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POST-TRAUMATIC STRESS DISORDER AND HEALTH PERSPECTIVE: VICTIMS OF MOTOR VEHICLE ACCIDENTS IN JORDAN

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Abstract

Motor vehicle accident survivors who develop post-traumatic stress disorder have become an important health issue. Trauma resulting from Motor Vehicle Accidents has been attracting of increasing concern, with death from injuries is projected to reach 8.4 million in 2020 as compared to 5.1 million in 1990, particularly in developing countries including Jordan. A descriptive phenomenological approach was used for this study to identify and explore the lived experience of post-traumatic stress disorder of individuals who have been involved in a motor vehicle accident in Jordan. Seven themes were explicated from the participants' transcripts of interview: feeling frustrated at a diminishing health status; struggling to maintain a state of independence; harboring feelings of not being able to recover; feeling discriminated against and marginalized by society; feeling ignored and neglected by health care professionals; feeling abandoned by family; moving toward acceptance through having faith in God. The current social services policies of the Jordanian Health Care System have given little credence to the health care needs of people with PTSD. As a result of this inattention, there is a noticeable lack of processes and protocols concerning care of the mentally ill and people with PTSD. The lack of policy direction has also led to a lack of health resources in this area including specialized clinics. Access to the limited services continues to place patients in vulnerable situations. Lack of policy direction has also impacted on access to health benefits. Presently, support of people with PTSD primarily falls to the family within Jordanian culture. Social support includes providing physical, emotional and financial assistance. Although change is taking place, it is slow and spasmodic.

Keywords: Psychiatric/Mental Health, Transcultural Health, PTSD, Motor Vehicle Accident, Lived Experiences

Introduction:

Trauma resulting from Motor Vehicle Accidents (MVAs) in Jordan is a phenomenon of increasing concern (World Health Organization, 2002). Approximately 8,000 individuals sustain trauma yearly MVAs, which ranks highest among all vehicle types (The Jordan Department of Statistics, 2006). Among other passenger-carrying vehicles, buses registered the second highest rate of accident involvement (Jordan Department of Statistics, 2006). Based on the report, the most prevalent group of road users are car and bus drivers. Car and bus drivers constitute approximately 60% of all MVA trauma events (Jordan Ministry of Health, 2005).

Furthermore, the report indicated that people involved in these traumatic events were primarily between18 to 60 years old (Jordan Department of Statistics, 2006). The most frequent causes listed for MVAs and subsequent hospitalization included speeding, failing to stop at traffic lights and failure to abide by traffic regulations (Jordan Ministry of Health, 2005; Jordan Ministry of Information, 2006). The availability of high-speed highways has contributed to an increase in MVAs and its corollary post-traumatic stress disorder (PTSD), which is now recognized by the Jordanian Government as a major public health problem.

In the majority of countries, a license to drive a motor vehicle can be obtained at 17 years (e.g. UK, France, Denmark, and Sweden), whereas most Jordanian obtain their permit licensure at 18 years but plan to reduce the age to 17 years. Despite the additional year in being able to obtain a driver’s license in Jordan the incidence of motor vehicle accidents for this age group is extremely high as compared to other age groups in the country. The main causes of accidents for this adolescent group were speeding and high vehicle occupancy (Jordan Department of Statistics, 2006) drinking violations, aggressive behavior on the road, and joyriding (Jordan National Highway and Safety Department, 2007).

Unlike developing countries, majority developer countries, social health care services are well established to provide the required assistance to patients with post-traumatic stress disorder (PTSD). In Middle Eastern countries including Jordan, the social protection systems are either non-existent or under-developed, placing patients who have developed PTSD in the unenviable position of having to rely on self or family for support and care (Jonsson & Halabi, 2006). Traditionally, care of the sick or ill person has been the obligation of family members, through the extended family structure (Clapp & Beck, 2009). Parents, grandparents and adult children were expected to provide support and look after the well being of their family members especially in relation to health problems. The presence of PTSD in a family member significantly increases the burden of care for families.

The Jordanian Government has initiated health care reforms. Examples of the reforms aimed at improving the quality of life for all Jordanians. According to the Ministry of Health (2002) report, the 1999 [the researcher needs to observe for the newly released health bylaws] health reforms were a significant step forward making the health of the Jordanian people a priority.

The outcome of the implementation of these reforms, the first national health strategies for PTSD patients in Jordan, addressed the health care needs of all Jordanians including the care of people with PTSD. However, the Jordanian health strategies have failed to achieve their stated outcomes in terms of health care services. Reasons for the ineffectiveness of the reforms were attributed to a lack of understanding and interpretation of the reforms, limited resources, poor service delivery, and the socio-economic situation of the country (Jonsson & Halibi, 2006). The continuing ineffective nature of the Jordanian health care system and a serious lack of health care professionals have exacerbated the lack of appropriate care and treatment for people suffering from PTSD with little evidence of improvement in the near future.

Study Purpose And Significance

This study was undertaken with the purpose of explicating the lived experience of PTSD as articulated by motor vehicle accident victims who have developed PTSD as a result of the accident. This study used a descriptive phenomenological approach to inquiry (Colaizzi, 1978). This study is significant as it addresses a previously unexplored phenomenon. As such, the findings of this study have the potential to contribute to extant knowledge about the experience of PTSD and contribute to academic and clinical debate and future directions of inquiry to inform health care policy and professional health care practice concerning PTSD in Jordan.

Research Design

The experience of PTSD is a human response to a traumatic event lived out in the everyday lives of many people. As the study is located in lived experience a phenomenological methodology is an appropriate research approach for exploring the phenomenon of PTSD.

The philosophical underpinnings of phenomenological thought are consistent with the values of nursing practice, the uniqueness of the person, the importance of personal discovery, acceptance of life situations, the need for exploration of meaning, constructed reality and the potential for personal growth. In this context, phenomenology as a philosophical framework and research methodology can provide knowledge about aspects of a person's life in health and illness, which cannot be accessed by observation alone

(Munhall, 2001).

The population Sample

Purposive sampling was the primary mode of participant recruitment for this study. The purposive sampling method has been singled out as the most appropriate means of participant recruitment as it provides an opportunity for the researcher to select potential participants who are best positioned to provide rich descriptions of their experiences (Clifford, 1997; Polit & Beck, 2008). Purposive sampling is an acknowledged method for a qualitative study (Minichiello et al., 1999; Munhall, 2001).

Fifteen (15) participants were recruited at the Orthopedic unit in Amera Basma Hospital, Irbid Jordan.

Data was collected by face-to-face in depth interviews. Interviews were digitally recorded and transcribed verbatim. Individuals who met the inclusion and exclusion criteria were invited to participate in this study. The inclusion and exclusion criteria for participation in the study are presented in table 1.

Data analysis

Data analysis was informed by Colaizzi’s (1978) eight-step phenomenological method as well as two additional steps as outlined below. Colaizzi’s (1978) eight-step framework for analyzing qualitative data includes (1) transcribing all the participants’ descriptions; (2) extracting significant statements; (3) creating formulated meanings; (4) aggregating formulated meanings into theme clusters (refer these clusters back to the original protocols to validate them, note discrepancies among or between various clusters, and avoiding temptation of ignoring data or themes that do not fit); (5) developing an exhaustive description of the phenomenon; (6) formulating the exhaustive description into an unequivocal statement of identification of the structure; (7) validating the findings (the structure) with the participants; (8) integrating information from the validating interview into the final description. Two additional steps were included: participants sharing their metaphors and/or pictorial representations of their experiences and a review of literature in relation to the findings of the study making it a 10 step approach to analysis.

Significant statements explicated from the participants’ interview transcripts were then reread several times to obtain a sense of their respective meaning. The fundamental question asked by the researcher was: “what is the meaning of the experience of PTSD inherent in each significant statement?”

Formulated meanings were developed from each significant statement and then sorted into theme clusters. The researchers reviewed significant statements and formulated meanings. The following table provides a succinct example of three significant statements and corresponding formulated meanings for Seven themes were explicated from the participants’ transcripts of interview: Feeling frustrated at a diminishing health status; Struggling to maintain a state of independence; Harboring feelings of not being able to recover; Feeling discriminated against and marginalized by society; Feeling ignored and neglected by health care professionals; Feeling abandoned by family; Moving toward acceptance through having faith in God.

Results

Themes

Seven themes were explicated from the participants’ transcripts of interview: Feeling frustrated at a diminishing health status; struggling to maintain a state of independence; harboring feelings of not being able to recover; feeling discriminated against and marginalized by society; feeling ignored and neglected by health care professionals; feeling abandoned by family; moving toward acceptance through having faith in God.

Theme one: Feeling frustrated at a diminishing health status

The participants in this study spoke of the frustrations they felt regarding their inability to attend to the simple everyday activities such as of caring for themselves and their families as a result of a gradual decline in their physical strength and mental capacity. For example, a participant stated, *‘my health was good until I had the car accident. I can no longer think clearly and my physical health is now poor. I feel frustrated that I cannot do what I used to’.*

Disturbed sleep patterns fuelled by flashbacks and nightmares exacerbated the situation. In the absence of no tangible improvement in their health status participants became increasingly angry and frustrated. One participant mused, *‘I think I became more irritable when I could not sleep. I just screamed and stayed in the room by myself’.*

Anger and frustration fed into a negative cycle in which there appeared to be from the participants’ perspectives a downward spiral into a world of disability, restriction, and reliance on others.

Theme Two: Struggling to maintain a state of independence

For the participants of this study the struggle to maintain a state of independence was thwarted with difficulties, which encompassed feelings of extreme tiredness, loss of energy, a reluctance to rely on others, and a strong desire to regain control over one’s life. This was expressed by a participant, who stated, *‘I used to prepare breakfast for myself, now I have lost that* *ability. To lose one's independence is a terrifying experience. It is a constant struggle not to give in and not having to rely on others. I want to regain my independence, but it is so difficult…you lose your independence and you became totally dependent on others. I can't concentrate; I have lost my ability to think clearly'.*

However, at times the struggle to once again be independent became overwhelming to the point that some participants expressed the thought of wanting to give up. One participant articulated that, *'I have always been in control of my life. Now everything is such a struggle. I want to be my old self not having to rely on others. At times I feel so tired I just want to give up trying'.*

Theme Three: Harboring feelings of not being able to recover

The very thought that recovery may never be a reality engendered in a number of the participants feelings of fearful apprehension. Inability to pay for hospitalization, medical and psychiatric consultation, and medication surfaced questioning uncertainty about what seemed to them to be an unknown future about the possibility of recovery. As time passed hope of recovery gradually dwindled only to be replaced with a growing sense of hopelessness. This experience was explained by a participant as, '…like being a beggar always asking for help.

It makes you feel terrible to ask or receive help from others even if they are family and friends. It is quiet humiliating but what else can I do? Without help I fear I will never recover'.

Theme Four: Feeling discriminated against and marginalized by society

Feeling discriminated against and marginalized by society was for a number of participants a disquieting and humiliating experience that engendered feelings of rejection, dejection, and a sense of imprisonment. One participant in the study felt that, *'being a person with PTSD is like being a prisoner. No one wants to know you or be associated with you. They avoid you as if there is something wrong with you'.*

Seeking support in once close friends, and neighbors was met with suspicion, fear, and distance. One participant reported that, 'when I asked my friends and neighbors for help because of my condition they turned their backs and walked away. They think I'm crazy and don't want anything to do with me. Society is much the same. Society just laughs at you and wants nothing to do with you. It just wants you to keep out of sight'.

Theme Five: Feeling ignored and neglected by health care professionals

Feeling ignored and neglected by health care professionals engendered in a number of the participants a sense of vulnerability at not receiving what they believed to be appropriate quality care. One participant explained, *'all I received from the hospital staff was neglect and rudeness. The way they spoke to me and looked at me was as if there was something odd about me, as if I was not human. They didn't seem to care or have any idea what I was going through nor did they even try to understand. I just wanted to leave and never come back even if it means not getting over this condition'.*

In the face of neglect and being ignored some of the participants resorted to asking their families to take over their hospital care and provide the emotional and physical support expected to be provided by hospital staff. The stress of being treated in this manner left some participants in an emotional and psychological state of wanting to 'escape' from the hospital and never to return. One participant articulated this experience saying, *'I had to depend on my family to take care of me while I was in hospital not on the nurses. They seemed to have no idea about what I was suffering from. Each time I asked for help to move because I had no energy they just ignored me. Being ignored is a terrible feeling'.*

Being ignored and neglected by health care professionals led to self-doubt and questioning the legitimacy of their illness. One participant who reported described this experience that, *'when hospital staff treat you as if there is nothing wrong with you, treat you as if you are not ill, don't respond to your requests for assistance, you start to think what is wrong with me? Am I making all this up? Is this the type of person I am? At one stage I was really afraid that I was going mad'.*

Theme Six: Feeling Abandoned by Family

Feeling abandoned by family engendered in the participants' moments of quiet desperation and at times fearful apprehension that the very fabric of daily living – family love and support - had dissipated to the point of being non-existent. Indeed, a participant of the study stated that, *'I desperately need my family to stay and be with me whatever happens. I fear each day that will not happen. It is only a matter of time till they leave me because of my illness. There have already been signs that they are preparing to leave. Without them I have no life or hope for a future'.*

Loss of family support was exacerbated by multiple losses including diminishing health, loss of employment, financial insecurity, and physical incapacity. Belief that family would be there in times of need eroded in the face of family fears, and misunderstanding about the nature of the participants' illness. Family support was tenuous which was reliant on the ability of the participant to contribute to daily financial needs of the family. One participant explained, *'you know…if you live with children or relatives whom you are able to support financially; they are more willing to* *look after you [however] your chances of being neglected or abandoned are higher if you are not able to support them. Family can be fickle at times especially when you become a burden. I thought they would be there for me but they weren't'.*

Theme Seven: Moving toward acceptance through having faith in God

Having faith in God was an anchor amid, overwhelming physical and emotional difficulties, frustrations, uncertainties, self-doubt, family abandonment, social rejection, quiet moment of desolation and despair. Belief that Allah would be their raft through turbulent and uncertain seas of living with PTSD provided a much needed buffer and a source of strength and resolve to 'survive' these traumatic times. This belief was expressed by one participant who said that, *'if I have to survive and get through this ordeal it will be because of God. Each day I pray to God that I will recover. God is my only source of hope and comfort in this difficult time',* God is my strength. I believe He will come to my aid and be my protector'. Having faith in God was also a source of strength for the participants in coming to a point of acceptance of their illness and associated disabilities and limitations. Reaching the point of acceptance that life had forever changed as a result of their accident and subsequent illness surfaced feelings of personal liberation that gave rise to being able to look at the future in new and affirming ways within the context of their disabilities. One participant expressed that, *'it is time to accept my situation if I want to be happy once again and get on with my life'*. There are many things I cannot change but there are things I can. It is God's will what has happened to me and I must accept it. I have faith in Him to guide my future'.

Discussion

The experience of PTSD was one of the frustration at a diminishing health status among all participants. A gradual waning of strength exacerbated by sleep deprivation, flashbacks, and nightmares coupled with feelings of loss of independency and control over one's life surfaced feelings of anger and frustration. However, amid the frustration of diminishing strength and inability to care for self, participants spoke of their struggles to maintain a sense of independence. Johansen, Schanke and Frosile (2009) in their study of the impact of post-traumatic stress on severely injured patients found that the participants of their study described similar experiences to those of this study in which feeling physically and emotionally restricted because of PTSD engendered feelings of frustration and anger.

Similarlly, findings to both this present study and that of Johansen, Schanke and Frosile (2009) were explicated in studies by Lauterback, Vora and Rakow (2005), Karatzias and Chouliara (2008), and McNutt and

Postmus (2002) concerning the relationship between PTSD and self-help problems. Lauterback et al. (2005) and Palyo, Winer, Schwagler and Ang (2007) posited a direct relationship between the physical health status of individuals who have experienced trauma (PTSD), and the trauma event itself. The findings of both of these studies suggest that trauma exposure impacts significantly on an individual’s physical health status to the extent that the ability of the person to perform their daily activities are severely compromised, leading to feelings of frustration. The above mentioned studies are consistent with the findings of this current study in which the inability to care for self as a result of developing PTSD impacted on the participants to the extent that they became angry and frustrated.

For the participants of this study, the struggle for independence was thwarted with difficulty that encompassed feelings of extreme tiredness, lack of energy, a reluctance to rely on others, and a strong desire to regain control over one’s life. However, at times the struggle to once again be independent became overwhelming to the point that some participants expressed the thought of wanting to give up.

Ray and Vanstone’s (2009) study concerning the impact of PTSD on family relationships revealed that their participants’ history becomes present and viewpoint loses all meaning other than never-ending repetition of the individual’s struggle to become independent, which is similar to those PTSD patients of Jordan.

The findings of Zeilani’s (2008) and Jonsson and Segesten’s (2004) study, which studied the notions of struggle and independence were theoretically were consistent with findings of the current study. Zeilani (2008) suggested that everyday life’ after serious illness has the potential to give rise to many challenges and struggles impacting on all aspects of a person’s life. Jonsson and Segesten (2004) posit similar views to that of Zeilani (2008) in suggesting that the very thought that recovery may never be a reality can engender feelings of fearful apprehension. The inability to pay for hospitalisation, medical and psychiatric consultation, and medication can create uncertainty about their future. With the passing of time hope of recovery gradually dwindles only to be replaced with a growing sense of hopelessness. Carlson, Greenberg, Rubin and Mujica-Parodi’s (2010) recent study found that social isolation that is not self-imposed can result in significant anxiety for the person being isolated. Similarlly, Sayce (2001) found that social attitudes and responses toward individuals with a mental illness in USA and Britain have a significant element of stigma and discrimination attached leading to rejection of the people involved. Studies by Sellers and Shelton (2003), and Laffaye et al.’s (2008) found that losing one’s social status and social connections can be extremely isolating leaving the person feeling abandoned and marginalized. Turner and Avison (2003) suggested that the victim may also feel that nothing will ever be the same – precluding the use of the past to build the future. However, Carlson et al. (2010) suggested that when victims feel betrayed by individuals in their social support network, feelings of self-blame and blame of others may contribute to feelings of isolation and marginalization.

Feeling ignored and neglected by health care professionals engendered in a number of the participants a sense of vulnerability at not receiving what they believed to be appropriate quality care. In the face of neglect and being ignored some of the participants resorted to asking their families to take over their hospital care and provide the emotional and physical support expected to be provided by hospital staff. The stress of being treated in this manner left some participants in an emotional and psychological state of wanting to ‘escape’ from the hospital, and never to return. Being ignored and neglected by health care professionals led to self-doubt and questioning the legitimacy of their illness. Although a number of participants spoke of relying on family for support and care while in hospital, other participants spoke of being abandoned by family as a consequence of having PTSD.

Litz (2008) explored challenges for researchers, decision makers, and care providers in providing health care interventions for patients with PTSD. The findings indicated that patients felt ignored by nurses, as they became the subject of inflexible routines, which made no allowances for individual differences or special health care needs such as PTSD sufferers.

Litz (2008) study also found that participants became increasingly frustrated at not receiving appropriate care. The participants in this current study expressed similar views when describing their experiences of the health care delivery services in Jordan. A study by Maercker and Muller (2004) investigated two samples – one of 178 former prisoners of war in East Germany who had developed PTSD and 151 recently traumatized crime victims who developed PTSD. The findings of their study suggest that the survivors of a traumatic event who develop PTSD are likely to be in “extreme need of support from health care professionals” (p. 345). Similar findings by Laffaye et al. (2008) indicated that the extent to which the experience of PTSD are consensually validated or invalidated by society, particularly by health care professionals, might have a significant effect on the person’s psychological adaptation and ability to cope.

Blanchard and Hickling’s (2007) found that poor social health care services have the potential to have a negative psychological impact on people suffering from PTSD. Similar findings to both this present study and that of Blanchard and Hickling (2007) were explicated in studies by Vranceanu et al. (2007), Laffaye et al. (2008) and Beck et al. (2009) in which poor health care delivery was identified as a significant contributor to the development of behavioural changes among PTSD patients. The findings revealed that behavioural changes impacted negatively on the person’s pattern of daily living. Feeling abandoned by family engendered in the participants moments of quiet desperation and at times fearful apprehension that the very fabric of daily living – family love and support - had dissipated to the point of being non-existent. Loss of family support was exacerbated by multiple losses including diminishing health, loss of employment, financial insecurity, and physical incapacity. The belief that family would be there in times of need eroded in the face of family fears, and misunderstanding about the nature of the participants’ illness. Family support was tenuous which was reliant on the ability of the participant to contribute to daily financial family needs.

Using a baseline survey to identify the prevalence of family support in individuals with PTSD, Adams and Boscarino’s (2006) found that there was a strong relationship between the level of economic security of the family and level of family support. Also, the current study and Adams and Boscarino (2006) has similar findings were explicated in a study by Norris, Friedman, Watson, Byrne, Diaz and Kanasty (2002) concerning the relationship between, family stress, PTSD, and family abandonment. The findings indicated that family stress as a result of a family member developing PTSD can lead to the person being abandoned by family. These findings are further corroborated by Jordan Ministry of Health (2007) in positing that changes to the Jordanian family situation as a result of a family member being involved in a traumatic event and subsequently developing PTSD leads to family stress and may lead to family disintegration or the abandonment of the family member.

The notion of faith as a human experience has been the focus of many disciplines in PTSD patients. One example provided by a sufferer of PTSD (Murphy & Bradley. 2010) described faith as being the anchor through difficult times and a source of strength in her recovery. Faith was the impetus to moving on: I want my work to please me as well as others, but if my spirit isn’t pleased with it, I’m not finished. I go home and pray on it, I ask God to give me that feeling of satisfaction. Similar findings to those of Murphy and Bradley (2010) and this current study were identified in Tan et al.’s (2008) study about the experience of motor vehicle accident victims among six orthopaedic patients in which the notion of optimism in PTSD sufferers as a consequence of a MVA was explored. The findings suggest that one of the ways in coming to terms with and overcoming their illness experience was through their Christian faith. God was their source of strength in moving toward acceptance and hope of recovery. At times of feeling they were loosing control of their lives; they asked God to take control as they moved to accepting God’s will. Zielani (2008) suggested that moving toward acceptance is essential for continued existence.

The findings of the above mentioned studies are consistant with the findings of current study in which the participant's spoke of having faith in God helped them to come to a moment of acceptance of their condition despite fears that they may never recover.

Despite the differences in the socio-cultural context of this study the findings are consistent with other studies worldwide. However, not all themes explicated in this study were found in one other single study. The combination of themes suggest that victims of PTSD and their families in Jordan are at a significant disadvantage as a result of the many barriers in accessing appropriate support and treatment

Conclusion

The current social services policies of the Jordanian Health Care System have given little credence to the health care needs of people with PTSD. As a result of this inattention, there is a noticeable lack of processes and protocols concerning care of the mentally ill and people with PTSD. The lack of policy direction has also led to a lack of health resources in this area including specialized clinics. Access to the limited services continues to place patients in vulnerable situations. Lack of policy direction has also impacted on access to health benefits. Presently, support of people with PTSD primarily falls to the family within Jordanian culture. Social support includes providing physical, emotional and financial assistance. Although change is taking place, it is slow and spasmodic.

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Table 1. Selection criteria for the study

Inclusion criteria

- Men and Women who have been involved in a MVA
- Have, as a consequence of the accident developed PTSD
- Over the age of 18 years
- Deemed competent to participant in the study by a qualified psychiatrist
- Willing to share their experiences of PTSD
- Can speak English

Exclusion criteria

- Unduly distressed (meaning unable to control one's emotion; reacting to the memory of initial trauma)
- Exhibit florid/severe symptoms of PTSD
- Present as overtly vulnerable

Table 2

Selected Example of Three Significant Statements and Corresponding Formulated Meanings for Theme 1

SIGNIFICANT STATEMENT (AND NO.)	FORMULATED MEANING	THEME
I am disabled both physically and mentally. I am unable to even help myself. I feel there is no hope and I am unable to care for myself. At times I just want to die	The experience of PTSD limits a persons' capacity to care for self.	*Feeling frustrated at a diminishing health status*
It has been a difficult time in my life. I lost my Independence to do for myself and I need to depend on others. I have no strength to do for myself. I have to depend on others.	The experience of PTSD is to live with the frustration of not Being able to do things for yourself.	