

The image is a composite. In the foreground, a woman with dark hair is shown in profile, looking down with her hands pressed against her temples, suggesting stress or distress. In the background, a long, brightly lit hospital hallway with a glass door at the end is visible. The overall tone is somber and reflective.

A REPORT PREPARED BY THE **MANITOBA NURSES UNION**

POST-TRAUMATIC STRESS DISORDER
(**PTSD**) IN THE NURSING PROFESSION

HELPING MANITOBA'S WOUNDED HEALERS

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Trauma
doesn't end
when the
shift does.

POST-TRAUMATIC STRESS DISORDER

PTSD

Executive Summary

Post-traumatic stress disorder (PTSD) is increasingly prevalent in the nursing profession. As PTSD is cumulative and manifests over time, many nurses are not able to recognize the signs of PTSD triggers as these triggers are subjectively based on each individual's response to trauma. Furthermore, common elements to the nursing profession, such as critical incident stress, emotional labour and occupational burnout, are important to recognize as key contributors to PTSD as they cause an increase to nurses' susceptibility and exposure to PTSD development. The intent of this report is to provide a humanistic perspective towards recognizing the mental health effects nurses experience as a result of their exposure to traumatic and critical incidents encountered on a daily basis. An analysis on the diagnostic criteria of PTSD combined with an accumulation of PTSD research serve as the integral components of this report to form the basis to conclude that PTSD is an occupational illness directly related to the work environment of nurses. The legislative scan assesses viable opportunities for Manitoba to consider in adopting presumptive legislation to not only recognize PTSD as an illness, but an occupational hazard in the nursing profession. A key section of this report reflects upon the qualitative data the Manitoba Nurses Union (MNU) received through its PTSD focus groups and membership survey in which it emphasizes the deep-rooted effects PTSD has on Manitoba's nursing workforce. This data helps formulate the recommendation that management needs to recognize its responsibility to improve the working conditions for nurses, and provide more access to improved supports.



Key Findings

- Approximately 65% of MNU's members say that compassion fatigue is a common element in their work environment, furthermore 52% of members have stated that critical incident stress and PTSD are common in the workplace¹.
- According to research studies in Manitoba, the top five stressors of PTSD for nurses are: (1) death of a child, particularly due to abuse; (2) violence at work, (3) treating patients that resemble family or friends; (4) death or injury of a patient after undertaking extraordinary efforts to save a life; and (5) heavy patient caseloads².
- Core contributing factors of critical incident stress and PTSD in the nursing profession include: exposure to trauma and critical incidents, lack of employer and organizational supports, emotional labour and compassion fatigue, and workplace violence. Violence plays the largest role in development of PTSD for Manitoba's nurses as 52% of nurses have been physically assaulted, while 76% have been verbally abused, which highlights the prevalence of violence in Manitoba's healthcare facilities.
- Due to overlapping symptomology, PTSD is often misdiagnosed as occupational burnout or compassion fatigue in nurses.
- Nurses are susceptible to primary, secondary and vicarious trauma, all of which are based on events that are not typically seen as traumatic, but are emotionally and physically tolling.
- PTSD in nurses also has organizational implications as it is linked to a decrease in job satisfaction and an increase in sick leave and staff turnover³.

¹ Manitoba Nurses Union Member Survey, November 2014

² Powell (1996): 38

³ Andriaenssens 2012: 1419

Core Recommendations:

Based on the presented research findings, MNU has proposed the following recommendations and strategic priorities for addressing PTSD in nurses:

- 1** Develop and enforce presumptive PTSD legislation for nurses in the Workers Compensation Act;
- 2** Develop comprehensive employer and organizational supports in addressing PTSD;
- 3** Create a healthier work environment within the healthcare facilities;
- 4** Increase the education and awareness of PTSD amongst nurses and management; and
- 5** Develop a fundamental way to track and access PTSD cases for Manitoba's nursing workforce.

Introduction

Encountering extreme cases of abuse and injury, witnessing more deaths than the average person, feeling like you could have done more to save a life, seeing firsthand the signs of intense grief and pain: all of these are experiences the general population would find traumatic, yet form the bulk of daily occurring experiences for nurses. Irrefutably, the exposure nurses have to trauma and critical incidents have lasting effects on their mental health.

While the nursing profession is one that can be gratifying, challenging, and rewarding, it is also one that causes nurses to be ongoing witnesses to trauma and an inordinate amount of pain, suffering and death. The exposure to mentally exhausting and challenging work is not openly discussed or recognized publicly even though research claims now identify that 30 to 40% of nurses are suffering from PTSD⁴. The statistics for PTSD in nurses also pose a challenge of being under-represented due to the fact that nurses suffering from PTSD are either under-reported or under-recognized. This is partly attributed to the social stigma associated with mental health and the strenuous efforts nurses make in upholding society's perception of them as care providers. This forms the foundational question: how can those who are expected to heal others, simultaneously heal themselves?



Understanding PTSD from a nursing perspective illuminates the complexity involved in recognizing how key components of the nursing profession influence the exposure nurses face to trauma and critical incident stress. Unlike other first responders, nurses are interacting with individuals once they have been removed from a crisis situation and accompany patients on their journey to recovery or end of life care. The length of exposure to trauma is significant to recognize given that as the exposure to suffering and trauma is prolonged, the intensity and breadth of stress increases for nurses⁵. The core trigger of PTSD is not only the experience of trauma itself, but also the threat of violence or perceived trauma, as this can induce equal or higher levels of stress than experiencing an incident directly. As PTSD remains a reality for nurses, more attention is required in recognizing the contributing factors that prime PTSD in the nursing profession. This includes critical incident stress, occupational burnout, emotional labour, and workplace violence. By recognizing and understanding these factors as core contributors to PTSD, it will become apparent that the nature of the nursing profession increases the exposure to traumatic events, and the susceptibility of PTSD development. This recognition will help ensure that adequate, accessible supports are implemented effectively in order to provide relief.

This report provides a comprehensive analysis of the prevalence of PTSD in the nursing profession in general, and specifically nurses in Manitoba. The analysis throughout the report features both qualitative and quantitative data that recognizes PTSD in nurses by highlighting: (1) the definitive scope of PTSD, which includes diagnostic criteria; (2) the contributing factors found to be key influencers of PTSD in the nursing profession; (3) the prevalence of PTSD in Manitoba's nurses, which provides insight into the severity of exposure to traumatic events, along with the subjective nature of PTSD; and (4) an overview of current PTSD legislation across Canadian jurisdictions to discuss the issue of access to PTSD benefits and supports. The report concludes with a summary of recommendations based on the presented research findings, anecdotal evidence from MNU's focus group sessions, and best practices formulated from jurisdictional legislation.

“To this day people will say, ‘oh you have PTSD,’ but I still don’t want to face that fact. I don’t want that label.”

⁴ Laposa and Alden 2003: 56

⁵ Meadors and Lamson 2008: 24

Defining Post-Traumatic Stress Disorder

1.0 Contextual Background of PTSD

PTSD development is considered to be a normal reaction to an extraordinary event outside the range of human experience. PTSD was first introduced in 1980 in which veterans of the Vietnam War were the first individuals to have been diagnosed with this disorder⁶.

Since then, more documentation has been established to show how direct exposure to traumatic stressors outside of a military context can lead to PTSD, with recent research showcasing how nurses may be more prone to PTSD than war veterans⁷. The hallmark symptoms of PTSD include: intense fear, helplessness, flashbacks, and/or horror, however symptoms are broken down into four diagnostic categories as outlined in this report.

Clinically, trauma is generally defined as an event that involves actual or threat of death or serious injury, another type of threat to one's physical integrity, or even witnessing an event that involves death, injury or a threat to the physical integrity of another person. The definition of trauma is further extended to differ between primary, secondary, and vicarious trauma. Primary trauma refers to an event experienced directly, such as being physically assaulted at work. Secondary trauma, refers to instances where an individual witnesses a traumatic event. Vicarious trauma, also referred to as compassion fatigue, refers to the empathetic toll a person feels as a result of caring for a traumatized person⁸.

The nature of nursing is such that a nurse can experience all three forms of trauma simultaneously on a daily basis, even more so if they are working in areas that have high exposure to trauma such as emergency or intensive care units. As such, trauma and PTSD development become daily elements of the nursing profession, inevitably and adversely impacting the well-being of nurses. During the course of their career, nurses witness and experience various critical incidents that can accumulate and manifest as burnout, depression, anxiety and stress⁹.

Furthermore, a specific research study has found that two days to four weeks after a critical incident, severe post-traumatic stress, also known as acute stress disorder, develops. Acute stress disorder however, is easier to diagnose and the affected individual begins displaying some of the symptoms of PTSD¹⁰.

PTSD research has consistently identified that its development is cumulative and manifests differently for each individual as PTSD is a result of the unique, individualistic processing of an event. Regardless of the variations of PTSD diagnosis, research has

provided concrete evidence that nurses involved in critical and traumatic incidents are deeply affected due to the increased frequency and exposure of trauma that occurs within their occupation¹¹.

1.1 Measuring PTSD

The current scale used to measure PTSD is The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)¹², which features enhanced diagnostic categories that emphasize the behavioural symptoms that accompany PTSD. This scale along with the less enhanced model, DSM-4, is included in the majority of PTSD related research. The new diagnostic categories include: re-experiencing, alterations in arousal, avoidance, and negative alterations in cognition and mood. The new categories have been proven to provide more flexibility in the diagnosis of PTSD and are more suitable for measuring the extent of PTSD development.

The following categories represent the current measurement model for diagnosing PTSD:

A. Exposure to actual or threatened death, serious injury, or sexual violence in the following ways (individuals must exhibit at least one of these symptoms):

- 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 close family member or close friend. In cases of actual or

“ Sometimes I felt as if the universe was conspiring against me. That was the only way to explain things. I lost confidence; wasn’t self-assured. I became anxious and hyper-vigilant. ”

threatened death of a family member or friend, the event(s) must have been violent or accidental

- 4** Experiencing the repeated or extreme exposure to aversive details of the trauma event(s) (e.g. first responders collecting human remains, police officers repeatedly exposed to details of child abuse

B. Intrusion Symptoms (individuals must exhibit 1 out of the five symptoms)

- 1** Intrusive distressing memories of the traumatic event(s)
- 2** Recurrent distressing trauma related dreams
- 3** Dissociative reactions (e.g., flashbacks)
- 4** Intense psychological distress when exposed to traumatic reminders
- 5** Marked physiological reactivity after exposure to trauma-related stimuli

⁶ Beck 2011: 1

⁷ Powell 1996: 3

⁸ Beck 2011: 1

⁹ de Boer et al 2011: 317

¹⁰ de Boer et al 2011: 317

¹¹ Powell 1996: 9

¹² American Psychiatric Association. Diagnostic and statistical manual of mental disorders 5th ed. (2013).

C. Avoidance of Stimuli/ Numbing of General Responsiveness (individuals must exhibit 1 out of the 2 symptoms)

- 1** Persistent avoidance of thoughts and memories
 - 2** Persistent avoidance of external reminders (DSM-IV C2)
-

D. Negative alterations in cognitions and mood (individuals must exhibit 2 out of the 7 symptoms)

- 1** Dissociative amnesia of the traumatic event(s)
 - 2** Persistent negative expectations
 - 3** Persistent distorted blame of self or others about the traumatic event(s)
 - 4** Persistent negative emotional state
 - 5** Diminished interest or participation in significant activities
 - 6** Feeling of detachment or estrangement from others
 - 7** Persistent inability to experience positive emotions
-

E. Alterations in arousal and activity (individuals must exhibit 2 out of the 6 symptoms)

- 1** Irritable behavior or angry outbursts
- 2** Reckless or self-destructive behavior
- 3** Hyper-vigilance

4 Exaggerated startle response

5 Problems with concentration

6 Sleep disturbance

F. Persistence of symptoms (in Criteria B, C, D and E) for more than one month

G. Functional Significance: the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. Exclusion: the disturbance is not due to medication, substance use, or other illness.

In conjunction with diagnosing PTSD, a new dissociative subtype has been developed. Dissociative PTSD can be diagnosed in both youth and adults and is diagnosed using the following criteria:

- Meets PTSD diagnostic criteria;
 - Experiences additional high levels of depersonalization or derealisation; and
 - Dissociative symptoms are not related to substance use or other medical condition
-

NOTE: It is important to note that the measurement scale may be used in combination with other measurement and diagnostic tools, however the method described above is common to all PTSD studies and research.

1.2 The Role of Gender in PTSD Development and Diagnosis

As nursing is a predominantly female occupation, it is important to highlight how gender plays a role in diagnosing PTSD in women compared to men. In observing how nurses are vulnerable to PTSD due to the nature of the profession, literature is addressing the importance of applying a gender lens in analyzing PTSD susceptibility.

By applying a gender-based analysis, it is important to attribute the role gender plays in the prevalence of mental health issues. In using the historical *Social-Role Theory of Eagly*, men and women behave according to their social role¹³. In modern culture, women are expected to be more passive, and in accordance with their role expectation, would be expected to report their symptoms more readily than men. In contrast, men are expected to be more resilient and “stronger” than women, and would not be assumed to talk about diseases and disorders¹⁴. This can lead to an unintentional social bias to take the accounts of men more seriously than women as when a man can no longer meet the role standard, society may consider it as a sign of serious personal crisis.

Gender, amongst other personal characteristics, is also a predictor in effectively diagnosing PTSD. For example, key studies examining the role of gender and the exhibition of PTSD symptoms, highlights evidence that women and men differ in the types of traumatic events they experience and the variations of symptoms they may exhibit. It has been found that men report higher numbers of traumatic events whereas women are more often to

develop PTSD symptoms at a later rate after a traumatic event¹⁵. PTSD in men is manifested in a way that is very noticeable, since behaviours of a man with PTSD are outside the range of “normal” male behaviour and thus, quite noticeable. For instance, many men, as there have been several documented public cases, commit suicide and experience panic attacks more often than women¹⁶. Numerous studies substantiate this claim as they have shown that men and women differ in their management of stress and crisis, and thus diagnosis can be a challenge. In the case of PTSD development, women display emotional vulnerability in which symptoms of anxiety, depression, and emotional instability are not usually seen as signs of crisis, rather as signs of stress. Hence, when women display these symptoms, they are not taken as a sign of crisis, but rather some type of instability and disruption. This can lead to the onset delay of PTSD diagnosis and treatment. Many studies also offer in-depth support by examining how women have a higher prevalence of PTSD due to their vulnerability to develop similar other associated mental health disorders such as depression and anxiety¹⁷.

The challenge here is to recognize that women who experience trauma and severe stress are just as likely to have PTSD compared to their male counterparts, if not even more so. It is important to recognize that it is the effects of social norms and the profession's expectations that present obstacles in recognizing PTSD development.

¹³ Gavranidou and Rosner 2003: 134

¹⁴ Peters, Issakids, and Slade 2005: 81

¹⁵ Gavranidou and Rosner 2003: 130

¹⁶ Saddichha, Sahoo et al. 2014: 3

¹⁷ Peters, Issakids, and Slade 2005: 82

Literature Review

Core Contributing Factors of PTSD in Nurses

Comprehensive research findings identify that nurses are susceptible to PTSD on two levels: an individual level as a result of performing their job; and an organizational level based on the workplace environment, availability of workplace supports, and quality of interpersonal relationships. These findings demonstrate that PTSD development is not only a psychological effect of an individual's reaction to a traumatic event, but rather the result of work environment factors that contribute to the increased susceptibility of PTSD. Through an in-depth compilation of PTSD related studies, research has found the following factors to increase nurses' susceptibility to PTSD:

1 Critical Incident Stress

Medical literature has found that from two days to four weeks after a critical incident, severe post-traumatic stress or critical incident stress develops¹⁸. Critical incident stress refers to the psychological, physiological and emotional response an individual encounters after experiencing a traumatic event. The symptoms of critical incident stress closely mimic those of PTSD in which they can present themselves physically, emotionally, cognitively and behaviourally. Individuals with critical incident stress may experience great changes in their behaviour such as withdrawing from social encounters, restlessness, and a change in usual communications¹⁹.

A 1996 Canadian study examined the rate of PTSD in Manitoba's nurses, specifically

those employed in areas that experience high exposure to critical incidents. The study found that 42.1% of nurses had high or moderate PTSD symptoms; 32.9% of these nurses had moderate symptoms, and nearly ten percent had severe symptoms (9.2%). The study outlined the five most commonly cited triggers which included: 1) death of a child, 2) abuse from patients and patient's families and friends, 3) personal identification with victims, 4) loss of life following extraordinary expenditure of energy during rescue efforts and, 5) death of a patient or serious injury as a consequence of a medical procedure²⁰. Further research in other studies have found that maternity nurses confirmed that they developed critical incident stress after repeatedly caring for infants of mothers with addiction issues, who subsequently developed birth defects and were taken into foster care.

During 1994, the unexplained deaths of twelve children who had undergone cardiac surgery prompted the Manitoba Pediatric Cardiac Surgery Inquest for the Children's Hospital facility at the Winnipeg Health Sciences Centre. It was during this inquest, the public became aware of the emotional trauma and critical incident stress many nurses suffered based on their ongoing experiences within the surgical unit. For instance, many nurses at Manitoba's Children Hospital reported emotional discomfort and stress due to unexplained sudden deaths which eventually led to the cancellation of the pediatric heart program due to higher than expected deaths. During the inquest, nurses came forward and identified the increased amount of critical incident stress they were experiencing as they "found it exceptionally difficult to orient parents pre-operatively for their child's heart surgery when they 'knew' that in all probability, their baby would die post-operatively²¹." One nurse even commented that she felt she was always struggling with her role as a nurse and her role as a compassionate person as she was always tempted to tell the parents to cancel the surgery. This inquest also highlighted how the experiences and observations the nursing staff witnessed, led them to voice serious and legitimate concerns yet because the nurses were never treated as equal members of the surgical team, their concerns fell silent with other staff²².

These examples demonstrate that due to the increased nature of trauma within the work environment, nurses must force themselves to experience a greater emotional dissonance to separate

themselves from the event, and thus form a habit of normalizing trauma. This leads to an increased development of critical incident stress and over time, can accumulate to PTSD. Research has identified that the likelihood of PTSD development is directly related to the severity of PTSD symptoms that are exhibited, specifically the exaggerated use of avoidance behaviours such as emotional repression, denying or dissonance in response to the event²³. Specifically noted in the 1996 study, workplace issues such as behaviour of co-workers, heavy patient loads, behaviour of medical personnel and management, and healthcare re-structuring were all found to be core triggers for PTSD. It was also found that the heavy workloads, feeling overwhelmed, fear of making errors, and a sense of responsibility to provide a high level of care, were also situations that were psychologically taxing and traumatizing²⁴. Nurses in the study commonly reported experiencing the following PTSD symptoms in order of significance: an inability to control images of traumatic events while engaged in other activities; recurrent dreams, sudden acting or feeling as if the event is recurring, and feeling distressed when exposed to an event resembling the initial trauma. This study concluded that if nurses do not have adequate organizational supports, it jeopardizes their ability to maintain their professional standards.

¹⁸ de Boer et al 2011: 317

¹⁹ de Boer et al 2011: 318

²⁰ Powell 1996: 38

²¹ Powell 1996: 39

²² The Report of the Manitoba Pediatric Cardiac Surgery Inquest 1998

²³ Rassin, Kanti and Silner 2005: 883

²⁴ Powell 1996: 40-44

2 Emotional Labour

Emotional labour is characterized as providing services that are nurturing, caring, compassionate, and empathetic. This extends beyond an emotional bond a nurse may develop as emotional labour requires nurses to suppress or evoke certain emotions in themselves and others²⁵. This may result in dissonance between one's true feelings and the emotions a nurse is expected to display in a stressful situation in order to uphold the professional image and conduct of the nurse-patient relationship²⁶.

As some treatments may be physically and emotionally tolling on patients, nurses may be viewed as the inflictor which can lead to painful, unintentional physical demands of patients causing more emotional distress to a nurse's mental energy²⁷. Prolonged exposure to pain and suffering, and the possibility of forming an emotional bond, makes the nurse both a witness of trauma, and one who directly experiences it. On the other hand, when a nurse's efforts to save a life are unsuccessful, multiple emotional responses may occur, which in turn may pose negative effects on job performance. These effects include self-doubt, guilt, anger, or despair — all major influences of a nurse's perception of their ability to perform their job. In a study of nurses who made medication errors, nurses reported experiencing stress-related physical symptoms while one nurse started experiencing all of the side effects of the fight-or-flight instinct²⁸. This is considered a typical reaction, as the professional ethos for nurses governs them to care for

the patient first, then take responsibility for their own actions and emotions²⁹.

The hazards of emotional labour are largely unexplored, particularly because emotional labour is seen as something that nurses, particularly women, are naturally predisposed for. Furthermore, few studies exist on nursing as a profession of emotional labour and hazards of this nature of work. To reiterate, the fact that the public expects nurses to be caring, nurturing and compassionate, while nurses, on the other hand, expect trauma as part of their job, creates a complex dynamic which is not yet sufficiently understood.

3 Occupational Burnout and Secondary Traumatic Stress (STS)

Occupational burnout refers to a state of physical, emotional, or mental exhaustion combined with doubts about the competence and value of an individual's work. It can be an effect of a variety of factors including unclear job expectations, lack of control over decisions that affect one's job, lack of resources to complete one's job, feelings of isolation at work and in personal life, extreme chaotic activities in the workplace and consistent work-life imbalance. For many nurses, the work environment and the strenuous workloads challenge their belief that their work has value³⁰.

Specifically applied to the nursing profession, occupational burnout can also be recognized as compassion fatigue or secondary traumatic stress (STS)³¹. Compassion fatigue is referred to as “the

emotional stress experienced from working with traumatized people”, while STS is typically applied specifically to healthcare workers as an emotional response originating from witnessing another individual experience trauma³². In assessing the emotional costs nurses pay in providing care for patients, Cheryl Beck referenced four key factors that influence STS: 1) empathy as a resource for individuals who work within traumatic environments, 2) when an individual has personally experienced trauma in the past, 3) unresolved trauma that is activated by reports of similar trauma with patients, and 4) trauma that involves children³³. These factors are not only apparent in the daily responsibilities of nurses, but also influence similar behaviour to that of PTSD symptoms. For example, studies related to nurses and STS found the most frequent reported symptoms have included irritability, avoidance behaviour, difficulty sleeping, intrusive thoughts, diminished activity level and emotional numbing³⁴.

In surveying its members, MNU has found that 62% of nurses in Manitoba currently experience compassion fatigue and 71% of nurses have experienced burnout at some point in their career. This highlights how the daily working conditions of nurses exerts various pressures personally and professionally which can lead to moral distress. For example, nurses want to provide the best possible care, but may be limited by working conditions such as short staffing and high patient acuity. It is important to recognize that compassion fatigue is an inter-generational issue for nurses

both with accrued experience, and those just entering the profession³⁵. This notion was apparent in a recent Canadian study that identified that approximately 43% of new nurses reported, a high level of psychological distress, from which 62% intended to quit their present job, and 13% intended on leaving the profession. Regardless of their work setting, nurses often work short staffed, long shifts and have crippling work assignments³⁶, which when coupled with lack of autonomous decision making and input, can lead to unprecedented levels of burnout in the nursing population³⁷.

“ I had a case where a child was badly beaten by her parents and died as a result, and the parents are standing there in the room. I was so upset and angry. Then the whole family comes, and you wonder, where were you when this was happening? You still have to continue with your day. ”

²⁵ Wolkowitz 2006: 77

²⁶ Wykes and Whittington 1998:653

²⁷ Houston-Acker 1993: 559.

²⁸ Rassin, Kanti and Silner 2005: 877

²⁹ Rassin, Kanti and Silner 2005: 878

³⁰ Hinderer, et al. 2014: 165.

³¹ Hinderer et al. 2014: 161

³² Beck 2011: 3

³³ Beck 2011: 3

³⁴ Dominguez-Gomez and Rutledge 2009:203

³⁵ Berry, Lois and Curry, Paul 2012: 34

³⁶ Berry, Lois and Curry, Paul 2012: 34

³⁷ Berry, Lois and Curry, Paul 2012: 35

“ So when it’s one of those nights when you can’t sleep or whatever it is, those are the things that come to you — those images. You always think, ‘why can’t I forget those things?’ I don’t know why. Are they there so I can help someone else? I don’t know. All I know is that they’re stuck in my head and I wish I could get rid of them, but I don’t know how to do that or if I even could if I tried. ”

An area pending critical analysis is the notion that occupational burnout has similar symptomatology to PTSD and how this influences diagnosis. Studies have shown that there are complexities in ensuring that nurses are diagnosed correctly with PTSD as opposed to solely being diagnosed with occupational burnout. Some studies have also indicated that burnout and compassion fatigue are precursors to PTSD in that nurses who experience burnout also display some symptoms of PTSD. This is important to recognize as occupational burnout is increasingly high in the nursing population, and a multitude of studies link it to compromised patient care. For example, in the article, *“The Prevalence and Impact of Post-Traumatic Stress Disorder and Burnout Syndrome in Nurses”*, researchers found that 87% of nurses had symptoms of anxiety, depression, PTSD and burnout³⁸. In fact, 98% of nurses in the study, who fulfilled

the diagnostic criteria for PTSD, were positive for at least one of the three types of burnout syndrome. Furthermore, nurses who have developed PTSD represent a subset of those with burnout, and uniformly have symptoms of burnout³⁹. In another study of staff nurses and clinical nurse specialists in an American trauma center, nurses with occupational burnout and compassion fatigue also showed signs of STS, seen as an early stage of PTSD⁴⁰.

Despite the fact that occupational burnout is well recognized and is being explored within various research fields, there is little formal research regarding occupational burnout’s causal relationship with PTSD. In 2003, a Canadian study attempted to define this causal relationship by providing a clear distinction between the relationship of workplace supports, occupational burnout and PTSD for emergency department nurses⁴¹. The study captured the experiences of 51 respondents in which the majority were emergency department nurses. The core findings in relation to occupational burnout found that interpersonal conflict with staff and management was significantly associated with occupational burnout and contributed to PTSD symptoms. The majority of respondents (67%) believed they had received inadequate support from hospital administrators following the traumatic incident and 20% considered changing jobs as a result of the trauma. Only 18% attended critical incident stress debriefing and none sought outside help for their distress. These results point to a relationship between stress caused by

interpersonal conflict in the workplace and PTSD symptoms. The previously mentioned 1996 study further substantiates these claims as difficult interpersonal relationships with members of the healthcare team, management and co-workers were all cited as factors that make it challenging for nurses to cope with highly charged and stressful work environments, which is a direct trigger for PTSD development⁴². In Manitoba's perspective, the commonality of management lacking a medical background has been seen as a severe impediment for nurses to effectively deal with occupational burnout. In instances where it is critical for nurses to turn to management for support and guidance, many nurses have stated this is not a possible option and fear they will be blamed or judged based on the fact that management cannot comprehend the depth and severity of their experiences.

Nursing staff working with PTSD also poses implications for the employing organization. Research has found that those who endure PTSD are more likely to reduce their work hours or even switch jobs and PTSD can also lead to a decrease in job satisfaction , and increases in psychosomatic distress, sick leave and staff turnover⁴³." These findings draw conclusions that addressing PTSD requires management to make changes in the workplace, specifically by recognizing the value of offering stronger debriefing supports in order to effectively mediate workplace stressors.

³⁸ Mealer et al. 2009: 1122

³⁹ Mealer et al. 2009: 1124

⁴⁰ K. Hinderer, et al. 2014: 164

⁴¹ Laposa, Alden and Fullerton 2003: 23

⁴² Powell 1996: 42

⁴³ Adriaenssens, de Gucht and Maes 2012: 1419



4 Workplace Violence

There is no shortage of research dedicated to exploring violence in the workplace, specifically for nurses and healthcare personnel. As nursing has never been traditionally viewed as a dangerous profession, there is still a lack of general understanding towards recognizing the risks of violence for nurses, and attributing nurse violence as a causal factor in mental health. Specifically, the International Council of Nurses has found that nurses are more likely to be attacked at work than any other professions including, police officers and prison guards, even more so in smaller facilities, or during evening shifts when they often feel they are at risk of assault. This has led many nurses to come to accept that they are legitimate targets and that violence is part of the job⁴⁴.

In early studies focusing on Manitoba's nurses, it was found that the area of a nurse's responsibility can play a large role in developing PTSD. For example, it was found that nurses who worked in emergency or intensive care units were either exposed to or experienced a greater amount of trauma and violence than nurses in other areas⁴⁵. The increased exposure of violence has contributed to nurses having to normalize violence as part of their job and to expect various forms of abuse from some of the patients they care for. For instance, physical abuse has been found to be predominant in emergency departments, in-patient psychiatric units, and long term care facilities. MNU's research has shown that 37% of nurses working on psychiatric

“ It’s scary when you have to sit there at night wondering who’s there in the dark? Who’s in danger now? And you go home with that and you are jumpy. Then you’re just waiting for something like that to happen again. You go home with these stories thinking, damn, I’m grateful for what I have, but then you dream about their stories. ”

units, 31% of long term care nurses and 30% of ER nurses reported experiencing physical violence at least once per week. Given a high incidence of violence experienced by nurses across Manitoba; 52% of Manitoba's nurses have been physically assaulted, 17% have dealt with an individual with a weapon, and another 76% have been verbally abused.

Other research has shown that the perceived threat of violence is equally a trigger to PTSD as experiencing violence directly as it has been found that frequent exposure to workplace violence combined with the perceived threat of violence has impacted nurses' emotional states by increasing their level of stress which increased the exhibition of PTSD symptoms⁴⁶. One study that focused on risk factors for psychiatric nurses found that the perceived threat of violence alone can be just as strongly correlated with PTSD as actual forms of violence⁴⁷. It can be assumed that this may be due to the nature of work and the exposure of

high patient acuity, however Manitoba's own nursing demographic supports this finding as approximately 10% of MNU's members indicated they have had to normalize the expectation that they are to accept violence as part of the profession while external research has shown that 72% of nurses do not feel safe from assault in their workplace⁴⁸.

When nurses experience violence from a patient or patient's family, these incidents evoke emotional responses such as anger, fear of the patient, a need to debrief, discomfort in caring for the patient, suppression of unpleasant feelings, a desire to keep the incident a secret⁴⁹. Research has found that nurses who experience assaults of any nature while continuing to work in environments densely populated with trauma, are at risk of encountering a more severe reaction to PTSD than individuals who are permitted to recover away from high levels of activity⁵⁰." Thus, subsequent assaults that follow an initial violent incident can pose as a further stressor that affects emotional processing unless the workplace is equipped to deal with the distressful incident immediately. If the workplace lacks appropriate supports, the experiences accumulate over time and can gradually manifest as either mild or severe PTSD⁵¹.

While recognizing the role violence has in the nursing field, it is important to acknowledge Manitoba's strength in addressing and validating workplace violence for nurses. In May 2011, Manitoba became the first province in Canada to reform its health and safety legislation

by introducing The Provincial Violence Prevention Policy. This legislation is the first of its kind in Canada and is one of the strongest pieces of health and safety legislation. Additional progress has also been made from the standpoint of MNU in which a clause was negotiated in the collective agreement that obligates employers to commit to ensuring safe workplaces. There are now strengthened violence free policies that obligate all healthcare facilities in Manitoba to do the following: have a violence prevention policy and strategy in place, a procedure for summoning immediate assistance, a procedure for flagging potentially violent patients, and a system for reporting and reviewing incidents.

“ I replay that night and immediately start to make a plan in my head of what I will do next time. It will affect me and the way that I live for the rest of my life. I'll never forget that night. It's something I hope I never have to experience again in my career, and to be honest it's something no one should ever have to experience. ”

⁴⁴ International Council of Nurses 2009

⁴⁵ Powell 1996: 2

⁴⁶ International Council of Nurses 2009

⁴⁷ Jacobowitz 2013: 791

⁴⁸ International Council of Nurses 2009

⁴⁹ Jacobowitz 2013: 788

⁵⁰ Wykes and Whittington 1998: 645

⁵¹ Wykes and Whittington 1998: 646

Prevalence of PTSD in Manitoba's Nurses


Focus Groups

In December 2014, MNU hosted six focus group sessions to gain an understanding about the severity and prevalence of trauma and PTSD nurses encounter within their work environment. The focus group sessions were held across Manitoba and featured a diverse mix of nurses from acute care, surgery, recovery, cancer treatment, mental health, palliative care, long term care and public health. Experienced nurses, some who have been in the profession for more than forty years, as well as more recent graduates took part in the research. The feedback received from the focus groups

reinforced MNU's existing research on PTSD and has helped shape the recommendations within this report.

Focus group questions focused on the frequency of critical incidents and/or traumatic experiences; the symptoms participants have felt as a result of these experiences; coping mechanisms used to respond to trauma and critical incident stress; and the perceptions of employer supports in providing education and tools following a traumatic event. It's important to note that during MNU's focus group sessions, many nurses discussed the symptoms they experienced and effects of critical incident stress that registered in the diagnostic categories for PTSD. This included flashbacks, nightmares and physiological stress, such as nausea or vomiting at work, or avoidance registers in the first cluster of the PTSD scale. While the intent of the focus groups was not to diagnose nurses with PTSD, it is important to reflect upon the fact that many the nurses self-reported symptoms of PTSD.





The following sub-sections highlight the key findings formulated from the focus group sessions:

1 Major Contributing Factors and Symptoms of PTSD

A Nature of Work

The focus group participants noted that patient acuity, traffic accidents involving multiple deaths, incidents of elder and child abuse, and situations in which nurses must compromise their honesty regarding recovery outcomes, contain the most amount of stress. Through MNU's member survey, it was reported that over half (53%) of nurses have experienced critical incident stress at one point in their career. Feedback received from the focus groups confirmed that the death of a child is the most traumatic situation a nurse could experience at work, particularly children's deaths from physical abuse.

Many participants confirmed that they faced moral distress and experienced great difficulty managing stress. They noted that they had lost the ability to respond in a "normalized" way to death, and have difficulty experiencing normal emotions as they tend to withhold their true emotions in order to cope with critical incident stress. Symptoms such as sleep disturbances, nightmares, difficulty eating and developing neurotic behaviour in both personal and professional lives were all common symptoms amongst

the focus group participants. Some of the participants stated that they would even try to avoid situations that were traumatizing, while others confirmed that they dreaded going to work for fear of experiencing a traumatic incident or being bullied. This feedback was further complemented by MNU's member survey in which it was found that 1 in 4 nurses consistently experience PTSD symptoms.

In rural and smaller communities, nurses reflected that they may know or be related to patients, and are cast in the dual role of both a family member or friend, and health care professional. These situations are considered challenging and stressful when these nurses are to respond to traumatic medical incidents involving individuals who are personally close to them. Furthermore, some nurses, especially in the rural areas, reported that there are few clear procedures and protocols for nurses to follow when responding to different medical situations. Many nurses stated that this leaves them vulnerable to losing their licenses and subject to fear of management reprimand.

“ Sometimes I felt as if the universe was conspiring against me. That was the only way to explain things. I lost confidence; wasn’t self-assured. I became anxious and hyper-vigilant. ”

A consistent factor amongst all focus groups was the report of violence, including physical and emotional assault in which some nurses noted that they are assaulted on a daily basis. In many facilities, particularly those in northern and rural Manitoba, there is no effective security which has led to escalating violence. In general, the nurses’ sense of powerlessness and frustration were particularly evident when they were discussing the lack of support they receive from management when they address traumatic or violent events. The lack of management support has caused more nurses to blame themselves for their reactions to trauma, or even doubt their competencies as a nurse when trying to independently process their reactions to critical incident stress. It is important to note that these examples were all noted as being key categories under the PTSD symptom of self-blame. It was noted that even though the discussed challenges are common to the nature of the profession, some of the stress could be alleviated if there were more responses to short staffing.

B Lack of management responsibility for debriefing supports

The challenges nurses face at an organizational level increase the likelihood of encountering various challenges with patients and being exposed to incidents that can lead to critical incident stress and PTSD. The most common workplace challenge identified among the focus groups were the lack of support nurses felt they had from management in coping with traumatic experiences. Some nurses also discussed the lack of responsibility some managers display in addressing workplace bullying. It was also highlighted that some managers lack the ability to recognize how the ongoing nature of critical incidents is directly linked to workplace stress, burnout and PTSD. This may be due to the fact that some managers lack a professional nursing background therefore, they are not able to understand the level of stress and trauma a nurse may be encountering and how this affects team relationships.

In the past twenty-years, the Critical Incident Stress Model (CISM) has served as the model for managing trauma and is a process administered by nurses for all facility staff. CISM has shown to be an effective method in dealing with critical incident stress, however, it is not known whether it exists in facilities other than the Health Sciences Centre and St. Boniface Hospital in Winnipeg. Furthermore, in conversations with clinical directors with experience in CISM, it was made clear that PTSD is not a topic that would be addressed during a session. This is partially due to the fact that CISM is not about diagnosing conditions, rather to allow an opportunity to de-brief and process an event.

Even though there is a connection between increased workload and critical incident stress, there are also linkages between critical incident stress and patient acuity due to inadequate staffing. One tool currently available throughout Manitoba's healthcare facilities is the Nursing Workload Staffing Report (NWSR). The NWSR is a tool for nurses to use to document workload and staffing concerns that in their professional opinion, have or possess the potential to impede upon the care of patients. This tool is designed for management to be aware of the effects that inadequate staffing has on a nurse's workload, and how these concerns impede upon a nurse's ability to provide quality care (i.e. high patient acuity, poor nurse-patient ration, performing non-nurse duties). Furthermore, nurses are experiencing an increased disregard from some managers when the NWSR's are brought to their attention.

C Lack of team cohesiveness and/or poor interpersonal relationships

Some participants noted that while police officers and firefighters have a sense of "brotherhood" to rely on in hard times, nurses are more likely to attack one another than form a cohesive bond. One speculation for this is the fact that each nurse is responsible for their own license therefore one nurse's mistake may reflect poorly on their co-workers. Nurses reported that bullying by co-workers, patients and families, as well as lack of support and bullying from management creates significant workplace stress. As a consequence, nurses are not able to rely

on emotional support from colleagues and management when experiencing critical incident stress, so they begin to experience feelings of isolation and a decrease in their professional self-worth. They often dread going to work, retire early and experience negative situations in their personal lives. Despite this, the nurses in the focus groups were able to acknowledge the realistic demands and challenges each nurse can face in their units and commended each other on their level of work and professionalism.

D Existing Biases

Even though gender was not a structured point of the focus groups, the topic emerged as participants, particularly female, felt that their pleas of stress or trauma were not taken as seriously as they would be if it was delivered from male nurses. For instance, female nurses felt that doctors were more likely to be dismissive or even become verbally abrasive with them in comparison to their male counterparts due to the societal view that if a male is emotionally upset, it must be serious. One of the obstacles in recognizing nursing as a dangerous, demanding and courageous profession is the fact that "women's" work is not regarded as such. Lastly, the majority of participants stated that the general public does not recognize the true nature of the nursing profession and the risks associated with being a nurse. Nurses stated that they wish the public could gain a more accurate perception of the risks and issues nurses face on a daily basis, along with showing more regard towards the commitment and dedication nurses have in providing the most quality care possible.

2 Recommended Supports

The core recommendations MNU received from its focus groups consisted of increasing the employer's responsibility to provide more comprehensive debriefing supports, strategize ways to improve interpersonal relationships amongst management and staff, and the development of succinct legislation that will recognize PTSD as an occupational illness for nurses.

A Debriefing Supports

A comprehensive debriefing process that is immediate and open was cited as an effective tool for reducing the trauma of critical incidents. Mitigation strategies in relation to critical incidents are most effective when a de-briefing model and process is implemented. Recent polling by MNU shows that de-briefing is a random process in which only 50% of Manitoba's facilities currently deliver. Furthermore, these debriefing sessions are infrequently scheduled and are facilitated by nurses on a volunteer basis. This means that due to staffing constraints, some debriefing sessions are not scheduled until days or weeks later and many nurses are left to cope independently. Even though the current CISM model has been proven to be successful in managing critical incident stress, a major concern is still present in the fact that only St. Boniface Hospital and the Health Sciences Centre administer CISM. There are also scheduling conflicts with CISM given the 24/7 nature of the profession and chronic understaffing. This concern is attributed to the lack of time nurses have to schedule a CISM session with the expectation that their unit may be understaffed.

The objective of debriefing should not be to assign blame, but rather to have an open forum to process the traumatic event and find ways to alleviate critical incident stress. It is presumed that nurses are not likely to self-identify as being in need of counseling based on their self-perception that they are the ones responsible for providing care, not the ones who need it. This ignites the need to increase promotion of self-care practices and other pathways that can help address the psychological, emotional, and physical health of nurses.

B Legislative Amendments for PTSD

When asked if MNU should engage in efforts to ensure presumptive legislation is developed for nurses with PTSD, nurses were generally receptive and supportive. It was agreed that presumptive legislation would recognize the array of occupational risks nurses are consistently subjected to in relation to trauma and PTSD in the workplace. This legislation would also help address current issues nurses have experienced with the Workers Compensation Board of Manitoba

as currently regulatory stipulations require nurses to identify a single acute incident as the source of their PTSD.

C Improving Team Cohesiveness

Nurses who work in specialized units, such as surgery and palliative care, or in smaller workplaces, seemed to rely successfully on co-workers to help them cope with critical incident stress. Others, who do not consistently work with the same staff or who work with a large staff unit, do not experience the same team-based bond with their co-workers. In general, nurses believe it should be a priority for managers to find ways to increase healthy work environments, and promote a team-based approach in providing emotional supports when dealing with critical incident stress, PTSD and burnout. It was noted that if more managers had a nursing background, there would be a deeper understanding towards the experiences of front line nurses in order to offer more responsive supports.



Jurisdictional Review

Workers' Compensation Legislation and Post-Traumatic Stress Disorder

Across Canada, occupational health and safety regulations recognize stress as an occupational illness however, stress is a broad category and can manifest as numerous physical and mental health ailments. In many workers compensation cases, it has been difficult to prove that PTSD is an occupational illness based on the nature of work.

This section provides an overview of jurisdictions that have amended, or are in the process of evolving their legislation to feature presumptive clauses for PTSD. It is important to recognize that the main commonality in the legislation, with the exception of Alberta, is that the onus is on the worker to prove that PTSD developed as a result of a series of events that took place in the workplace. As under-reporting of personal trauma is very common in the nursing profession, this presents an obstacle in successfully receiving compensation for PTSD. There are two main legislative challenges common across Canada's provincial jurisdictions. The first being that it is difficult to recognize PTSD as an occupational hazard, and secondly, when PTSD is recognized as a hazard, there may be strict guidelines in place that impede upon an individual's ability to make a claim, thus being excluded from receiving benefits.

British Columbia (B.C.) | **Workers Compensation Act**

B.C. is currently the only province in Canada that does not consider stress caused “by acute reaction to a traumatic event” as an occupational disease in which a claim can be made at any time. However, B.C. has expanded the definition of mental stress to include certain conditions, including PTSD in BC’s Workers Compensation Act. The condition must be diagnosed by a psychologist or psychiatrist, and must be accumulated, rather than a reaction to a single event. The causes must be work-related and can be a result of harassment or bullying. The length of exposure to trauma is significant, since the longer the exposure, the stronger the case. Applicants have a timeline of one calendar year by which they must apply to worker’s compensation, however, as PTSD develops over an extended period of the time, the prescribed deadline may not suffice in acknowledging PTSD once it is diagnosed.

Alberta | **Workers’ Compensation Act**

Alberta is presently the only jurisdiction that features presumptive PTSD legislation, specifically applicable to emergency medical technicians, peace officers, police officers and firefighters. Presumptive legislation refers to inferences in legislation that exist due to well-known existence of causes or other facts. Specifically in the context of Alberta’s legislation, the presumption of PTSD simplifies the adjudication process in reference to a claim as clear connections between PTSD and the nature of work have already been made and applied. As per Alberta’s Workers’ Compensation Act, if a first responder is diagnosed with PTSD, the condition will be presumed that it has been a result of the employment unless proven otherwise. Similar to the legislation in B.C., PTSD must be diagnosed by a psychiatrist or psychologist, and the cause must be found to be a series of events experienced as a result of work.

Ontario | **Workplace Safety and Insurance Act**

On May 2, 2014, Ontario passed Bill 2, allowing for amendments to the Workplace Safety and Insurance Act to include PTSD. Despite the fact that Ontario’s legislation is currently under development, the PTSD amendment would be similar to Alberta in which it would provide automatic coverage to emergency workers such as, paramedics, police officers and firefighters. The nature of employment, length of employment, time during which a worker was employed and the age of the worker are all proposed factors to be considered when assessing one’s eligibility for compensation. As is typically the case, the condition must be assessed and verified by a psychologist or psychiatrist. It is challenging to assess the obstacles Ontario’s legislation may pose in claiming benefits other than those imposed by legislation in other Canadian jurisdictions.

Nova Scotia | **Workers' Compensation Act**

Currently, emergency responders in Nova Scotia must prove they acquired PTSD on the job and apply for care within one-year of the traumatic event that resulted in the symptoms. In October 2014, the former Minister of Health and Wellness introduced Bill 11 to amend the Act to permit workers who are or were emergency responders to obtain workers' compensation with respect to PTSD, regardless of when the PTSD is recognized or diagnosed. The bill did not pass second reading and in response, the new Minister of Health and Wellness made a commitment to establish a committee to further explore opportunities to support firefighters, police, paramedics and correctional officers with PTSD. As the committee has failed to be established, unions have increasingly been urging the new Minister to instill a committee for PTSD especially when statistics showed that within a six month period in 2014, 24 first responders had committed suicide in Nova Scotia.

Manitoba | **Workers Compensation Act**

Despite the fact that PTSD is currently compensated under Manitoba's legislation, it is difficult to prove a causal link between workplace incidents and PTSD, specifically for nurses. In the 2014 Throne Speech, the Government of Manitoba made a commitment to provide new legislative supports in order to increase the awareness of workplace mental health for front-line personnel who routinely face exposure to traumatic events.

Recently, the Government of Manitoba has recognized the prominence of PTSD as a work-related condition. A private member's bill, Bill 205, was the impetus of proposing an amendment to Manitoba's Workers Compensation Act as it was proposed that the Act should extend the presumption of PTSD to emergency responders who are in contact with circumstances that induce PTSD. Bill 205 identifies emergency responders as either a) a full-time or part-time firefighter, or Office of the Fire Commissioner personnel; b) an emergency medical response technician; or c) a police officer. The Bill further proposes that "if a worker who is or has been an emergency response worker suffers from post-traumatic stress disorder, the disorder must be presumed to be an occupational disease the dominant cause of which is the employment as an emergency response worker, unless the contrary is proven (4.1 (2))."

In response to Bill 205, the Workers Compensation Board of Manitoba has solicited consultation responses from key labour stakeholders including the MNU. The consultation feedback will form the basis of a report that the Workers Compensation Board will provide to the Government of Manitoba in anticipation to accurately develop legislation that will respond to the needs of employees who face exposure to trauma in the workplace.



Recommendations

As indicated throughout this report, PTSD is cumulative and symptoms are manifested differently for each individual nurse. Social stigmatization, lack of employer supports, and a need for more education and awareness are the most significant barriers that need to be addressed in order to effectively respond to PTSD in the nursing profession.

Taking into consideration the analysis and detailed findings from MNU's PTSD research, MNU presents the following recommendations that will serve as key preventative measures in minimizing the effects of PTSD for nurses. When appropriate, future responses to these recommendations should incorporate consultation with stakeholders, and include sufficient capacity, accountability and evaluative measures.





1 Presumptive Legislation for Workers Compensation Coverage

As a valuable stakeholder in Manitoba's labour legislation, it is recommended that the Government of Manitoba amend its existing *Workers Compensation Act* to enforce presumptive PTSD legislation that is inclusive of nurses. Similar to Alberta, occupations identified under the legislation would no longer have to prove that PTSD is a result of their work in order to access and receive workers compensation benefits. In Manitoba's context, the presumptive legislation should acknowledge the increased susceptibility nurses have to PTSD, and recognize that PTSD is an occupational illness for the nursing profession.

MNU is currently working towards addressing this recommendation through its consultation with the Workers Compensation Board of Manitoba in recommending an appropriate structure for PTSD legislation. MNU will be presenting its research on PTSD in the nursing profession to clearly demonstrate how the nature of the nursing profession increases the exposure and prevalence of PTSD. There is active support of MNU's position towards presumptive PTSD legislation from MNU's membership, specifically made apparent through the focus group sessions as participants felt such legislation would provide more concrete protection for nurses in the event of being diagnosed with PTSD.

2 Comprehensive Employer and Organizational Supports

While it is a priority to acknowledge the personal role a nurse has in addressing and responding to PTSD, it is even more important to recognize the pivotal role the employer, specifically management, has in providing a range of organizational supports for PTSD and critical incident stress. As many studies have shown, it is equally important to focus on providing adequate post-event supports. It is also equally important to recognize that there needs to be an adoption of a variety of stress supports as a one-size-fits-all approach does not address the subjectivity of PTSD symptoms and experiences. Therefore, it is recommended that there needs to be a stronger onus on the employer to provide an adequate range of supports that can be accessed in a timely manner when a nurse is faced with a critical incident. This includes but it is not limited to debriefing supports,

workload accommodation, and the need to create a healthier work environment.

In recognizing the responsibility of healthcare facilities providing adequate supports, it is recommended that any individual who is responsible for managing nurses, should have professional background in nursing. This will help address the nurses' priority of receiving more recognition and understanding from managers in regards to their frontline experiences dealing with trauma. This would also help develop more relevant debriefing supports within the workplace.

Critical Incident Stress Management Models

While CISM has been proven to be a successful process at the Health Sciences Centre, there are many opportunities the employer can consider in designing a CISM process that is unique to their staff and is provided in a timely manner. This includes a stronger emphasis on the debriefing stage, and utilizing or interchanging other forms of CISM. Such examples include defusing sessions and offering grieving sessions. Defusing

is considered to be a shorter, less formal intervention than debriefing in which it is held no longer than 12 hours after an incident. Similar to debriefing, it is voluntary and confidential however its main purpose is to provide an outlet for individuals to process the event, stabilize themselves, and return to normal work routines without experiencing unusual amounts of stress. Grieving sessions typically consist of either a group or individual session following a traumatic experience or critical incident. These sessions are focused on providing a cohesive network of personal support and fostering an open dialogue and environment for individuals to process their experience. As highlighted throughout the focus groups, there would be a benefit in providing opportunities for nurses across generations to share their experiences on what has helped them cope in order to foster a collective camaraderie amongst nursing teams.

The current length of time it takes for nurses to attend a CISM session needs to be examined as in most cases in Manitoba, nurses do not have adequate support systems in place to debrief immediately following a critical incident. As such, it is recommended for employers to implement debriefing supports that are appropriately structured in such a way that assistance can be provided immediately. For example, employers can offer debriefing supports that are delivered by professional psychological staff, or peers within the healthcare field. This will minimize the amount of conflicts that occur due to cancelled debriefing sessions from volunteer staff that are not available.

“ I’m somebody who always wanted to be a nurse my whole life. As long as I can remember, I wanted to be a nurse. For me, it was the whole caring thing, and I should care for all the others before I care for myself. I always leave myself last. ”

It is also recommended that management implement resources, tools and services that can be used after the debriefing process that stem beyond referrals to the Employee Assistance Program. While it is recognized that due to staffing workload constraints and the nature of the work in specific departments, management may find it more efficient to refer staff to the Employee Assistance Program, or postpone scheduling of CISM. While these practices may be more efficient from an organizational standpoint, these practices provide more time for PTSD to develop and manifest as they are not adequately analyzing and mediating the source of concern.

3

Creating a Healthier Work Environment within the Nursing Profession

As relationships with management and coworkers have a significant influence on occupational burnout and stress, it is imperative for management to recognize the role their organization and organizational culture has on PTSD development. As such, it is recommended that management to develop and invest in initiatives that will create a healthier work environment, and emphasize the importance and requirement of positive relations between employees and management. This includes promoting quality practice environments, and offering concrete supports to address critical incident stress and occupational burnout. There are various ways management can achieve a healthier workplace from responding to intensive

“ After a death you have to push on and keep going like nothing has happened. I’ve become a lot more hardened to death. After a death, there is no break and no support from management. The culture in the department is basically if you’re too affected by a death then you shouldn’t be working here. I don’t feel supported when someone dies. You’re always looking back, wondering if you could have done something differently if there had been more communication. If there was a de-briefing and you could go over it that would be helpful. ”

workload issues, engaging employees in organizational decisions that affects their ability to provide quality care, and instilling a culture that prioritizes and supports the well-being of its employees. In taking into consideration the numerous accounts in which nurses stated that management was absent during stressful situations, or there was a lack of concern from management regarding the mental health of nurses, creating a healthy workforce will serve as the foundation in preventing future mental health issues in nurses. In order to foster a supportive and cohesive team environment amongst nurses, the organizational culture needs to be improved first.



4 Mandatory Education and Awareness of PTSD

It is clear that there is a social stigma attached to mental illness, however the most effective way to challenge the social stigma is through active education and awareness training. As such, it is recommended for management to develop an education strategy that is focused on PTSD awareness training at an employer and employee level.

Employers

It is recommended for employers to complete mandatory education on the effects of PTSD in nursing in order to strengthen their ability to provide adequate supports to their nursing staff and increase workplace satisfaction by reducing critical incident stress. It is important for this education training to provide information for managers to recognize critical incident stress in the workplace, to acquire the ability to scan their workplace for current practices and processes that manifest stress and PTSD, and to develop appropriate pathways that will respond to the concerns of nurses effectively and efficiently. Furthermore, appropriate education training should be provided to management to ensure they are able to effectively recognize their role in issues such as addressing bullying and difficult team relationships, which are all influential factors in PTSD development. At the very minimum, resources should be developed such as a management user guide, to act as an aide in developing best practices and processes for responding to PTSD in the workplace.

Education Institutions

It is recommended that education institutions become engaged in building awareness of PTSD throughout their curriculum for student nurses. This can be achieved through offering training on managing critical incident stress and providing realistic insight into the working environment of nurses. These measures will also help equip student nurses with the adequate knowledge and resources to manage critical incident stress and PTSD once they transition into the workforce. This early awareness may help alleviate the existing generational gap that exists in respect to how experienced nurses deal with stress, compared to those who are new to the profession.

Nurses

It is valuable for nurses to receive education and awareness training to become aware of how prevalent PTSD is in their profession, and to learn how to prioritize their own mental health. In educating Manitoba's nurses, it is important to emphasize the cumulative nature of PTSD and its symptoms; ensure they understand the relationships between critical incident stress, occupational burnout, emotional labour and PTSD; and how to prioritize self-care practices that will promote psychological, physical and spiritual health. This can be achieved through either formal avenues such as presentations on the effects and solutions to workplace conflict, or informally through actions such as time-efficient team building activities. A valuable education tool to offer

nurses is pre-crisis education in which there is a focus on incident awareness, crisis response strategies, and stress management coping skills. Many pre-crisis education models are in the form of employee handbooks, e-books or training seminars.

In supporting its commitment to provide continuous education for current issues and trends within nursing, MNU will be launching a robust education strategy for its members on PTSD. This will entail providing opportunities for nurses to learn more about PTSD in the workplace, recognizing signs and symptoms of PTSD, and more importantly, practicing self-care.

5 Effective Tracking and Analysis of PTSD Reporting

When conducting previous research for violence in the workplace, MNU has reiterated the priority of ensuring access to accurate information towards violence against nurses, information about the frequency and details of incidents of violence as a mechanism to prevent or minimize it. In building on this priority, it is recommended that the reporting of critical incident stress and CISM interventions should be tracked, either through MNU's membership or through the employer. This tracking will help employers, MNU, and the healthcare sector as a whole acquire a realistic reading on the level of PTSD apparent in each location, and provide an outlet for nurses to address the contributing factors of critical incident stress.

Conclusion

As there is a lack of public awareness towards PTSD in the nursing profession, it is important to highlight how the specific work environment factors prime the development of PTSD. The presence of critical incident stress, occupational burnout, and compassion fatigue will never completely disappear from the nursing profession which is why it is imperative to address PTSD by establishing a two-fold response strategy actioned by government and the employer.

The first step involves placing more onus on the employer to become aware of their responsibility to provide a safe and healthy work environment. This will enable management to implement valuable workplace supports that are conducive to the mental health stresses nurses experience. Secondly, the Government of Manitoba needs to recognize the merit of enacting presumptive PTSD legislation that is inclusive of nurses. This accomplishment would legally recognize PTSD as an occupational illness for the nursing profession and as a result, would increase access for nurses to receive benefits and supports to respond to mental health concerns related to PTSD. Adequate workplace supports, a commitment to mental health education and training, and presumptive legislation are not only attainable recommendations, but these recommendations will help build a healthier workforce and provide Manitoba an opportunity to become a model jurisdiction in challenging the social stigmatization of mental illness for nurses.

While the recommendations brought forward will not eradicate PTSD from the nursing profession, they will serve as a positive launching force in transitioning workplaces of nurses from one that harbors stress and conflict, to one that is in recognition of their profound efforts in providing quality care, even in the most traumatic situations. Addressing PTSD in nurses is a priority that requires active participation from government and the employer. As the quality of Manitoba's healthcare remains to be a critical priority, this cannot be achieved until there is equal emphasis on prioritizing the care of nurses, the wounded healers who continuously care for us.



Trauma
doesn't end
when the
shift does.

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