Posttraumatic Stress Disorder in Emergency Medicine Residents

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INTRODUCTION

The emergency department (ED) is an environment of high intensity and stress for all its staff members. In addition to the daily challenges experienced in the ED, emergency medicine resident physicians are also regularly exposed to trauma, illness, death, and violence, which compose the primary triggers for the development of posttraumatic stress disorder (PTSD). They are confronted with these difficult scenarios and tragedies from the onset of their training, leaving them prone to the emotional effects. The terms *burnout* and *depression* are often discussed and dissected in relation to physician well-being; however, PTSD may be a more applicable concept than we realize. In fact, physician PTSD has become a new topic of investigation, and with good reason.

The prevalence of PTSD is approximately 2 times greater in physicians, at 14.8%, than in the general population, with emergency medicine resident physicians' incidence falling in the range of 11.9% to 21.5%. Although all practitioners of medicine are at risk for PTSD, ED workers are particularly vulnerable, and oftentimes, emergency medicine resident physicians are left to learn coping skills on their own. Fortunately, some programs have sought to combat the effects of their stressful work environment, but the future health of our specialty demands that we broaden our search for answers. The extrapolation of data from military, emergency medical services (EMS), and trauma victim studies may serve as a significant means to address the issue of emergency physician PTSD and provide management strategies.

BACKGROUND

Emergency physicians experience high rates of burnout, at 65% during a career,[1] and ranging from 49% to 65% among emergency medicine resident physicians.[2,3] Such statistics have attracted the attention of the Accreditation Council for Graduate Medical Education and resulted in a movement to improve mental health among physicians.[4] However, a critically important and largely overlooked aspect has been the recognition and treatment of PTSD in emergency physicians. The purpose of this article is to explore the rarely discussed concept of PTSD in emergency physicians, its influence, and how this problem may be managed through early interventions on the residency level.

Emergency physicians are regularly exposed to trauma. Despite these exposures, the majority of emergency physicians will not develop PTSD, likely because of personal and professional protective factors.[5,6] PTSD results from trauma and is characterized by the 4 symptom categories of intrusive thoughts, avoidance, negative alterations in cognition and mood (including numbing), and alterations in arousal and reactivity, causing distress or impairment for more than 1 month and not caused by medication, substance use, or other illness.[7] A temporal or contextual relationship must exist, with the symptoms worsening or beginning after the trauma. With the advent of the *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition) (*DSM-5*), several major changes were made to the definition of PTSD, including additional symptomatology (Figure). Most important, a new exposure type was added, type 4A, which likely captures the essence of the emergency physician experience with PTSD: "repeated or extreme exposure to aversive details of a traumatic event(s), which applies to workers who encounter the consequences of traumatic events as part of their professional responsibilities."[8] Should an emergency medicine provider experience any of the 4 major symptom categories, further exploration with a trained professional may be warranted because this may represent a pathologic response.

PREVALENCE OF PTSD AMONG EMERGENCY PHYSICIANS

The evolving definition of PTSD over time and surrounding controversy have hindered attempts at estimating its prevalence among physicians.[8] The lifetime

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
   1. Directly experiencing the traumatic event(s)
   2. Witnessing, in person, the event(s) as it occurred to others
   3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental
   4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (eg, first responders collecting human remains; police officers repeatedly exposed to details of child abuse)

B. Intrusion symptoms: the traumatic event is persistently re-experienced in the following way(s) (one required):
   Recurrent, involuntary, and intrusive memories
   Traumatic nightmares
   Dissociative reactions (eg, flashbacks), which may occur on a continuum from brief episodes to complete loss of consciousness
   Intense or prolonged distress after exposure to traumatic reminders
   Marked physiologic reactivity after exposure to trauma-related stimuli

C. Avoidance symptoms: persistent effortful avoidance of distressing trauma-related stimuli after the event (one required):
   Trauma-related thoughts or feelings
   Trauma-related external reminders (eg, people, places, conversations, activities, objects, situations)

D. Negative alterations in cognitions and mood that began or worsened after the traumatic event (2 required):
   Inability to recall key features of the traumatic event (usually dissociative amnesia; not caused by head injury, alcohol, or drugs)
   Persistent (and often distorted) negative beliefs and expectations about oneself or the world (eg, "I am bad," "The world is completely dangerous")
   Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences
   Persistent negative trauma-related emotions (eg, fear, horror, anger, guilt, shame)
   Markedly diminished interest in (pretraumatic) significant activities
   Feeling alienated from others (eg, detachment, estrangement)
   Constricted affect: persistent inability to experience positive emotions

E. Alterations in arousal and reactivity: trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event (2 required):
   Irritable or aggressive behavior
   Self-destructive or reckless behavior
   Hypervigilance
   Exaggerated startle response
   Problems in concentration
   Sleep disturbance

F. Duration of the disturbance (criteria B, C, D, and E) greater than 1 mo

G. Disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

H. Disturbance not attributable to the physiologic effects of a substance (eg, medication, alcohol) or another medical condition

Figure. PTSD diagnosis by the *DSM-5*.

prevalence of PTSD among adults is estimated to be 6.8%, and certain subgroups such as veterans and torture victims have higher rates, ranging from 14% to 30%. A meta-analysis of 1,616 physicians found a prevalence of PTSD, diagnosed by *DSM-5* criteria, of 14.8%, and an abstract recently presented at the Society of Academic Emergency Medicine conference demonstrated emergency medicine–specific rates of 15.1% among 526 emergency physicians[9]; emergency medicine resident physicians' data fall in the range of 11.9% to 21.5% for diagnosed PTSD, with symptoms of PTSD affecting 30% and significantly increasing as resident level of training increases.[10,11]

PTSD in physicians is further linked to the specific stressors of residency training, treating trauma patients, multiple trauma with massive bleeding or dismemberment, death of a child, providing care to a traumatized patient who resembles the resident or family members, treating the severely burned, death after prolonged resuscitation, and workplace violence or threats.[10,12] Unfortunately, PTSD is often underdiagnosed because of failure to recognize a specific inciting traumatic event, as well as failure of the patient to seek help because of stigma, and therefore experts agree that statistics are likely underreported.[13,14]

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