The curse of complex post-traumatic stress disorder

By Mike Webber, counselling psychologist

The fire and emergency services are an extremely demanding occupational environment to work within that exposes its members to multi-dimensional stressors. Fire services are of necessity hierarchically and bureaucratically organised structures that lead to significantly higher organisational stressors than most other professions. Due to the nature of emergency operations, a high premium is placed on discipline, conformity and group homogeneity that results in a relatively controlling management approach. This mitigates against a consultative or participatory management style. This is not necessarily to criticise such a management style that may maintain a cohesive and effective response to emergency incidents but it is never-the-less a difficult environment for individuals to work in outside of emergency incidents.

In addition, emergency services have undergone significant transformation over the past 20 years. Local government transformation and new labour-related legislation have significantly changed the structure, functions and role of fire and emergency services. These rapid and far-reaching changes have been difficult for members of fire services to work through and have been perceived as being stressful. And let's not even get into the challenges that women face in the fire and emergency services! But that's a story for another article.

Then there's the nature of the work. The work of the emergency services is both physically, emotionally and intellectually challenging. The working hours spent away from home are long. Personnel are regularly expected to confront complex, high risk situations that test both their physical strength and ingenuity. In addition, many of these situations involve death, mutilated and burnt bodies, grossly disfiguring injuries, human suffering and loss that test the emotional resources of crews.

However, whilst previous articles on PTSD in this journal focussed on significant or catastrophic traumatic exposures that result in 'classic' PTSD, there is a far more sinister form of trauma prevalent in the emergency services. Prolonged exposure to traumatic events, such as the death or injury to colleagues, handling lifeless bodies, working with traumatised patients, witnessing violence and working under threat results in a constellation of distressing symptoms known as complex post-traumatic stress disorder (C-PTSD). Whilst we don't have any data regarding its incidence or prevalence in South African Emergency Services, my 30 years of experience working both within operations in the fire and emergency services and as a psychologist over the past 10 years suggests that it is an endemic disorder in the emergency services. It may constitute an unseen and unreported epidemic. Regrettably, for many members of the emergency services that suffer from this condition, their maladaptive behaviours, symptoms, emotions and coping mechanisms become their new 'normal'.

Complex post-traumatic stress disorder (C-PTSD)

C-PTSD is not currently classified as a specific mental disorder in either the official diagnostic system used in South Africa, the International Classification of Diseases and Related Disorders – 10th Edition (ICD-10) or the Diagnostic and Statistical Manual of Mental Disorders – fifth edition (DSM-5) that the mental health profession is so fond of. The closest 'official' diagnosis is "Disorders of extreme stress not otherwise specified." However, in practice, a sufferer is probably more likely to be misdiagnosed with either depression or Borderline Personality Disorder (BPD). This is unfortunate as the treatment for depression misses the bigger picture and aetiology here and treatment for BPD differs significantly from that needed for C-PTSD.

C-PTSD develops gradually over time with repeated exposures to trauma, such as community violence eg as

in South African townships, being subjected to violence (abused women, abused children, molested children, abduction victims, etc), being exposed to threats of violence (by communities or gang members at emergency incidents), dangers inherent in fire fighting operations or crime suppression, dealing with dead and dying patients and continually treating gruesome injuries. A significant number of C-PTSD sufferers will exhibit the typical symptoms of PTSD but are far more likely to exhibit some of the following:

- Emotional dysregulation (angry outbursts, generally grumpy behaviour and even aggression – physical, verbal and emotional)
- Emotional blunting (lack of empathy and flat emotion except for anger – switching off to feelings)
- Loss of pleasure in social relationships, activitiesand life that were previously pleasurable (anhedonia)
- Feelings of hopelessness and loss of meaning in life and career
- Feelings of shame and guilt
- Increasing substance abuse (including prescription and over-the-counter medications, smoking, alcohol consumption and sometimes illegal substances)
- Social isolation and mistrust
- Suicidal thinking

One need not tick all of the above boxes; just experiencing more than three of the above symptoms may be suggestive of a problem that would benefit from treatment.

C-PTSD case study

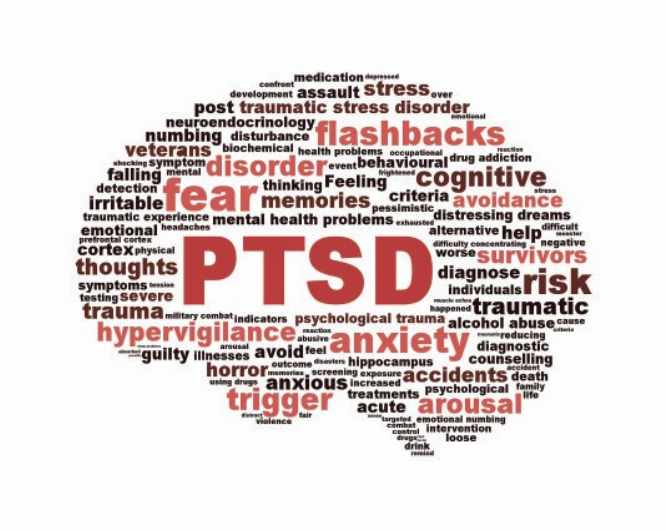
This case study does not represent a single individual as it would be unfair to use one single case that may result in the person being identified. This is rather a composite case study that draws on several cases of C-PTSD that I have seen in my practice going back to 2004 that illustrate the typical features of a C-PTSD case.

John Smith is a senior fire fighter in a city fire and emergency service. He has ten years' experience in this one fire service in the operations division. After being appointed he underwent the Firefighter I and II courses and became a basic life support (BLS) emergency care practitioner. He has subsequently moved on to train as an intermediate life support (ILS) emergency care practitioner and trained as both a hazmat technician and rescue diver. He is a special appliance operator/driver. He has passed the SAESI Higher Certificate in Fire Technology but has experienced difficulty in passing the Diploma in Fire Technology. He ascribes this to fatigue, shift-work and a lack of lectures. He does not acknowledge the extent to which his alcohol consumption negatively affects his ability to study. He has diverse experience in structural fire fighting, informal settlement fire fighting, wildland fire fighting, emergency medical response, rescue work (both vehicle, high angle and water) and hazmat incidents.

In spite of his operational experience over a decade, John has not reported any catastrophic traumatic exposure that has resulted in unpleasant symptoms such as flashbacks, nightmares, hypervigilance, avoidance, insomnia or fluctuating emotions. He has, however,

experienced a number of events that he tends to gloss over and trivialise. These include minor burns from a structural fire, medical treatment for smoke inhalation, a fractured humerus from a fall into a kloof at a bushfire and a snakebite. He was also the driver of a response vehicle that was struck by another vehicle and rolled whilst en route to a call in which his partner was killed. Another colleague was also killed at the scene of a motor vehicle accident (MVA) that they were attending on a freeway at night when a drunken driver drove through the barriers.

John has been married to Janet for six years and they have two small preschool children. Approximately three years ago during an argument with his wife, she shouted at him ▶



that he had changed for the worse and was not the man that she had married. She presented him with an ultimatum that they should go for couples counselling or she would leave with the children. They consulted a psychologist for couples counselling. During the couples counselling process the psychologist noted that John's behaviour was typical of depression and recommended that he go for individual psychotherapy with another psychologist. The symptoms that the psychologist was concerned with included:

- Blunted emotions and lack of empathy. John did not display any affection or emotions apart from anger
- Outbursts of anger and verbal aggression, especially towards his wife and children
- Becoming over-controlling, especially with his family
- Increased alcohol consumption, the frequency and severity of which amounted to alcohol abuse, mostly at home but also included occasional driving whilst under the influence of alcohol
- Social withdrawal. John no longer socialised with his friends or colleagues when off duty, preferring to drink alone
- Extreme discomfort with watching emergency services work and medical programmes on TV
- Lack of interest in any activities that he had previously enjoyed. John showed no further interest in adding to his collection of helmets, badges and model fire engines.

John became angry with the psychologist, accused him of not understanding how the fire services operate and terminated therapy. John objected to being diagnosed as "weak, unable to cope, needing help and being less than a complete man", none of which was said by the psychologist! John's wife continued to see a psychologist alone in an effort to learn how to deal with his changed behaviour. After two years they finally divorced. John is now in an intimate relationship with a female colleague in the emergency medical services.

John reached a breaking point when he became enraged with a junior that questioned his judgement. He became verbally abusive towards this junior. He was then called to order by an officer. He then swore at the officer and walked out of the fire station. John had reached his breaking point. He was suspended from duty and advised to seek professional help, failing which he would face a disciplinary enquiry regarding his behaviour towards both the officer and junior. He elected to go into therapy with a psychologist.

Treatment of C-PTSD

John was fortunate in finding a therapist that recognised his behaviour as being indicative of C-PTSD and believes that C-PTSD can be effectively treated and cured. The therapist was experienced in treating both PTSD and C-PTSD and based his treatment approach on the principles contained in the International Society for Traumatic Stress Studies (ISTSS) Expert Consensus Treatment Guidelines for Complex PTSD in Adults. John was booked off sick for several days to initiate treatment and remove him for the occupational stressors. The treatment approach included a number of phases:

Phase 1: Symptom relief and skills strengthening (self-management skills)

- Psychoeducation about trauma and its effects
- Psychoeducation regarding responsible lifestyle management (exercise, social activities, recreational activities such as hobbies, sport, defusing stress, etc)
- Rational-Emotional and Cognitive-Behavioural Therapy (REBT) to improve coping skills with regard to anger; to improve emotional self-regulation, address maladaptive cognitive distortions and improve stress management
- Homework assignments regarding social and relationship skills building
- Meditation and mindfulness interventions.

Phase 2: Prolonged Exposure Therapy (P-ET)

- Describing traumatic experiences, retelling the stories in a safe environment
- Encourage emotional disclosure in the safety of the therapist's rooms

Phase 3: Developing resiliency and identity

- Develop a sense of identity separate from the work persona; who is the person inside and behind the uniform and epaulettes
- Dismantle the 'Detached defender' that protects the patient from their emotions; a longer term therapeutic objective
- Consolidate the therapeutic progress made in phases 1 and 2
- Re-establish the ability to engage in meaningful relationships through the therapeutic relationship
- Reaffirm the value that the patient brings to communities through their work

Treatment duration was limited in John's case due to shift work restricting his availability for therapy once he had returned to work and medical aid funding limits. The 'Gold standard' for this treatment should involve regular therapy consultations for six months, with follow up booster consultations as necessary but, as stated above, we work within certain constraints.

C-PTSD is real and is treatable. But perhaps the biggest obstacles to treatment for C-PTSD is its slow, insidious onset that goes unnoticed until a crisis point is reached and a reluctance to admit to anything that could be construed as weakness.