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Psychological Surveillance: Complex PTSD, Covid Fatigue & Carers

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Introduction

1. Evidence, psychological surveillance: Needs and benefits
2. Complex PTSD: Incidence and treatment
3. Covid Fatigue: What has happened to employees?
4. Caring: The risks to Occupational Health Professionals
5. What comes next?

The importance of evidence (Dawes et al 2005)

- How do we typically make decisions?
  - “We’ve always done it this way” “It is the latest thing!!” “Its what everyone is doing”
- Evidence based decisions involve
  - **Asking:** translating a practical issue into an answerable question
  - **Acquiring:** systematically searching for and retrieving evidence
  - **Appraising:** critically judging the trustworthiness and relevance of the evidence
  - **Aggregating:** weighing and pulling together the evidence
  - **Applying:** incorporating the evidence in the decision making process
  - **Assessing:** evaluating the outcome of the decision taken

Sources of Evidence

1. **Research data:** peer reviewed journal articles, screening and surveillance results
2. **Organisational data:** client/customer satisfaction, intentions to leave, sickness levels, employee surveys
3. **Expert judgement:** specialist practitioner knowledge, practitioner experience
4. **Stakeholders:** client satisfaction, internal and external stakeholders

Triangulation of evidence is the combination of theories, observations and expert opinions to help to remove the bias which may be present in a single source of evidence

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The Aims of Health Surveillance

- To eliminate occupational factors and conditions hazardous to health and safety at work. There is a focus to develop and promote healthy and safe work, working environments and organisations. This will enable workers to conduct socially and economically productive lives. (WHO, 1994)
  - **Health:** periodic clinical assessments of clinical symptoms in individuals and/or groups to detect the adverse health effects of work
  - **Hazard:** identification, elimination, reduction and management of hazards

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Psychological health surveillance

- Periodic clinical assessments of adverse health effects in high risk groups provides opportunities for:
  - Early detection of symptoms of disease
  - Preventative measures to be instituted promptly
- Clinical symptom measures
  - Psychological self-report questionnaires
  - Clinical Assessments by OH professional, psychologists and psychiatrists
- Surveillance measures can also include:
  - Mental wellbeing reviews e.g. NICE: Mental Wellbeing at Work
  - Workability Assessments e.g. Finnish Institute of Occupational Health
  - Sickness absence monitoring
  - Medical retirement monitoring

Psychological hazard surveillance

- HSE Management Standards (Cousins, MacKay et al. 2004)
  - Demand, Control, Support, Relationships, Role, Change

- Other Identified Hazards:

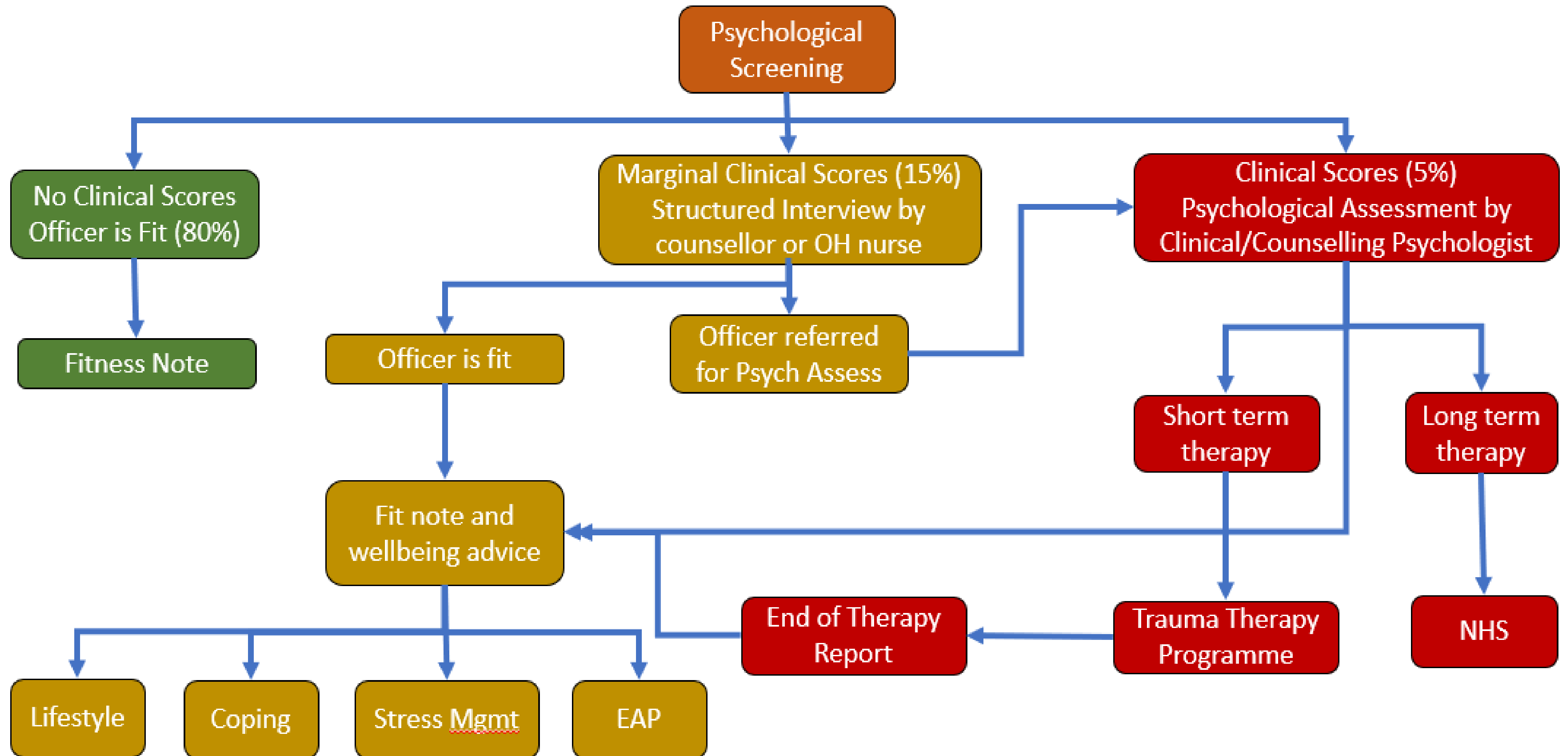
Personal

- Adverse Childhood Experiences (Felitti et al 1998)
- Frequency/intensity of traumatic exposure (Skeffington, Rees et al. 2017)
- Neuroticism/rumination (Wild, Smith et al. 2016)
- Avoidant coping style (Syed, Ashwick et al 2019)
- Gender (Kline, Ciccone et al 2013)
- Alcohol consumption (Syed, Ashwick et al 2019)
- Education level (Brewin Andrews 2000)

Organisational

- Stigma of mental health (Halpern Gurevich et al 2009)
- Poor leadership (Bartone 2006)
- Lack of social support (Armstrong et al 2014)
- Sense of Coherence (Antonovsky, 1979)

Screening, Assessment & Referrals in UK Policing (Tehrani, 2019)



Using Surveillance Data to Inform Practice

- Complex PTSD
- Covid
- Occupational Health Practitioners
- Trauma Informed Organisations

PTSD + DOS = Complex PTSD (ICD11: 2019)

Post Traumatic Stress		
Re-experiencing the traumatic event or events in the present as vivid intrusive memories, flashbacks, or nightmares.	Avoidance of thoughts and memories of the event(s), avoidance of activities, situations, or people reminiscent of the event(s)	Persistent heightened sense of threat, including hypervigilance or enhanced startle reaction to stimuli such as unexpected noises
Disturbed Self Organisation		
Emotional Dysregulation including: Persistent sadness, suicidal thoughts, explosive anger or inhibited rage and engaging in risky behaviour	Negative Self-Concept including: Being easily hurt, feelings of being worthlessness, helplessness, strong sense of guilt/shame	Interpersonal Problems including: Never feeling close to anyone, distrusting others, searching for a rescuer with a preoccupation with revenge

Causes of Complex PTSD

- Researchers suggest C-PTSD emerges from sustained traumatic experiences (e.g., Cloitre et al. 2018)
  - Prolonged childhood abuse
  - Domestic violence
  - Torture
  - Multiple exposures at work (e.g., Policing)
- However:
  - Evidence that some people with multiple traumatic exposures develop simple PTSD
  - Other people develop C-PTSD following a single exposure.
- Is C-PTSD caused by the nature of exposure
- or physical response to the trauma (Porges)

Risk Factors for C-PTSD in UK Policing

(Steel, Billings, Tehrani 2021)

- Cross-sectional study using psychological surveillance data from UK police forces
- 2444 officers were included 83% from high risk roles
- Clinical data included
  - ITQ measured PTSD and C-PTSD (Cloitre)
  - Anxiety & Depression (Goldberg)
  - Burnout & Compassion Fatigue (Stamm)
- Hazard data included
  - Adverse Childhood Experiences
  - Sense of Coherence
  - Lifestyle
  - Health Beliefs
  - Workability
- Demographic data included
  - Gender, age, tenure, role

Incidence of PTSD and C-PTSD in police personnel

Surveillance of police officers and staff indicated

- Sample size 2444 police officers
- 95% of officers and staff had no PTSD
- 3% had Simple PTSD
- 2% had Complex PTSD

An earlier survey of police officers (Brewin & Miller, 2020)

- 79% of officers and staff had no PTSD
- 8% had Simple PTSD
- 13% had Complex PTSD

Comparing Simple and Complex PTSD

- People with higher levels of Complex PTSD were:
  - Older: 39yrs v 42yrs
  - Had been in post longer
  - Experienced other adult traumas
- No difference between PTSD and C-PTSD based on:
  - Childhood trauma.
  - ACE scores
  - Recent traumatic events
- Increased odds of C-PTSD v PTSD when:
  - Higher tenure
  - High work stress
  - Low manager support

Odds Ratios

Tenure: working in high risk role

- Two years in role increased the odds of PTSD by 3.25 times and C-PTSD by 2.69 times
- 5-10 years in role increased the odds to 5.53 for PTSD and 6.12 for C-PTSD

Working Conditions

- Stress at work increased the odds of PTSD by 3.38 times and for C-PTSD by 4.21 times
- Good/Excellent manager support reduced PTSD by 74% and C-PTSD by 82%

Lifestyle

- Drinking 15+ units of alcohol increased odds of PTSD by 2.48 and C-PTSD by 2.65
- A lack of socialising increased odds of PTSD by 4.08 and C-PTSD by 4.39
- Sleeping less than 5 hours a night increased the odds of PTSD by 16.9 and C-PTSD by 22.51

Recommended treatment of C-PTSD- three phased approach

(Cloitre et al 2012)

1. Stabilization, increasing safety, reducing symptoms and skills training to increase emotional, social and psychological competencies.
2. Processing and reappraisal unresolved trauma memories into a more adapted representation of self, relationships and the world. (individual rather than group therapy)
3. Consolidating gains, including using these gains to engage in interpersonal relationships, work/education, and community life

The phased therapy approach is likely to take at least 2 years

Occupational Trauma related PTSD and C-PTSD: evaluating a trauma therapy programme (Biggs et al. 2021)

- 162 police personnel
  - 51% male and 49% female
  - Mean age 42 years
  - 90 met criteria for C-PTSD and 72 PTSD
  - No significant demographic or traumatic incident exposure differences between groups
  - 36 officers revealed childhood abuse of which 2/3 met criteria for C-PTSD
  - 23 officers with C-PTSD revealed no childhood trauma

Therapy

- Short-term: 9-12 hours of therapy
- Trauma Focussed CBT and EMDR trained therapists
  - 44% TF-CBT, 40% EMDR and 16% combination of TF-CBT and EMDR

Results

- At end of therapy 77% of police personnel no longer met the criteria for PTSD or C-PTSD
- No significant differences in the way officers with PTSD and C-PTSD responded to the brief trauma therapy programme

Covid Fatigue: What has happened to employees?

- 3863 police officers screened between Jan-March 2021
- 39% female, 61% male
- Tenure: Mean 5.7 years (20% 0-2 years, 30% 9+ years)
- Days sick in previous year mean 6 days, (59% no sick, 85% less than a week, 91% less that fortnight, 95% less than a month)
- Exposure to trauma 23% little, 44% some and 33% a lot
- Intention to leave job: none 42%, some 28%, moderate 20% high 10%

Study of 3863 Police Officers Covid Physical and Mental Wellbeing correlations with anxiety, depression, PTSD and Secondary Trauma

Variable	Covid Physical Wellbeing	Covid Mental Wellbeing	Anxiety	Depression	PTSD	Compassion Fatigue
Covid Physical Wellbeing	1	.067**	.044**	.043**	.022	.025
		<.001	.007	.007	ns	ns
Covid Mental Wellbeing	.067**	1	.434**	.427**	.381**	.368**
	<.001	<.001	<.001	<.001	<.001	<.001

Covid impact: wellbeing factors

- Sense of Coherence
  - Comprehensibility
  - Manageability
  - Meaningfulness
- Personal Factors
  - Age
  - Workability
  - Stigma (neg)
  - ACE Scores (neg)
- Coping
  - Involvement
  - Relaxation
  - Social support (neg)
  - Physical fitness
  - Time planning
  - Mental disengagement (neg)
  - Behavioural disengagement
- Emotional Literacy
  - Dissociation
  - Sympathy (neg)

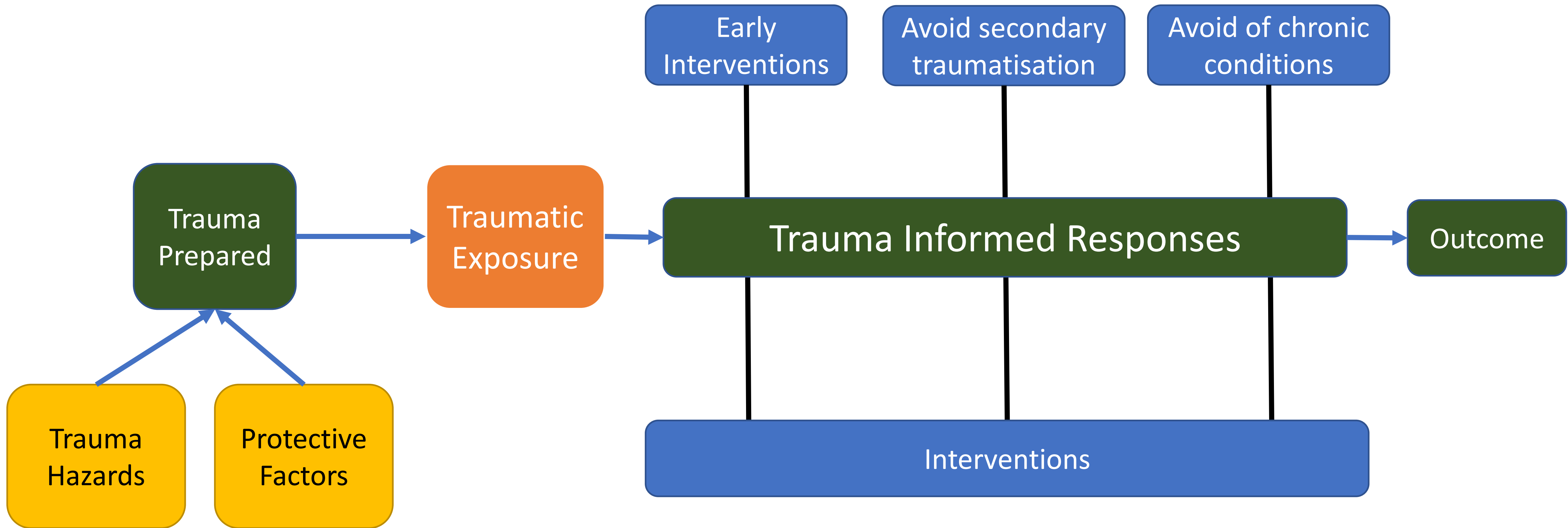
Caring: An Occupational Hazard

- Carers coming into continued, close contact with traumatised people may experience emotional disruption and become an indirect victim of the trauma
- The natural consequence of having knowledge of a traumatising event experienced by another person
- The stress resulting from helping or wanting to help a traumatised person

Psychological surveillance results in policing

Clinical Symptom	POLIT /ICAT (n=961)	DFT (n=597)	Child Abuse (n=5461)	ViSOR (n=539)	Police Negotiator (n=2546)	Roads Policing (n=1106)	CSI (n=696)	FLO (n=1355)	OHA/C (n=127)	General Public
Anxiety	21%	25%	21%	16%	19%	35%	29%	20%	25%	3.5%
Depression	25%	33%	25%	21%	23%	38%	34%	26%	31%	8-12%
PTSD	6%	8%	8%	4%	6%	13%	10%	6%	17%	3%
Burnout	17%	15%	15%	15%	22%	23%	21%	21%	19%	NA
Secondary Trauma	13%	16%	15%	12%	15%	33%	25%	18%	11%	NA

Trauma Informed Organizational System



The Future: Trauma/MH Informed Organisations

- Identify at risk groups
- Regular psychological surveillance and screening
- Education and clinical support for employees
- Training for supervisors
- Assessments and early interventions
- Access to psychological assessments and trauma therapy
- Management information and review of responses

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