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Research Article

Nurses' Role in Managing Post-Traumatic Stress Disorder (PTSD) Among Patients and Healthcare Staff After Disasters

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Abstract:

Nurses play a crucial role in the management of Post-Traumatic Stress Disorder (PTSD) among both patients and healthcare staff following disasters. In the immediate aftermath of a traumatic event, nurses often serve as the first point of contact for individuals impacted by the disaster. Their responsibilities extend beyond typical clinical duties; they are pivotal in providing emotional support, conducting mental health assessments, and identifying individuals at risk for developing PTSD. Through active listening, empathy, and psychoeducation, nurses can help patients understand their reactions and emotions, facilitating coping strategies to mitigate anxiety and distress. Additionally, their advocacy for timely psychological interventions can significantly influence recovery outcomes and promote resilience among patients. For healthcare staff, the stresses associated with disaster response can take a toll on mental

emotional support	well-being, resulting in burnout or secondary trauma. Nurses must be vigilant in recognizing the signs of PTSD among their colleagues and fostering a supportive work environment. Implementing peer support programs, stress management training, and debriefing sessions in the wake of a disaster are critical elements where nurses can lead. They can also ensure access to mental health resources, encouraging staff to seek professional help when necessary. By prioritizing mental health for themselves and their colleagues, nurses contribute to a healthier workplace, enhancing teamwork and ultimately improving the quality of care provided to affected populations.

1. Introduction

Disasters, whether natural (e.g., earthquakes, hurricanes, pandemics) or human-made (e.g., terrorist attacks, industrial accidents, armed conflicts), represent profound ruptures in the fabric of society. They leave in their wake not only physical destruction and mortality but also a less visible, yet equally debilitating, psychological scar: Post-Traumatic Stress Disorder (PTSD). PTSD is a severe anxiety disorder that can develop after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened, characterized by symptoms such as intrusive memories, avoidance, negative alterations in mood and cognition, and hyperarousal [1].

The global burden of PTSD in the aftermath of disasters is staggering. Recent data indicates that the prevalence of PTSD among direct survivors of disasters can range from 30% to 40% in the first year, significantly higher than the lifetime prevalence in the general population, which is estimated at 3.9% [2]. For instance, studies following major catastrophic events have consistently shown high rates of psychological morbidity. The COVID-19 pandemic served as a prolonged, global disaster, with research revealing that up to 23.8% of confirmed COVID-19 patients developed PTSD symptoms [3]. Similarly, among survivors of large-scale natural disasters like the 2011 Great East Japan Earthquake and Tsunami, PTSD prevalence was reported at over 30% in severely affected communities even years after the event [4]. This high prevalence underscores the critical need for systematic mental health interventions integrated into the disaster response continuum.

However, the patient population is only one facet of the crisis. Healthcare staff, particularly nurses who are on the front lines of disaster response, are themselves at a profoundly elevated risk of developing PTSD. The constant exposure to human suffering, high-stakes decision-making, moral distress, resource scarcity, and the personal risk of infection or harm creates a perfect storm for psychological trauma. A 2022 systematic review and meta-analysis found that the pooled prevalence of PTSD among nurses during the COVID-19 pandemic was 20.7% [5]. Another study focusing on nurses responding to mass casualty incidents found that over 25% met the diagnostic criteria for PTSD, with emergency and critical care nurses being at the highest risk [6]. This phenomenon of "secondary traumatic stress" or "compassion fatigue" is not merely an occupational hazard; it is a direct threat to the sustainability of the healthcare workforce, leading to burnout, staff turnover, and a diminished capacity to provide quality care, thereby creating a vicious cycle of deteriorating patient and staff well-being [7].

It is within this challenging context that the indispensable role of the nurse is fully realized. As the largest segment of the global health workforce and the professionals who spend the most time with patients, nurses are uniquely positioned to be the first line of defense against the mental health sequelae of disasters [8]. Their role transcends traditional boundaries and operates across the entire spectrum of care: from primary prevention and early detection to acute intervention and long-term support. In the immediate aftermath of a disaster, nurses are often the first to conduct psychological triage, using their clinical acumen to identify individuals showing acute stress reactions that may predict the development of PTSD [9]. They provide psychological first aid (PFA), offering comfort, safety, and practical support, which are crucial for mitigating initial traumatic stress.

As the situation stabilizes, the nursing role evolves into one of ongoing assessment, counseling, and referral. Nurses in primary care and community settings are essential in conducting follow-up screenings using validated tools like the PTSD Checklist (PCL-5) to identify at-risk patients who may not seek mental health services [10]. They provide essential psychoeducation to patients and families, normalizing PTSD symptoms and reducing stigma. Furthermore, nurses are instrumental in delivering trauma-informed care—an approach that recognizes the widespread impact of trauma and creates a therapeutic environment that promotes a sense of safety, empowerment, and healing [11]. This approach is vital for preventing re-traumatization within the healthcare system itself.

Crucially, the nurse's role is not limited to patient care but extends to the stewardship of their colleagues' mental health. Nurse managers and

leaders are at the forefront of fostering a supportive unit culture, implementing peer-support programs, advocating for adequate resources, and identifying staff members who are struggling. By championing wellness initiatives and creating psychologically safe spaces for debriefing, nurses help build resilience within the healthcare team, which is a critical component of organizational preparedness for future disasters [12].

2. Epidemiology of PTSD in Patients and Healthcare Workers

For patients and survivors, PTSD arises from direct life-threat, witnessing death or injury, the loss of loved ones, or the destruction of their homes and communities. The diagnostic criteria for PTSD, as outlined in the DSM-5, require exposure to actual or threatened death, serious injury, or sexual violence, and the ensuing symptom cluster of re-experiencing, avoidance, negative cognitions and mood, and hyperarousal [1]. In disaster settings, these exposures are often widespread and severe.

Recent epidemiological studies paint a concerning picture. While prevalence rates vary by disaster type, culture, and study methodology, meta-analyses confirm that a significant minority of directly affected individuals will develop PTSD. A landmark review of the mental health impact of natural disasters found that the point prevalence of PTSD typically falls between 30% and 40% within the first two years post-disaster [13]. For instance, following Hurricane Katrina, one of the most studied disasters in the U.S., studies found PTSD prevalence among survivors ranging from 20% to over 50% in highly affected communities like New Orleans, with many cases persisting for years [14]. The COVID-19 pandemic, a unique and pervasive global disaster, further illuminated this issue. Hospitalized COVID-19 patients, particularly those who underwent intensive care unit (ICU) stays with mechanical ventilation, showed exceptionally high rates of PTSD, with studies reporting incidences of 35% to 40% at one-year follow-up, a condition often referred to as "post-ICU syndrome" [15].

Specific risk factors predispose certain patient groups to a higher vulnerability. These include pre-existing mental health conditions, female gender, lower socioeconomic status, high perceived life-threat during the event, and the severity of the disaster exposure (e.g., losing a family member or one's home) [13, 16]. Furthermore, the type of disaster influences the psychological impact. Human-made or technological disasters, such as industrial accidents or acts of terrorism, often carry a higher risk of PTSD compared to natural disasters, potentially due to the element of human intent or negligence, which can exacerbate feelings of anger, betrayal, and injustice [17]. For patients, the trauma is often a singular, albeit catastrophic, event that is followed by a struggle to reclaim a semblance of their former lives, with PTSD acting as a major barrier to that recovery.

The statistics regarding PTSD among nurses in the wake of disasters are alarming and have gained significant attention, particularly during the COVID-19 pandemic. A large-scale multinational study conducted in 2021 found that the prevalence of PTSD symptoms among nurses was significantly higher than in physicians and other healthcare workers, with rates often exceeding 25% in frontline settings [18]. A systematic review focusing specifically on nurses during the pandemic corroborated this, finding a pooled prevalence of PTSD of 21.5%, with key predictors being younger age, less work experience, insufficient personal protective equipment (PPE), lack of social support, and high direct exposure to infected patients [19].

However, this risk is not new; it is merely magnified during large-scale disasters. Nurses responding to mass casualty incidents, such as terrorist attacks or major accidents, routinely face psychological sequelae. Studies following such events have shown that emergency and critical care nurses report higher levels of PTSD symptoms compared to other hospital staff, directly linked to their repeated exposure to traumatic stimuli, the high-acuity of their patients, and the chaotic nature of the disaster response [20]. The core risk factors for nurses are intrinsically tied to their work environment: high patient loads, long shift hours, making life-and-death triage decisions, and the emotional burden of caring for dying patients while simultaneously managing the distress of their families. Unlike many patients who are victims of a disaster, nurses are both victims and responders; they are exposed to the same community-wide threat while bearing the professional responsibility to act, a dual role that creates a unique and chronic form of traumatic stress.

The epidemiology of PTSD in these two groups is not isolated; it forms a dangerous and self-perpetuating cycle. When a significant portion of the nursing workforce is itself experiencing symptoms of PTSD, burnout, and moral injury, the quality and safety of patient care are inevitably compromised. A nurse struggling with hyperarousal and irritability may have difficulty establishing a therapeutic rapport. Another experiencing emotional numbing may fail to provide empathetic, patient-centered care. This degradation in care quality can, in turn, exacerbate the psychological distress of patients, leading to poorer recovery outcomes and a higher risk of developing chronic

PTSD [7]. Furthermore, high staff turnover and absenteeism due to mental health leave create staffing shortages, which increase the workload and stress on the remaining staff, further fueling the cycle of trauma within the healthcare system itself.

3. The Nurse's Pivotal Role in Early Identification and Psychological First Aid (PFA)

The first crucial step in managing mental health in a disaster is the systematic identification of those at highest risk. While all survivors are affected, their needs and capacities vary dramatically. Nursing-led psychological triage is the process of rapidly sorting survivors based on the severity of their psychological distress and their immediate needs, allowing for the prioritization of limited mental health resources. This process runs parallel to medical triage and is often conducted by the same nursing staff, requiring them to seamlessly integrate physical and psychological assessment.

Unlike medical triage, which relies on visible signs and vital parameters, psychological triage demands exceptional observational skills and empathetic engagement. Nurses are trained to look for subtle and overt signs of acute distress that may indicate a high risk for later PTSD. These signs include profound disorientation or confusion (dazed appearance), extreme emotional volatility (panic, uncontrollable crying, or intense anger), severe withdrawal and apathy, and psychomotor agitation [21]. A survivor who is utterly unable to care for their basic needs or follow simple instructions is in a state of acute crisis and requires immediate intervention. Furthermore, nurses use brief, focused screening questions to assess coping capacity and identify vulnerable individuals. Asking simple, validating questions such as, "How are you coping right now?" or "Do you have someone you feel safe with?" can provide critical insights into a person's internal state and social support system [22].

Beyond informal observation, nurses are increasingly utilizing validated short-form screening tools even in the acute phase. Instruments like the **Impact of Event Scale-Revised (IES-R)** or specific subscales from longer assessments can be administered quickly to quantify the level of distress related to intrusion, avoidance, and hyperarousal symptoms [23]. Identifying individuals with pre-existing mental health conditions, those who have suffered significant personal losses, or those who experienced a direct life-threat during the event is a key component of this triage, as these are well-established risk factors for PTSD [16]. By systematically identifying the most vulnerable, nurses ensure that psychological interventions are directed where they are most needed and most effective, moving beyond a one-size-fits-all approach to a targeted, strategic response.

Once individuals in acute distress are identified, the primary nursing intervention shifts to the application of Psychological First Aid (PFA). PFA is a humane, supportive, and practical response to people suffering from exposure to serious stressors. It is not professional psychotherapy or a debriefing technique that requires survivors to recount traumatic details; rather, it is a set of supportive actions designed to reduce initial distress and foster short- and long-term adaptive functioning [24]. The World Health Organization (WHO) and other leading international bodies endorse PFA as the preferred initial intervention for disaster survivors, and nurses are ideally positioned to be its primary providers.

The core principles of PFA can be summarized by the "**LISTEN**" model, which provides a practical framework for nurse action [25]:

- **L: Look** for safety, practical needs, and obvious signs of distress.
- **I: Inquire** about needs and concerns in a gentle, non-intrusive manner.
- **S: Screen** for serious concerns requiring immediate attention (as in psychological triage).
- **T: Touch** base with information and connect to practical resources.
- **E: Encourage** social support and adaptive coping.
- **N: Next** steps: facilitate access to further services as needed.

Operationalizing these principles, the nursing role in PFA encompasses several key actions. First and foremost is the **establishment of a sense of safety and calm.** In an environment that may feel chaotic and threatening, the nurse's calm, confident, and competent demeanor is itself a therapeutic intervention. They provide practical assistance by ensuring the survivor is in a safe location, offering water, food, and blankets, which addresses basic physiological needs and communicates care and stability [26].

The second key action is **active and empathetic listening.** Nurses create a supportive environment where survivors feel heard and understood without judgment. This involves using non-verbal cues (nodding, maintaining an open posture), reflecting back what the survivor is saying ("It sounds like you are feeling completely overwhelmed"), and validating their emotional responses ("Anyone who went through what you did would feel scared and upset") [27]. This validation is crucial in countering feelings of isolation and "going crazy," which are common in the wake of trauma.

Third, nurses in the PFA role are instrumental in **practical problem-solving and connection to social supports.** They help survivors address immediate practical problems, such as locating missing family members, making a phone call, or accessing emergency shelter. They actively encourage but do not force connection with available social supports, such as family, friends, or community groups [28]. Furthermore, nurses provide **accurate and timely information** to counter rumors and reduce uncertainty, which is a major source of anxiety. Clearly explaining the next steps in the evacuation process, the location of medical services, or how to register for aid can provide a crucial sense of predictability and control. Finally, and perhaps most critically, nurses **link survivors to additional services.** PFA is a bridge, not a destination. A core competency for the nurse is knowing when a survivor's needs exceed the scope of PFA and require a referral to specialized mental health professionals, such as psychiatrists or psychologists. This involves explaining the referral in a de-stigmatizing way, such as, "It's completely normal to need extra support after something like this. Let me connect you with someone who is specially trained to help people through these feelings" [29].

The role of the nurse in this acute phase extends beyond individual interactions; they serve as a stabilizing container for the collective trauma of the community. By modeling calm, compassion, and competence, they set the emotional tone for the entire aid environment. Their presence reassures not only the individuals they directly assist but also those observing their work, reinforcing a message that help is available, and order will be restored. This systemic impact underscores that the nurse's function in early identification and PFA is not a peripheral task but a central component of the public health response to disaster, fundamentally shaping the community's capacity for resilience and recovery in the weeks and months to come [30].

4. Nursing Strategies for Long-Term Patient Recovery

As the immediate crisis of a disaster subsides, the journey of recovery for survivors with PTSD transitions from the acute stabilization of Psychological First Aid to the long-term, nuanced process of healing and rehabilitation. In this phase, which can span months or years, the nurse's role evolves into that of a consistent, therapeutic partner. The guiding framework for this sustained interaction is Trauma-Informed Care (TIC). Moving beyond specific therapeutic techniques, TIC is a fundamental paradigm shift—an organizational and clinical culture that permeates every patient interaction. It recognizes the pervasive impact of trauma and creates environments of healing and recovery, rather than practices and settings that may inadvertently re-traumatize those seeking help [31]. This section explores the practical application of TIC principles by nurses across various healthcare settings, outlining the specific strategies that facilitate long-term patient recovery from PTSD.

Trauma-Informed Care is not a protocol but a lens through which all care is viewed. The Substance Abuse and Mental Health Services Administration (SAMHSA) outlines six key principles that form the bedrock of this approach: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues [32]. For nurses, translating these abstract principles into daily practice is the essence of effective long-term management of PTSD.

The foremost principle is ensuring **physical and psychological safety**. For a trauma survivor, the world feels dangerous, and healthcare settings—with their inherent power imbalances, invasive procedures, and potential for loss of control—can be potent triggers. Nurses actively create safety by ensuring the clinical environment is respectful and private. More importantly, they foster psychological safety by consistently demonstrating predictable, reliable, and non-threatening behavior. This includes always introducing oneself, explaining every procedure in detail before and during its execution ("I'm going to take your blood pressure now; this cuff will feel tight for a moment"), and ensuring the patient's physical privacy is maintained [33]. The nurse's goal is to make the patient feel like an active participant in a safe partnership, not a passive object of care.

Building **trustworthiness and transparency** is achieved through clear, honest communication and consistent follow-through on promises. A nurse might say, "I will be your nurse for the next 12 hours, and I will check on you every hour," and then diligently do so. This consistency helps rebuild a survivor's shattered sense of trust in others [34]. **Collaboration and mutuality** are operationalized by shifting from a paternalistic model to a participatory one. Instead of dictating a plan, the nurse uses phrases like, "Let's work together on this," or "What are your thoughts on this treatment option?" This approach dismantles the power differential that can mirror the dynamics of a traumatic event.

Finally, **empowerment, voice, and choice** are perhaps the most therapeutic principles in countering the helplessness that is central to PTSD.

Nurses can foster empowerment by focusing on a patient's strengths, no matter how small. They provide choices wherever possible, even in seemingly minor matters: "Would you prefer to take your medication with water or juice?" or "Would you like to sit in the chair or stay in bed for our conversation?" [35]. These small acts of choice restore a sense of agency and control, which is fundamental to the recovery of a trauma survivor.

Within the TIC framework, nurses employ specific, evidence-based interventions to address the core symptom clusters of PTSD: re-experiencing, avoidance, hyperarousal, and negative cognitions.

- **Managing Re-experiencing and Hyperarousal:** When a patient is experiencing a flashback or panic attack, the nurse's primary role is to ground the patient in the present moment. Grounding techniques use the five senses to pull the patient away from the traumatic memory. A nurse might calmly instruct the patient: "Can you name three things you can see in this room? ... Now, two things you can feel, like the texture of the blanket? ... Can you hear the sound of my voice?" [36]. This simple yet powerful intervention can help terminate a flashback. For persistent hyperarousal, nurses teach and encourage relaxation techniques such as deep, paced breathing (e.g., "box breathing") or progressive muscle relaxation, often during calm periods so the patient can use them during times of distress [37].
- **Addressing Avoidance and Negative Cognitions:** Avoidance is a maintaining factor for PTSD, and nurses play a gentle, supportive role in encouraging gradual engagement. This is done not by forcing, but by motivating and supporting. They can help a patient develop a hierarchy of feared situations and support them as they take small, manageable steps. Furthermore, nurses are instrumental in providing psychoeducation to both patients and their families. By explaining that PTSD symptoms are a normal reaction to an abnormal event, they help to normalize the experience and reduce the shame and self-stigma that often accompany the diagnosis [38]. They challenge negative cognitions (e.g., "It was my fault," "I am permanently broken") by offering alternative, compassionate perspectives, reinforcing the patient's resilience for having survived.

Implementing Trauma-Informed Care with PTSD survivors is emotionally demanding work. The constant exposure to stories of trauma and suffering puts nurses at high risk for secondary traumatic stress and compassion fatigue [39]. Therefore, a nurse cannot effectively provide TIC without also attending to their own well-being. This requires a high degree of self-awareness, the ability to recognize one's own triggers and emotional responses, and the proactive use of self-care strategies. Organizations must support this by creating a culture where staff debriefing, access to mental health resources, and work-life balance are prioritized. A resilient, self-aware nursing workforce is the most critical component in sustaining the long-term, trauma-informed relationships necessary for patient recovery [40]. By embodying the very principles of safety, trust, and empowerment they seek to instill, nurses become not just caregivers, but powerful agents of healing in the long and challenging journey out of trauma.

5. Nursing-Led Referral, Coordination, and Advocacy within the Mental Health Ecosystem

A referral is far more than a simple handoff; it is a complex clinical and interpersonal process that, when done effectively, can significantly increase patient adherence to specialized care. The nurse's role begins with the crucial task of **de-stigmatizing the referral**. For many patients, especially in cultures where mental health is stigmatized, a referral to a psychiatrist can be perceived as a label of being "crazy" or "weak." The nurse addresses this by normalizing the need for specialized support, using analogies such as, "Just as I would refer you to a cardiologist for a heart condition, I am connecting you with a trauma specialist for your PTSD symptoms. They have advanced tools and therapies that are very effective for what you're experiencing" [41]. This reframes the referral as a positive step towards specialized healing, rather than a failure or a judgment.

Following this, the nurse engages in **active facilitation** to overcome logistical barriers. A survivor grappling with PTSD symptoms like avoidance, concentration problems, and anhedonia may lack the cognitive or emotional capacity to navigate complex healthcare systems. The nurse's role becomes one of an active navigator. This can involve:

- **Identifying Appropriate Resources:** Maintaining and providing an up-to-date list of mental health professionals specializing in trauma, community-based support groups (e.g., for disaster survivors), and teletherapy options, which can be particularly accessible [42].

- **Assisting with Practicalities:** Helping the patient make the initial phone call, facilitating the transfer of relevant medical records (with patient consent), and providing clear, written instructions on the appointment time, location, and what to expect.
- **Implementing Warm Handoffs:** Whenever possible, the most effective method is a "warm handoff," where the nurse personally introduces the patient to the mental health provider, either in person or via phone/video call. This tangible transfer of trust significantly reduces no-show rates and builds immediate rapport between the patient and the new provider [43].

Once a referral is made, the nurse's role transitions into **ongoing care coordination**. The nurse acts as the central hub of communication between the patient, the primary care physician, the psychiatrist managing medications, and the therapist providing psychotherapy. They monitor the patient's adherence to treatment plans, report on progress or emerging side effects from medications to the prescribing physician, and reinforce the therapeutic strategies introduced by the psychologist during their own nursing interactions [44]. This continuous feedback loop ensures that the entire care team is aligned, preventing fragmentation of care.

The nurse's bridging function extends beyond individual patient interactions to the broader domain of advocacy. This occurs at multiple levels, from the micro-level of the individual to the macro-level of policy and resource allocation.

At the **individual patient level**, advocacy involves ensuring the patient's voice is heard and their rights are respected. A nurse might advocate for their patient by challenging an insurance company's denial of coverage for a specific trauma therapy or by speaking up during a multi-disciplinary team meeting to ensure the care plan accounts for the patient's specific trauma triggers and personal goals [45]. They empower the patient to self-advocate by coaching them on how to communicate their needs effectively to other providers.

At the **community and systems level**, nurses have a professional and ethical obligation to advocate for improved mental health services. The aftermath of a disaster often exposes pre-existing gaps in the mental health infrastructure. Nurses, armed with firsthand experience and data on patient needs, are powerful voices for change. They can:

- **Lobby for Resources:** Advocate to hospital administrators and public health officials for the integration of mental health screening and brief interventions into all primary care and post-disaster clinic settings [46].
- **Promote Integrated Care Models:** Champion the adoption of collaborative care models, where psychiatrists and psychologists are embedded within primary care teams, thereby reducing stigma and improving access [47].
- **Influence Policy:** Provide testimony and expert opinion to policymakers on the critical need for sustained funding for disaster-related mental health services, long after the physical debris has been cleared [48]. The American Nurses Association's Code of Ethics explicitly calls for nurses to "advocate for the protection of the health, safety, and rights of the patient," which includes advocating for the systems and policies that make such protection possible [49].

Finally, the nurse's bridging role encompasses that of an educator and community liaison. They are instrumental in educating not only patients and families but also other healthcare providers about PTSD and the principles of Trauma-Informed Care. By conducting in-service trainings for non-psychiatric staff, they help create a more universally supportive and less triggering healthcare environment [50].

Furthermore, nurses often serve as the vital link between the formal healthcare system and informal community supports. They connect patients with faith-based organizations, survivor networks, and social services that can provide practical aid (housing, employment) which is inextricably linked to psychological recovery. By mapping and leveraging these community assets, nurses ensure that the patient's support network is robust and multi-faceted, extending far beyond the clinic walls.

6. Conclusion

The multifaceted and devastating impact of Post-Traumatic Stress Disorder (PTSD) in the aftermath of disasters presents a profound and dual challenge to global public health, affecting both the survivor population and the healthcare workforce tasked with their care. This research has systematically delineated the indispensable and multi-phase role of nursing in confronting this crisis. From the initial chaos of the disaster to the long journey of recovery, nurses stand as the consistent, therapeutic thread connecting individuals to hope, healing, and resilience.The evidence presented confirms that the nursing role is not ancillary but central to an effective mental health disaster response. It begins with the critical tasks of early identification and psychological first aid, where nurses act as frontline stabilizers, providing safety, comfort, and a human

connection amidst the turmoil. As the acute phase transitions into long-term care, the nurse's role evolves into that of a trauma-informed practitioner, creating therapeutic environments built on safety, trust, collaboration, and empowerment. This approach is fundamental to helping patients manage their symptoms, rebuild a sense of agency, and engage meaningfully in their recovery process. Furthermore, nurses serve as the essential bridge within the complex mental health ecosystem, skillfully facilitating referrals, coordinating multi-disciplinary care, and advocating tirelessly for both individual patients and the systemic changes necessary to support them.Crucially, this paper has highlighted that the caregiver cannot be overlooked. The high prevalence of PTSD, burnout, and secondary traumatic stress among nurses themselves is not merely an occupational hazard but a critical threat to the integrity of the healthcare system. The sustainability of nursing care is contingent upon the well-being of the nurses who provide it. Therefore, the role of nursing leadership in fostering resilient teams through peer support, psychological debriefing, and a culture of wellness is not just a recommendation but an operational imperative.

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