

Psychiatric aspects of trauma care: survey of nurses and doctors

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This study reports on how 139 nursing and 42 medical staff in trauma units viewed psychiatric aspects of trauma, their training and the impact of their work upon them. Insufficient attention was paid in their units to the psychiatric aspects of trauma. There were important gaps in staff knowledge relating to the diagnosis and prevalence of post-traumatic stress disorder, and to the use of night sedation. Nearly all staff favoured providing information regarding post-traumatic psychiatric reactions for relatives, but nearly half had reservations about giving such information to patients. Job satisfaction was reported by most, but their emotional and training needs were generally not met.

Initially, our understanding of the psychiatric consequences of trauma was confined largely to military combat and major catastrophe (Alexander, 1996) but a growing body of knowledge confirms that road, industrial and domestic accidents also leave a legacy of adjustment problems (Malt, 1988; Mayou *et al.*, 1993). Medical and nursing staff who care for such victims in trauma units are well placed to identify those at risk of adverse reactions, to refer selectively and expeditiously to mental health professionals, and to reassure patients and families about reactions to traumatic events.

Little is known, however, about how such staff view the psychiatric consequences of trauma or about the emotional impact on these staff of regular exposure to unpleasant circumstances, although Whitley *et al.* (1989) have indicated that emergency care staff and medical residents find the emergency room emotionally demanding.

The aim of this study of staff of trauma units was to: (a) assess their level of psychiatric knowledge relevant to trauma, and (b) establish the emotional impact of their work and how they cope therewith.

The study

Subjects

This study, based at Aberdeen Royal Infirmary, involved 235 nursing and medical staff of four

units: the plastic surgery unit, the orthopaedic trauma unit, the intensive treatment unit and the accident and emergency unit (A&E).

Questionnaire

The questionnaire comprised three sections: the first, contained items relating to the management of trauma patients and to the psychiatric training of staff. The second was dedicated to the vulnerability to, and the features and management of, post-traumatic symptoms. In the third section staff were asked about the emotional impact of their work and how they coped with it (see Alexander & Wells, 1991).

The questionnaire was anonymous but respondents were asked to give their age, gender, professional grade and number of years of experience in the trauma field.

Findings

The overall response rate was 77% (181/235) representing 42 doctors and 139 nurses. The ratio of doctors to nurses was similar for all units except the intensive treatment unit where, for organisational reasons, the doctors did not contribute to the study. Reflecting the preponderance of nurses, 72% of the sample was female. The mean number of years of working in the trauma field was 5.64 (range 1–38 years). 'Junior' in relation to nurses refers to enrolled, auxiliary and student nurses; in relation to doctors it refers to house officers and registrars. Thirty-seven per cent of nurses fell into that category, and 64% of doctors did so.

Attitudes to teaching and general management of trauma victims

Few staff (apart from those in the A&E) had had teaching on the psychiatry of trauma but nearly all felt such teaching should be available (Table 1). Three-quarters of staff denied that trauma victims should be encouraged to put their experience out of their mind, although this

approach was more commonly endorsed by junior nurses ($P<0.0001$).

Providing information about typical reactions to trauma for families and spouses was viewed favourably by most staff; but about a third believed such information is likely to result in patients developing such symptoms. Junior nurses were more likely than their senior nursing colleagues to regard night sedation as an impediment to recovery ($P<0.006$).

Prognostic indicators

Staff were asked to indicate whether each of the factors listed in Table 2 is of prognostic significance in relation to adverse post-traumatic reactions. About a third of respondents in each case was uncertain about the prognostic significance of neurotic personality (39%), male gender (31%) and previous psychiatric history (30%). Most uncertainty was about the role of

amnesia for the trauma (41%). Over three-quarters of the staff correctly identified the prognostic significance of prolonged exposure to trauma (79%), serious physical injury (80%) and threat to life (85%).

Prevalence and chronicity

Staff were asked to estimate the community prevalence and duration of post-traumatic stress disorder (PTSD). Estimated prevalence rates were: 1% ($n=22$, 12%); 5% ($n=22$, 12%); 10% ($n=18$, 10%); 15% ($n=9$, 5%) and 'Don't know' ($n=110$, 61%). Most staff regarded PTSD as a rather chronic condition with duration: about a fortnight ($n=1$, 1%); about a month ($n=2$, 1%); about three months ($n=11$, 6%); about 12 months ($n=25$, 14%); longer ($n=84$, 46%) and 'Don't know' ($n=58$, 32%).

Table 1. Trauma staff attitudes to teaching and general management of trauma victims

Question	Yes n (%)	No n (%)	Don't know n (%)
Should all nurses in the trauma field have teaching specifically on the psychiatric aspects of trauma?	170 (94)	3 (2)	8 (4)
Should all doctors in the trauma field have teaching specifically on the psychiatric aspects of trauma?	172 (95)	2 (1)	7 (4)
Have you ever had teaching specifically on psychiatric aspects of trauma?	27 (15)	149 (82)	5 (3)
Generally, should victims of trauma be encouraged to put the experience out of their mind?	20 (11)	141 (78)	20 (11)
Generally, do you think it is helpful to families/spouses of victims if they are forewarned of the typical psychiatric reactions to trauma?	167 (92)	2 (1)	12 (7)
Generally, do you think victims are more likely to develop them if they are informed of the typical reactions to trauma?	34 (19)	100 (55)	47 (26)
Generally, does night sedation delay the emotional recovery of trauma victims?	32 (18)	69 (38)	80 (44)

Table 2. Trauma staff perceptions of prognostic indicators

Generally, do the following factors increase the likelihood of psychiatric symptoms after trauma?	Yes n(%)	No n(%)	Don't know n(%)
Prolonged exposure to trauma	143 (79)	14 (8)	24 (13)
Amnesia for the trauma	55 (30)	52 (29)	74 (41)
Threat to life	153 (85)	6 (3)	22 (12)
Serious physical injury	145 (80)	14 (8)	22 (12)
Being trapped	155 (86)	6 (3)	20 (11)
Poor social support	117 (65)	24 (13)	40 (22)
Previous psychiatric history	92 (51)	35 (19)	54 (30)
Neurotic personality	86 (48)	24 (13)	71 (39)
Male gender	88 (49)	36 (20)	57 (31)

Table 3. Frequency with which treatments are identified by trauma staff as the most effective for PTSD

Treatments	n (%)
Antidepressants	27 (15)
Anxiolytics	10 (6)
Counselling	152 (84)
Group psychotherapy	68 (38)
Hypnosis	13 (7)
Individual psychotherapy	68 (38)
Major tranquillisers	5 (3)
Don't know	11 (6)

Characteristic symptoms of PTSD

The frequency with which listed symptoms were identified as the three most characteristic symptoms of PTSD was: dizziness ($n=7$, 4%); *flashbacks* ($n=86$, 48%); depression ($n=87$, 48%); appetite loss ($n=48$, 27%); delusions ($n=13$, 7%); loss of libido ($n=18$, 10%); *numbing* ($n=29$, 16%), and *autonomic arousal* ($n=14$, 8%). (Those in italics are the characteristic symptoms according to ICD-10 and DSM-IV.)

Only four staff (2%) identified all three correct symptoms; 60 staff (33%) identified two of them; 101 staff (56%) identified one symptom and 16 staff (9%) failed to identify any correctly.

Treatments for PTSD

Staff had to select from a list of treatments two which they believed to be effective for PTSD (Table 3).

Their choice of treatment favours counselling ($n=152$, 84%), and individual and group psychotherapy ($n=68$, 38% in each case). Few staff selected medication as the treatment of choice.

Emotional impact of work

Eighty-seven staff (48%) claimed that they had experienced emotional difficulties due to their

trauma work; 78 (43%) felt they might experience such difficulties in the future. Compared to their junior colleagues, senior doctors ($P<0.05$) and senior nurses ($P<0.008$) were more likely to report having had emotional difficulties. Nurses more frequently than doctors stated that more attention should be paid to the emotional needs of staff ($P<0.00006$), although this may also reflect in part a gender effect. Female staff were more likely than their male colleagues to endorse this view ($P<0.0004$).

Coping methods

Staff were asked to indicate whether or not they had used any of a list of coping methods and with what success (Table 4).

Only one member of staff did not use 'talk with colleagues'; only two who did found it unhelpful. This method was the most likely to be endorsed as 'very helpful'. Black humour was also found to be helpful ($n=125$, 84%) as was thinking about the positive aspects of work ($n=136$, 77%). The least helpful method was keeping thoughts and feelings to oneself ($n=33$, 19%).

Job satisfaction

Ninety per cent found their work 'satisfying'; five per cent did not and the remaining five per cent were uncertain.

Comment

Nursing and medical staff have a special opportunity to identify and respond appropriately to the psychiatric needs of patients after traumatic events, but attention must be paid to their training and to the emotional impact of this work.

PTSD is only one condition which appears after traumatic experiences, but it has the highest profile. It is therefore reasonable to expect staff (particularly the medical staff) to know about its definitive features and its

Table 4. Coping methods used and with what success by trauma staff

Coping method	Do not use n (%)	Very helpful n (%)	Helpful n (%)	Unhelpful n (%)	Very unhelpful n (%)
Black humour	33 (20)	39 (33)	86 (51)	9 (5)	2 (1)
Talk with colleagues	1 (1)	110 (62)	64 (36)	—	2 (1)
Look forward to being off duty	19 (11)	42 (24)	78 (45)	31 (18)	5 (3)
Keep thoughts/feelings to self	11 (6)	4 (2)	29 (17)	90 (51)	41 (23)
Think about family	37 (21)	21 (12)	53 (31)	57 (33)	6 (3)
Think of outside distractions	27 (15)	29 (17)	79 (45)	38 (22)	3 (2)
Think of positive benefits of work	15 (8)	49 (28)	87 (49)	24 (14)	2 (1)
Avoid thinking about what doing	32 (18)	12 (7)	45 (26)	65 (37)	22 (12)

prevalence. The evidence from this study is that their knowledge is limited. They correctly identified psychological methods of intervention as the most effective, and few endorsed medication as the treatment of choice. However, 18% believed that night sedation delays the emotional recovery of trauma victims. Sleep problems (due to hyperarousal and intrusive phenomena) are common after trauma, but there is no evidence that the selective use of night sedation is contraindicated. Their knowledge of prognostic indicators was better. The majority did recognise correctly the prognostic significance of features of a trauma, namely threat to life, being trapped and prolonged exposure to the trauma (Weisaeth, 1996).

The value of providing information about reactions to trauma for patients and their families evoked a mixed response. Over 90% thought it helpful to make such information available to families and spouses but a quarter were uncertain about the value of telling patients, and a further 19% believed such information would increase the likelihood of their developing such reactions.

It is a challenge to busy staff in trauma units to provide psychological care as well as medical care for trauma victims. But it is not reassuring that 11% of this sample believed patients should be encouraged to put out of their minds their traumatic experiences. That junior nurses were more likely to hold this opinion may be particularly important because they are often the ones who spend most time in face-to-face contact with patients. Perhaps young and inexperienced staff find it too painful to listen to harrowing accounts and to their patients' distress. Their view may therefore be a self-protective one.

About half of these staff (and, interestingly, more often the senior ones) did admit that their work created emotional difficulties for them. Moreover, only 17% asserted that they would not have such difficulties in the future. Further enquiry is necessary to establish the nature of these difficulties and whether they were a product of recurrent exposure to unpleasant scenes or to one particularly distressing event. The effects of recurrent exposure to trauma have not yet been delineated. Recurrent exposure may have a sensitising effect or a desensitising effect or it may depend on how the staff thought they had coped with previous incidents. This matter is an important one in relation to 'compassion fatigue' (Figley, 1995).

The staff were fairly consistent in their choice of methods of self-help. The most frequent and successful was to talk with colleagues. Whereas those staff who tended to keep things to themselves found this approach unhelpful. Talking with colleagues appears to provide protection against 'burnout' (Maslach, 1982). Those who

manage such units would be advised to encourage and facilitate this helpful (and inexpensive) psychoprophylaxis. Black humour or 'gallows humour' was also popular but these staff did not use it as much as police officers in a body handling exercise (Alexander & Wells, 1991). Perhaps as a rather aggressive form of humour, black humour may not appeal so much to females (who comprised the largest proportion of this sample) as it did the male police officers. Also, the police officers dealt only with the remains of adult males, whereas staff in these units would have to deal with the whole age spectrum, including children. It is unlikely that black humour is appropriate when children are involved. Three-quarters of the staff found it helpful to remind themselves of the positive aspects of their work. Consequently, during and after highly stressful times, trauma staff may need to be reminded of the intrinsic value of their work.

Staff in trauma units appear to find their work satisfying, but this does not justify complacency with regard to the need to consider their welfare. Emergency personnel display high job satisfaction even when they report stress and dissatisfaction with the internal features of their employment, e.g. the managerial climate and form of leadership (Alexander *et al*, 1993; Robinson, 1993).

Conclusion

The full value of early contact with trauma patients requires trauma staff to have a better level of knowledge about the diagnosis and management of post-traumatic conditions. It is also important that, even when job satisfaction is high, the emotional needs of staff are addressed.

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