

2nd Place Winner 2022 New Zealand PIF Essay Competition

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Essay topic – What is the role of psychiatry in recovery from severe trauma?

Where are the families now?

By Emma Cadman

Introduction

During my training, I was told by a doctor one thing that I have never forgotten. “Whilst this might be every day for you, this could be the most important day in this patient’s life.” Doctors discuss cases in the hospital, forgetting that patients are people and the lives that surround them. Of course, they do, it is their job to treat medical problems. Is this part of a coping mechanism? It makes the case complicated to deal with a patient on paper than get involved in your own emotions surrounding the case as well as the patient’s own complexities. The more senior the doctor, I have noticed, the better they are at compartmentalising these experiences. I have also noticed that the doctors whose speciality involves distressing cases such as Intensive Care, deal with these instances almost without skipping a beat. Perhaps it is practice and experience within this environment that gives them such fluidity.

It is not that I believe these doctors do not care about the patients or that they do not address the social aspects and concerns of the patient and family. These events impact them less. It is easy for them to forget that other people may be shocked by the trauma they see, by their loved one hooked up to multiple monitors and then death that might arise from this. The family do not have the time to adapt or to compartmentalise like doctors do. In cases of sudden severe trauma, the patient and family are rushed into hospital, into an unfamiliar environment which, particularly when busy, can seem unwelcoming and sterile (excuse the pun). They are spoken to by doctors in a language they cannot always understand and plunged into an environment where they struggle to communicate their needs with the doctors.

As a medical student I had one week of placement in the ICU. I was involved in a case where a young man fell off a ladder and had a devastating head injury. He went from a healthy man to two days later being declared brain dead and donating his organs. I followed the man from when he arrived in ED, through a bilateral craniotomy, and then was present for the family conversation where the surgeon delivered the news, he was unlikely to survive. The amount of grief I felt in that room was overwhelming as I saw his young wife and his parents try to come to terms with the news that they had just been given. Their husband and their son, who had woken up that morning as if it were any other day, was now unlikely to be alive next week. It also broke my heart to see them in the ICU bed trying to be there for their husband and son but not knowing how to touch him with all the tubes and lines that were attached to him. The day for them had started normally and ended in tragedy. This experience affected me greatly, I can only imagine what it did to them.

Prolonged Grief Disorder is a new diagnosis in the DSM-V and allows clinicians to identify patients who, after an extended period, are still struggling to live with their grief (American Psychiatric Association, 2022). Despite these problems gaining more acceptance within the medical community, it is still not a disorder that is widely discussed. There is a variety of symptoms with this disorder with a wide range of severity as well (Szuhany et al., 2021).

Research is still being done in this area as it has only recently been added to the DSM-V but there are known risk factors such as previous mental illnesses, age, and sudden and unnatural loss of a significant family member (Guldin et al., 2017). In most situations the medical history of the family is unknown, and it would be inappropriate to ask. However, in a case where the person you are looking after has died because of a traumatic death, these risk factors for the family developing complicated grief symptoms are blatant and should not be ignored.

Currently, the healthcare system makes these people seek help for themselves. It relies on them to go to their GP and seek counselling or therapy for which they are then required to pay. They are not covered by any ACC funding even if their partner died due to an accident (ACC, n.d.). This places an extra burden on the Mental Health System which is already struggling to cope. I envision that it would be better for these people to be identified early with preventative measures put in place so that if they were to receive therapy in the future, hopefully it would not need to be so intensive if there has already been work done.

Research has been done assessing the use of preventative tools for Prolonged Grief Disorder. One study showed good outcomes using such a tool which decreased rates of prolonged grief, anxiety, and depression over the following 3 months (Litz et al., 2014). It could not be done over a larger time because it would be unethical to refrain from treating the control group for longer than this. The tool given to these people required minimal professional oversight (Litz et al., 2014) which shows that it could be used to lessen the workload of clinicians.

It shocked me to see a family leave a hospital, devastated by the loss of a loved one, without any help for themselves. The clinicians of course will be kind and even suggest counselling, but there is no formal help for these people that they do not have to pay for. It did not seem right to me that we spend our whole time at medical school talking about how we can prevent various illnesses and yet here was someone in front of me who is, according to research, more likely to struggle in the near future. Perhaps it is the underlying want to give something to that family, anything, after all they have lost, but it feels unjust to thrust them back out into society to fend for themselves. Research needs to be done in this area for prevention of mental illnesses after trauma. All it needs is a tool such as the one trialled in the above research which needs little clinical input. But the least it would do would be to provide these individuals with a steppingstone to help if they were to need it. It is easy for clinicians to identify these people from their hospital cases, and it could be a way to save lives. The mental health system has been forced into being the ambulance at the bottom of the cliff. It is time to shift our focus to stop at risk people getting to the cliff in the first place.

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