UNDERSTANDING POST TRAUMATIC STRESS DISORDER

BY PAUL J. ANTONELLIS JR., FLOYD "SHAD" MESHAD, AND DABNEY STACK

HARDLY A DAY GOES BY IN THE FIREHOUSE THAT someone does not mention the word "stress." Many trade journal articles and research projects have determined that firefighters are subjected to a higher rate of stress responses than the average person. According to the American Psychiatric Association, the rate of post-traumatic stress disorder (PTSD) in the general population ranges from seven percent to nine percent. Various research studies pertaining specifically to firefighters have cited PTSD rates for firefighters ranging from 16 percent to as high as 24 percent. As you can see, firefighters have a higher rate of PTSD than the general population. Therefore, it is well established that firefighters are impacted by critical incident stress.

Many of the normal stress responses firefighters experience will diminish over time and will not require assistance. Some firefighters may develop acute stress disorder (ASD)—(the symptoms occur within a month and last a few days) or PTSD. Firefighters suffering from PTSD who receive the proper intervention can recover fully and lead productive lives and have successful careers. However, many will receive no intervention and will live with the symptoms of PTSD, attempting to cope using destructive behavior. PTSD symptoms may even force some firefighters into retirement.

This article is *not* intended for self-diagnosis or the diagnosis of others. Its purpose is to help firefighters, coworkers, family members, and fire service administrators to better understand the dynamics of this illness.

Most people associate PTSD with the military (combat veterans). It has been referred to as "shell shock" and "battle fatigue." The use of these terms has been slowly fading as public awareness of PTSD has increased. What has also changed is that there is an increased willingness to seek professional help for PTSD. Also, it has been recognized that PTSD occurs in all demographics.

INCREASE IN PTSD-RELATED INJURIES

The fire service is seeing an increase in PTSD-related injuries partly because of better diagnosis and treatment, although there is no definitive information to confirm this. The United States Fire Administration, National Fire Protection Association, International Association of Fire Fighters, and International Association of Fire Chiefs do not track the number of PTSD cases. On a national front, it is difficult to determine the number of firefighters filing injury reports based on a diagnosis of PTSD. One of the challenges of establishing a tracking method is to get a "truthful" response. Many firefighters will not admit they have PTSD. Fire service agencies are reluctant to report employees with PTSD for fear of fiscal responsibility, and workers' compensation standards for determining a job-related injury vary from state to state. If a tracking method is established, it will have to be confidential to protect the reporting individuals.

A HELPLESS FEELING

When a firefighter is exposed to a traumatic incident, there is the possibility that the firefighter will experience significant psychological distress. Given that this is the very nature of the job, it is imperative that firefighters are able to identify and attend to psychological injuries.

What exactly is PTSD? The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (revised fourth edition), the nationally recognized medical diagnostic/criteria manual used in determining mental disorders/illnesses, defines PTSD very specifically.[1] According to its definition, all of the following components must be present for PTSD:

- Exposure to a traumatic event in which the individual was confronted with actual or threatened death or serious injury to himself or others and experienced intense fear or helplessness.
- Reexperiencing of the event triggered by cues associated with the event through thoughts or dreams or by the individual's acting or feeling as if the event were reoccurring. The individual avoids any reminders of the incident, and the person's responses to normal events

■ **PAUL J. ANTONELLIS JR., MA, CEAP, CAS**, is a 20-plus-year veteran of the fire service and has held various positions including chief of department. In addition, he has 11 years of law enforcement experience. He has lectured to emergency service providers nationally and internationally and has authored and had published many articles and two books. He is on the faculty for two colleges, where he teaches in the undergraduate and graduate fire science programs.

■ **FLOYD "SHAD" MESHAD, MSW, LCSW, CTS, TFTDX**, is president and founder of the National Veterans Foundation, Los Angeles, California. He is the author of *Captain for Dark Mornings* (Los Angeles: GR Press). He is the coauthor/founder of the Veteran Administration's Vet Center Readjustment Counseling Program and past president of the Association of Traumatic Stress Specialists. He is a member of the International Critical Incident Stress Foundation faculty and has lectured nationally on treatment methods for PTSD.

■ **DABNEY STACK, MSSW**, is a licensed clinical social worker in the state of Tennessee, where she is in private practice focusing on emergency trauma. She has an MSSW from the University of Tennessee and is a member of the NASW and the Nashville Psychotherapy Institute. She does volunteer work at the Veterans Hospital in Nashville.

become numb.

• The experiencing of "increased arousal," evidenced by the inability to fall or stay asleep, exaggerated startle responses, unusual irritability, or outbursts of anger and heightened vigilance.

These symptoms must endure for *at least* one month and interfere with important areas of the individual's life such as work or socialization.

Some manifestations of ASD or PTSD firefighters have reported include concerns for their safety and an overwhelming sense of helplessness. Men and women accustomed to handling life-threatening situations with competence can find it difficult to deal with this phenomenon.

ASD VS. PTSD

What is the difference between ASD and PTSD? According to the *Diagnostic and Statistical Manual of Mental Disorders*, the symptoms described above are basically the same for each disorder. What distinguishes the two disorders is the duration of the symptoms. In ASD, the symptoms occur within the first month and last for two or more days. On the other hand, PTSD symptoms must last longer than a month. The symptoms may develop immediately after the traumatic incident, or they may be delayed. If the symptoms develop more than six months after the traumatic incident, this is classified as a "delayed onset" of PTSD. Regardless of when the symptoms develop, they must be present for longer than a month.

CATEGORIES OF PTSD SYMPTOMS

PTSD symptoms fall into three categories:

• **Intrusion.** Unexpected memories of the trauma can reoccur unexpectedly. In waking hours, these episodes are called "flashbacks." They bring with them the strong emotions felt at the time of the incident. They can be so vivid that it feels as though they are actually occurring. These memories can also appear in dreams and cause a fear of sleep. Often, memories of the incident intrude on the individual's thoughts when trying to concentrate on some other task. The flashbacks can be experienced days later, weeks later, months later, and—in some cases—years later. People experiencing flashbacks are reliving the experience, and they have a difficult time understanding why now? The brain has captured the traumatic event and will keep playing it back like a movie, a flashback.

• **Avoidance of reminders.** These cues can be internal or external. Thoughts, feelings, conversations, activities, places, or people—anything that can be a reminder of the incident—are avoided.[2] The firefighter may start calling in sick at work, arriving late, or not showing up at all, in an effort to avoid the stimuli of the work environment. If this goes on for any length of time, chances are that the department may take progressive disciplinary action against the firefighter without knowing that the real issue here is trauma. The firefighter may be disciplined for actions resulting from PTSD. Most people will not admit that they are experiencing these symptoms. They may feel that no one will believe them, that their coworkers will look on them as weak, or that only they are experiencing the symptoms.

Most coworkers, family members, and supervisors are not trained to confront the affected firefighter on his feelings. They often will ask, "What is bothering you?" or "How are you feeling?" The affected firefighter generally will lie about what is going on, preferring not to talk about it. The truth is that avoiding these questions is part of the PTSD syndrome.

• **Hyperarousal.** The symptoms may show up in several ways. One is that the firefighter may have trouble falling asleep or staying asleep. This is a common complaint and is considered normal after a traumatic incident. After about a month, this situation should improve. If the sleep disturbance has not changed in that time, it may be linked to PTSD. Experiencing sleep problems for a prolonged time most likely will affect the body physically and emotionally. Not receiving proper sleep will create a domino-like effect: With each night of less than optimal sleep, the toll on the body will increase. The lack of sleep can lead to increased anger and sudden outbursts of emotion.

People close to the affected firefighter may start to distance themselves because of the increase in anger, when, in reality, the opposite should occur. The people close to the affected firefighter should be understanding, supportive, and nonjudgmental.

Increased irritability or uncharacteristic outbursts of anger may show up in the firefighter's personal life or on the job. This behavior quickly will become an issue on the job, but it can often go undetected if it occurs only at home. A fire service administrator may be taking progressive discipline steps against a firefighter masking the by-products of PTSD (anger and outbursts). It is easier for the firefighter to hide behind the "anger shield" than to admit that a critical incident is bothering them. Let's face it; it is much more macho to be disciplined for anger and outbursts than to admit experiencing some strong feelings from a traumatic incident.

The firefighter may notice that he is always on guard at work, ready to respond, heart racing, and no place to go—all signs of hypervigilance. The firefighter may claim that he cannot get the job out of his head. He is always thinking about the next call and staying in a perpetual state of readiness, never allowing time to unwind. Over time, this takes a toll on the body. Keep in mind that these symptoms must be present for more than a month.

The firefighter generally does not understand or recognize that he is in this increased arousal state. The body and mind have kicked into action, as so many times before, to deal with the traumatic incident. However, this time the body does not come back down to the normal state. In simple terms, the brain is stuck in a constant arousal state. As Schiraldi explains: "The nervous system has become sensitized by an overwhelming trauma. Thus, two things happen. General arousal becomes elevated while the nervous system overreacts to even smaller stressors."[3]

Firefighters have a different response to every call to which they respond. There is no predictor to identify which call, if any, will become a traumatic event for a particular firefighter. Sometimes the effect is cumulative over a series of events, and symptoms are triggered by a seemingly small incident. The psychological distress expressed through nightmares, bad dreams, people and places and other stimuli associated with the incident, and heightened vigilance are indicators of this invisible injury. A firefighter who experiences these or other symptoms for longer than a month may meet the criteria for a diagnosis of PTSD.[4] (3)

The symptoms discussed above are acute symptoms. Sometimes, PTSD symptoms may not surface for months and even years after a traumatic incident. "Delayed onset" symptoms, for example, appear at least six months after the stressor. (1) If the symptoms last longer than three months, the PTSD is considered chronic; if the symptoms last less than three months but more than one month, the PTSD is considered acute.

After a traumatic incident, it is common for firefighters to experience feelings of fear or anxiety, anger or sadness, but this is *not* PTSD. These are normal reactions to an abnormal event. (2) As Fire Chaplain David P. Akin of the Yarmouth (MA) Fire Department observes, "You are in a great job with some lousy side effects. If you deal thoroughly with the side effects, the career will be long and fulfilling." Many firefighters will *not* develop PTSD. However, those who do need to be supported in

their battle to regain their emotional stability. With support, encouragement, and therapy, they will go on to lead productive lives.

THE HIDDEN COSTS OF PTSD

The image of a firefighter is one of a strong, independent, and unemotional individual. Firefighters are expected to carry out their duties day in and day out without any emotional toll. They quickly learn that they must suppress their emotions during an incident if they are to perform their job. Over the long haul, this suppression of emotions becomes quite natural and may be carried over into the firefighter's personal life. The firefighter becomes unaware of his emotions and is said to be "out of touch" with reality.

This image can lead to a firefighter's trying to present to the world a mask that hides emotions or feelings that could be perceived as weak or unfit. When this happens, all emotions and feelings are blocked, leaving behind a man or woman with no signs of any feelings, referred to as having "restricted affect." The firefighter may no longer be able to show feelings of intimacy, tenderness, or sexuality.

In an effort to mask the restricted range of affect, the firefighter may try to recapture the ability to feel by engaging in extramarital affairs, having unprotected sex with multiple partners, or undertaking dangerous activities. Restricted range of affect has been the center of many relationship problems. If caught engaging in one of these behaviors, the firefighter can just hide behind the risky behavior and not address the real issue behind the behavior, the PTSD symptoms. Firefighters faced with emotional trauma feel they cannot ask for help because of the stigma associated with mental health and PTSD.

It is unfortunate that some people believe PTSD can be faked or that people with PTSD are just "playing a game." In most cases, firefighters are reluctant to admit they are suffering from any kind of psychological injury. Therefore, the number of cases involving firefighters "faking" (malingering) PTSD is very low. To avoid malingering, experts recommend that the firefighter be independently evaluated at least twice.

In one case, a local town manager asked an employee with PTSD if he could "just take a pill," suggesting that PTSD could be cured with just a pill. This illustrates how poorly understood PTSD is. Municipal officials and fire service administrators need a clear understanding of PTSD as they navigate up a very slippery legal slope. Over the past few years, the courts have seen an increase in PTSD claims and defenses.[5] An administrator/supervisor can find himself in a legal battle that could be of significant cost to the city/town. The bottom line is that people with PTSD have a medical condition that must be treated.

WHO CAN DIAGNOSE?

To properly diagnose and treat PTSD, a firefighter *must* be examined by a professional mental health clinician. The treatment methods for PTSD vary. Each case must be determined individually. What works for one person may not work for another. Among the most common treatment methods for PTSD are behavior therapy, cognitive-behavioral therapy, pharmacotherapy, eye movement desensitization and reprocessing (EMDR), and thought field therapy (TFT). It is strongly recommended that the firefighters become familiar with each method and select, with the therapist, the approach best suited to the situation. If the affected firefighter does not buy into the treatment method, it may be doomed from the beginning, and valuable time and resources may be lost. A good starting point is to ask the health insurance company for a referral list of providers in your area, the treatments that will be covered, and any coverage limits.

PTSD is treatable. Unfortunately, statistics have routinely shown that many firefighters, police officers, and military veterans suffering from PTSD symptoms do not seek help because of machismo, a warrior mentality, or the fear of being stigmatized within their work environment.

Mental health professionals who specialize in the diagnosis and treatment of PTSD are commonly known as "traumatologists." They should be certified through an agent such as the Association of Traumatic Stress Specialists (ATSS; www.atsss.info). Depending on the state/city, a list of certified technicians can be accessed by contacting ATSS directly.

Traumatologists specialize in working with certain types of PTSD victims (i.e., children, domestic violence victims, veterans, fire, police, for example). A therapist who is properly certified and has experience working with the fire service population would be the most effective. Since the relationship between the firefighter and the therapist is an important factor in determining the success of the therapy, it is a good idea to interview more than one therapist before committing to one. Also, if no progress is being made with one therapist, consider switching to another therapist. Each person has unique needs specific to his personality, and no therapist, no matter how skilled, is able to meet everyone's needs. A good therapist understands this and may even recommend someone who would be a better fit with the firefighter.

All therapists in private practice are required by law and their training to maintain strict confidentiality. What is discussed behind closed doors should never be repeated to anyone without the client's express permission. Firefighters concerned about confidentiality should ask the therapist about the legal issues surrounding the sessions. Before signing "release of information" forms for the therapist or fire department, it is recommended that the firefighter consult with a labor attorney. No therapist is going to risk losing his license to practice and incur the possibility of being sued civilly by releasing medical information about your case. A therapist has a great deal of legal responsibility to protect your medical records.

TREATMENT METHODS

A good treatment plan for PTSD is much like a puzzle with many pieces. Standard psychoanalytical techniques (reality therapy, group therapy, behavior modification), depending on the experience of the therapists, have proven effective. Over the past 15 years, several additional treatment methods for PTSD have emerged. Four of the most widely used techniques include the following:

- **EMDR (Eye Movement Desensitization and Reprocessing).** In this approach, the therapist asks the patient to bring to mind the incident the patient wants to work on, the negative thinking caused by the incident, and the positive thoughts the patient wants to have. Then the therapist moves her or his fingers rapidly back and forth in front of the patient. While focusing on the traumatic emotions and desired positive feelings, the patient follows the fingers with his or her eyes. Sometimes, taps to hands, right and left; sounds alternating ear to ear; and even alternating movements by the patient are used to trigger the alternating stimulation of the two sides of the brain. After a number of sets of movements, patients generally think and feel quite differently about the incident, similar incidents, and themselves.
- **Neuro-Linguistic Programming (NLP).** NLP therapy is based on learning how we perceive the world through our five senses, to understand how some people can respond very resourcefully in a situation while others do not. Models that enhance our ability to communicate, use the senses, speak, and perceive are applied to help individuals improve the way they remember traumatic events or react to traumatic episodes as a means of eliminating or reducing PTSD-related symptoms.
- **Thought Field Therapy (TFT).** TFT gives immediate relief for

PTSD, addictions, phobias, fears, and anxieties by directly treating the blockage in the energy flow created by a disturbing thought pattern. The therapist asks a person to think about a situation or an event and to rate how uncomfortable he feels at the moment on a scale of 1 to 10, where 10 is the worst you can feel and 1 represents no trace of the problem. Then, at the direction of the therapist, the patient taps with two fingers on various acupressure points on the body. During this process, the patient rates how he feels. The tapping is done according to a prescribed pattern (algorithm). The algorithm is based on the particular emotions elicited by the upset. After the series of tapping, patients are asked to continue rating the problem until it reaches 0-2, at which point the treatment is complete.

• **Trauma Incident Reduction (TIR).** TIR is a brief, one-on-one, nonhypnotic, person-centered, simple, and highly structured method for permanently eliminating the negative effects of past traumas. It involves repeated viewing of a traumatic memory under conditions designed to enhance safety and minimize distractions. During TIR, the therapist or counselor gives appropriate instructions to the client to have him view a traumatic incident thoroughly from beginning to end. The desired outcome is to minimize the stress associated with the event through a more thorough understanding of and confrontation with the feelings, emotions, and intentions surrounding the trauma.

Floyd "Shad" Meshad, coauthor of this article, who has worked with combat veterans, notes, "In my 30-plus years of working in trauma, there has been a tremendous amount of reported success with each of these tools of trauma treatment. In the early 1990s, I was given an opportunity to train diagnostically with the modality of TFT. For the past 11 years, I have used this in addition to my psychoanalytical techniques and have had great success with trauma victims from all walks of life. In addition, I have heard numerous colleagues relay their successes in working with NLP, EMDR, and TIR."

We recommend that the rate of PTSD injuries to firefighters be tracked on a national front, even though this will be difficult to accomplish for a number of reasons. First, every state has different workers' compensation laws. Second, firefighters fear reporting a mental health injury. Third, many times, PTSD injuries are reported as another form of injury. This is an area the fire service should examine without bias to determine if PTSD is a significant health issue for firefighters. If this is done, the fire service could then move forward and develop programs for identification, education, and prevention programs.

The fire service cannot afford to turn a blind eye to this issue facing our firefighters. The financial impact to the firefighter and the community is high and can be avoided. PTSD does not have any boundaries; it can strike full-time firefighters and call/volunteer firefighters, city firefighters and small-town firefighters, young and old firefighters, male and female firefighters, and firefighters with ranks up to and including chief. ■

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