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PTSD as the second tsunami of the SARS-Cov-2 pandemic

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Comment on: 'Posttraumatic stress symptoms and attitude toward crisis mental health services among clinically stable patients with COVID-19 in China.'

Abstract

Since the first cases, the coronavirus disease (COVID-19) rapidly spread around the world, with hundred−thousand cases and thousands of deaths. Post-traumatic stress disorder (PTSD) is a common consequence of major disasters. Exceptional epidemic situations also promoted PTSD in the past. Considering that humanity is undergoing the most severe pandemic since Spanish Influenza, the actual pandemic of COVID-19 is very likely to promote PTSD. Moreover, COVID-19 was renamed severe acute respiratory syndrome coronavirus 2 (SARS-Cov-2). With a poor understanding of viruses and spreading mechanisms, the evocation of SARS is generating a great anxiety contributing to promote PTSD. Quarantine of infected patients evolved to quarantine of 'infected' towns or popular districts, and then of entire countries. In the families of cases, the brutal death of family members involved a spread of fear and a loss of certainty, promoting PTSD. In the context of disaster medicine with a lack of human and technical resources, healthcare workers could also develop acute stress disorders, potentially degenerating into chronic PTSD. Globally, WHO estimates 30–50% of the population affected by a disaster suffered from diverse psychological distress. PTSD individuals are more at-risk of suicidal ideation, suicide attempt, and deaths by suicide – considering that healthcare workers are already at-risk occupations. We draw attention towards PTSD as a secondary effect of the SARS-Cov-2 pandemic, both for general population, patients, and healthcare workers. Healthcare policies need to take into account preventive strategy of PTSD, and the related risk of suicide, in forthcoming months.

Since 8 December 2019 and the onset of the first cases of coronavirus disease (COVID-19) in China, the disease rapidly spread around the world, with hundred−thousand cases and thousands of deaths (Dutheil, Navel, & Clinchamps, 2020). Post-traumatic stress disorder (PTSD) is a severe mental health condition caused by a terrifying event outside the normal range of usual human experience (Belrose, Duffaud, Dutheil, Trichereau, & Trousselard, 2018). Exceptional epidemic situations also promoted PTSD in the past (Cénat et al., 2020; Xu et al., 2011). Considering that humanity is undergoing the most severe pandemic since Spanish Influenza (Morens, Daszak, & Taubenberger, 2020), the actual pandemic of COVID-19 is very likely to also promote PTSD. Moreover, COVID-19 was renamed severe acute respiratory syndrome coronavirus 2 (SARS-Cov-2) on the basis of a phylogenetic analysis of related coronaviruses (Jiang et al., 2020). The SARS in 2003 was very traumatizing for populations, with a poor understanding of viruses and spreading mechanisms (Koralek, Brown, & Runnerstrom, 2015; Wendlandt et al., 2018). The evocation of SARS is thus generating a great anxiety and biased responses to threat, which can both promote PTSD (Bo et al., 2020; Mekawi et al., 2020). Despite a vaccine that was quickly found for SARS 2003, the prevalence of long-term PTSD was high (one-fourth) among hospitalized SARS survivors (Mak, Chu, Pan, Yiu, & Chan, 2009). The handling of the SARS-Cov-2 crisis evolved through different stages, that can all participate to future PTSD. First, cases were quarantined in hospitals to avoid spreading. Patients were surrounded by healthcare workers in hazmat suits recalling some disaster movies about pandemics. As media lay a great emphasis on the SARS-Cov-2 mortality, the fear of dying adds to the terror initially felt. Then, worldwide authorities started by promulgating quarantine status of 'infected' towns or popular districts. Finally, because of the continuous worldwide spreading, authorities promulgated massive quarantine status of entire countries (Parmet & Sinha, 2020). In Europe, as in most developed countries, this blackout period has not happened since the dark moments of the World War II. In similar extreme

distressing situations, some individuals discontinued social bearings and traditional values, to seek in wrongful acts, asocial behavior or civil disobedience, aggravating the sense of insecurity. Furthermore, in the families of cases, the brutal death of family members involved a spread of fear, panic, anger and a loss of certainty (Wang et al., 2020), which can contribute to PTSD. Moreover, healthcare workers could also develop acute stress disorders, potentially degenerating into chronic PTSD. In a context of disaster medicine with a lack of human and technical resources, emergency teams had to separate SARS-Cov-2 cases from others, and contagious from non-contagious (Wong et al., 2020). In routine clinical practice, life-and-death emergencies are already a major stressor for medical doctors (Dutheil et al., 2012, 2013). In the context of the SARS-Cov-2 pandemic, choosing which patients may benefit from assisted ventilation – and thus live or die – is an additional major factor of stress. In countries where the death is a social non-common fact, filtering the patients is a shocking and violent picture for the entire society. Globally, WHO estimates 30–50% of the population affected by a disaster suffered from diverse psychological distress, experiencing injury or death of family members (Brooks, Amlôt, Rubin, & Greenberg, 2020). PTSD symptoms involve chronic severe anxiety with re-experiencing the traumatic event, flashbacks, nightmares, increased arousal, and reduced social life. PTSD individuals are more at-risk of suicidal ideation, suicide attempt, and deaths by suicide, in huge proportions (2–5 times) (Thibodeau, Welch, Sareen, & Asmundson, 2013) – considering that healthcare workers are already at-risk occupations (Dutheil et al., 2019). This is particularly preoccupying considering that people suffering from PTSD are prone to not seek care, because of barriers such as lack of information and cost of mental health care, being afraid of stigmatization, or beliefs that symptoms may decrease with time (Fuhr et al., 2019). We draw attention toward PTSD as a secondary effect of the SARS-Cov-2 pandemic, both for the general population, patients, and healthcare workers. Healthcare policies need to take into account preventive strategy of PTSD, and the related risk of suicide, in forthcoming months.

Conflict of interest. The authors of this work declare no conflict of interest.

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