunately walked away from without major physical trauma. The nurse had noted that Derek had become very agitated and hurried to change the channel when the scene of a bad accident was shown on the TV of a crime show he had been watching.

So, on the admission assessment, Derek has also noted to be having a drink every night to help him sleep. The nurse was concerned about the behavior and approached the hospitalist at the nursing station saying that she thought Derek might be in an unhealthy, have an unhealthy pattern of drinking. So, the hospitalist then shared that Derek had told him about his previous car accident.

As they talked, they shared information from each of them regarding things Derek had shared separately to each of them. They began to discuss whether consulting with the psychologist on the staff might help Derek before he was discharged after his appendectomy. So, a psychologist walked by the nurses' station, and the hospitalist and the nurse began to talk to ask him about evaluating the patient.

The psychologist described how PTSD can manifest after a traumatic event and how it was better to not delay seeking treatment. After the psychologist's consultation, the three team members were able to come up with a collaborative plan to provide patient education, initiate pharmacologic intervention to help some of the current symptoms, and connect him to an outpatient therapy clinic for follow up for his PTSD.

So, by communicating as a team, Derek was able to begin his journey of therapy and healing before he was discharged to home instead of continuing to struggle months on his own. So, in this scenario, you have Derek, the patient. You have the nurse and the hospitalist who were attentive to Derek, to what Derek had reported. He reported not sleeping well, the accident. And they reported what they saw of Derek to each other. So, the objective findings, noticing the agitation in his demeanor, the change of the television when an accident was there. The team of professionals with your nurse, your physician, your psychologist, collaborated to determine a treatment plan for Derek. So, this is how collaboration works.

And this is what is needed to provide an effective treatment plan for those individuals that are having these traumatic thoughts. So, Derek's physical and his mental health needs were simultaneously addressed, which is a great intervention for the client.

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MORALES: Well, this has been an interesting conversation for sure. And now we are nearing the end of the podcast. I know this has really made me think about how many healthcare workers might be affected by post-traumatic stress or even PTSD. I see where more awareness and conversations may be needed to better support our healthcare workers. Thank you so much for joining us. Another sincere thank you to Dr. Daphne Essex, and this is Maria Morales for Colibri Healthcare.

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