

Post-traumatic stress disorder: Early recognition and intervention in the emergency department

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Post-traumatic stress disorder (PTSD) has become an increasingly recognized condition in society, with significant and far-reaching consequences to the affected individual as well as those close to them. In this issue of the *Wisconsin Medical Journal*, Lee et al explore the awareness of and procedures for evaluation of PTSD risk in emergency departments (EDs) for victims of trauma. The study evaluates the awareness of the disorder and brings to light how under-appreciated the disorder actually is and how much more there is yet to learn about it. The importance of allied health professionals such as social workers, pastoral care, psychologists, and others in the total care of these patients is emphasized. Equally important is the awareness that effective and consistent risk recognition and intervention is best achieved with on-site professionals. These professionals see situations in the ED as they evolve, recognizing at-risk patients, as well as family members, and intervening with assistance and linkage to follow-up and treatment. Only by early recognition can we effectively reduce the incidence of this disorder.

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Emergency departments are the site where psycho-social stress develops in the wake of critical illness and injury. This is an everyday, every-shift occurrence in emergency medicine. With the increasing sophistication of medicine comes an increasingly fragile health status in patients with diseases that were previously not survivable and patients who are living longer. Both trends increase the acuity of illness presenting to EDs and the array and complexity of treatment options and procedures. Little wonder that the ability of ED physicians and nurses to simultaneously, competently, and consistently screen patients with suspected substrate for PTSD is limited.

The focus of the Lee study was to identify barriers to the assessment and referral of trauma patients at risk for PTSD. Their focus implies the existence of a standard of screening within emergency medicine and nursing that is unmet. However, no such defined standard exists. Various sources of psycho-social stress have been taught in medical and nursing schools to assist physicians and nurses to recognize these potentially adverse elements in their patients. Basic screening questions have been introduced into the ED patient intake routine to improve our recognition of and assistance for victims of domestic violence and abuse. These

questions also increase awareness of special patient challenges including economic situation, living situation, and linguistic issues. However, the skillful and consistent recognition of certain behavioral elements correlating with subsequent PTSD risk in victims of trauma is not currently a standard procedure in the workflow of emergency physicians and nurses.

The ED is the reception point of all levels of trauma. Victims of severe trauma in areas distant from major trauma centers must initially be stabilized in the local ED. Often there is separation from family or friends when the severely injured victim is transferred while the less severely injured must stay behind. This is a great source of stress, often more so to the lesser injured than to the severely injured who may be impaired by head injury or intoxication. The greatest stressors to the severely injured may develop in the days following the injury. In these circumstances, the social service and counseling team of the trauma critical care unit will be involved. It is often the less severely injured patient, whose memory and recollection are acute, who will be at the greatest risk for PTSD, particularly when critical injury or death of another victim is involved. The less injured patient, released from the ED more quickly, may dwell on the incident, and this repeated intrusive traumatic imagery

may become problematic and persistent. Without the built-in contact or referral from a trauma critical care unit counseling team, these individuals can often be the “silent” victims of PTSD.

Lee et al’s survey studied the barriers that emergency physicians and nurses face in the referral of patients at-risk for PTSD. Though limited by the size of the survey and the response rate of less than 25%, the findings do clearly suggest limitations in the referral and consistent intervention of these patients. Indeed, the low response rate itself may indicate other reasons for under-referral beyond the four mechanisms outlined in the survey. Responses may have been low if those surveyed do not take PTSD seriously as a “real” disorder, and may not recognize the significant consequences of lack of treatment for PTSD or the positive impact of early supportive intervention.

The four barriers outlined in the study certainly account for much of the under-referral. “Not enough time to conduct assessment” was the most frequently cited reason why patients were not referred. The second most frequent barrier was “PTSD symptoms are not yet apparent when I see injured patients.” As mentioned earlier, the time constraints of physicians and nurses make it difficult to maintain contact with patients long enough to be able to assess for PTSD. Routinely referring all patients with trauma for counsel would over-load an already burdened system of psychiatric health delivery. And such a system might still overlook the vulnerability of lesser injured patients or even family members who might be in greater need. It is, after all, the family members and significant others who are the key support for the trauma victim after returning home.

The Lee article raises awareness of a growing but under-appreciated problem. The solution will be different depending on the hospital size and resources that can be provided. What seems clear is that just as the delivery and continuum of health care for patients with chronic illness is extending well beyond the perimeter of the hospital, the array of professionals needed to effectively operate emergency departments is also expanding.

The effective and timely social and psychological support for patients can have a huge impact on the successful outcome of a patient’s care, whether the quality is measured by compliance to prescribed treatment, reduced recidivism, reduced hospital length of stay, or patient satisfaction. The most effective approach is the on-site presence of professionals, usually social workers, acting as independent practitioners, providing support to evolving situations, and effectively impacting care. This care serves to provide the patient and family timely support, which reduces escalation of anxiety and provides victims and families the understanding and perspective needed to move forward from these events. Finally, the face-to-face contact provides greater likelihood that follow-up counseling will be pursued when needed. Victims or their significant others will have been given some knowledge of warning signs as well as perspective on “healthy” emotions in the wake of traumatic events. This timely support is extremely valuable and effective, as well as pre-emptive.

Where on-site contact is not possible, or during periods where on-site support cannot be extended to 24 hours, a system of referral and follow-up phone contact is needed. Few EDs can support on-site coverage beyond a basic work-

week. Lee’s inquiry into the needed learning opportunities begins to address the need to provide education and training to ED health care professionals. Equally important is the systematic means of contact and providing enough augmentation of the institution’s social services to execute this follow-up in hospitals with smaller volume EDs.

As society evolves and social isolation increases, an increasingly sophisticated and robust system of social support services will be needed in health care. When these trends are considered with patients needing care in the ED because of more sophisticated disease management and advancing age, it’s clear that enhanced social support and counseling resources are needed in EDs. Trauma is a leading cause of morbidity in our society. The circumstances that cause it, as well as the rapid and often painful and frightening interventions needed to deal with it, are sources of extreme stress both to patients and their significant others. The psychological and social support for effective personal “closure” to such events is often inadequate or simply non-existent. Without this support, it is easy for patients and their family members to develop PTSD.

Lee et al have explored the arena of the ED and the awareness of PTSD among ED physicians and nurses. They also looked at the perceived level of support for referral and counseling that is available for potential victims of PTSD. Not surprisingly there is more education needed; but more importantly, more resources are needed for EDs to effectively intervene and reduce the incidence of this common disorder.