trauma survivors network provided by ATS

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Supporting Trauma Survivors and Families with Acute Stress Disorder or Post-Traumatic Stress Disorder: Psychoeducation and Screening

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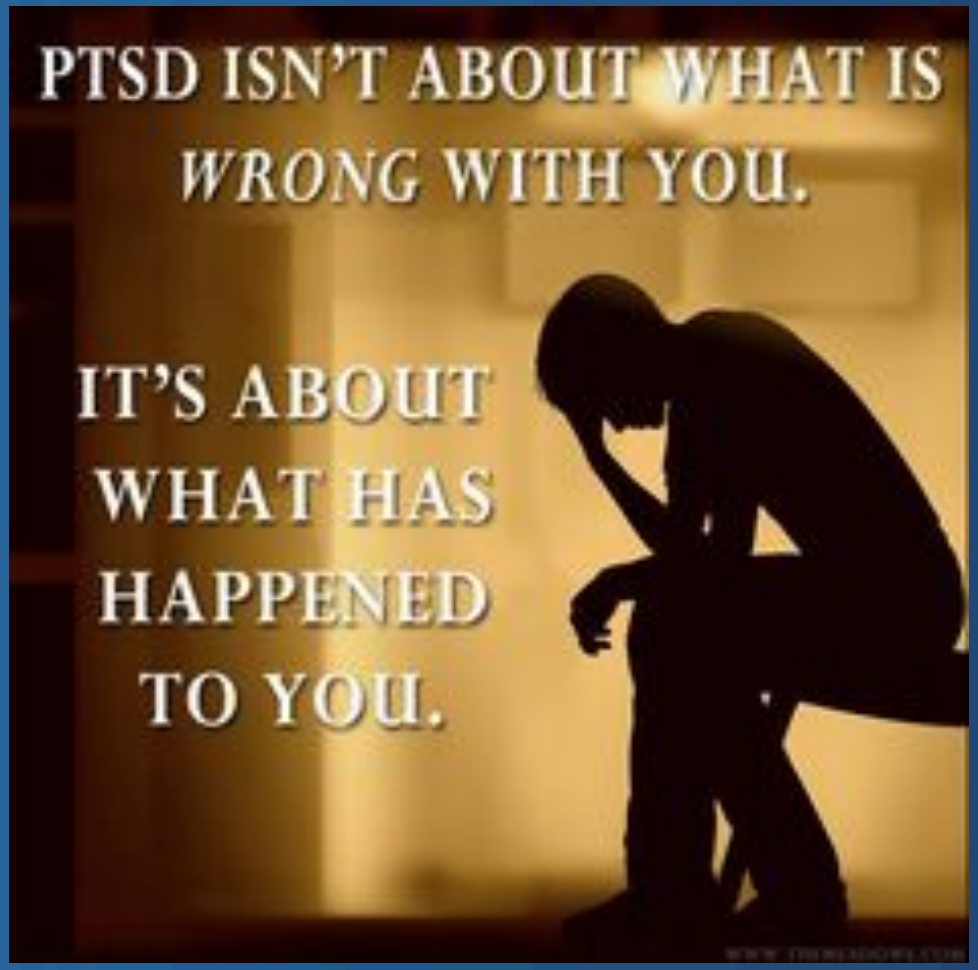
ATS American Trauma Society

Webinar Agenda

- Awareness of Acute Stress Disorder (ASD)
- Awareness of Post-Traumatic Stress Disorder (PTSD)
- Psychoeducation and Support within TSN services
- Using a Trauma-Informed Approach to Empower Survivors and Families
- PTSD Screening Tools to Consider
- Process for PTSD Screening and Referrals for Survivors

Using a Trauma-Informed Approach to Empower Survivors and Families



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Awareness of Acute Stress Disorder (ASD)

Acute Stress Disorder 308.3 Diagnostic Criteria from DSM 5 Chapter on Trauma- and Stressor-Related Disorders

A. Exposure to actual or threatened death, serious injury, or sexual violation.

B. Presence of nine (or more) of the following symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred:

- **Intrusion Symptoms**

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the event(s).

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring.

4. Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

- **Negative Mood**

5. Persistent inability to experience positive emotions.

- **Dissociative Symptoms**

6. An altered sense of the reality of one's surroundings or oneself.

7. Inability to remember an important aspect of the traumatic event(s).

- **Avoidance Symptoms**

8. Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

9. Efforts to avoid external reminders that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

- **Arousal Symptoms**

10. Sleep disturbance.

11. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.

12. Hypervigilance.

13. Problems with concentration.

14. Exaggerated startle response.

C. Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition (e.g., mild traumatic brain injury) and is not better explained by brief psychotic disorder.

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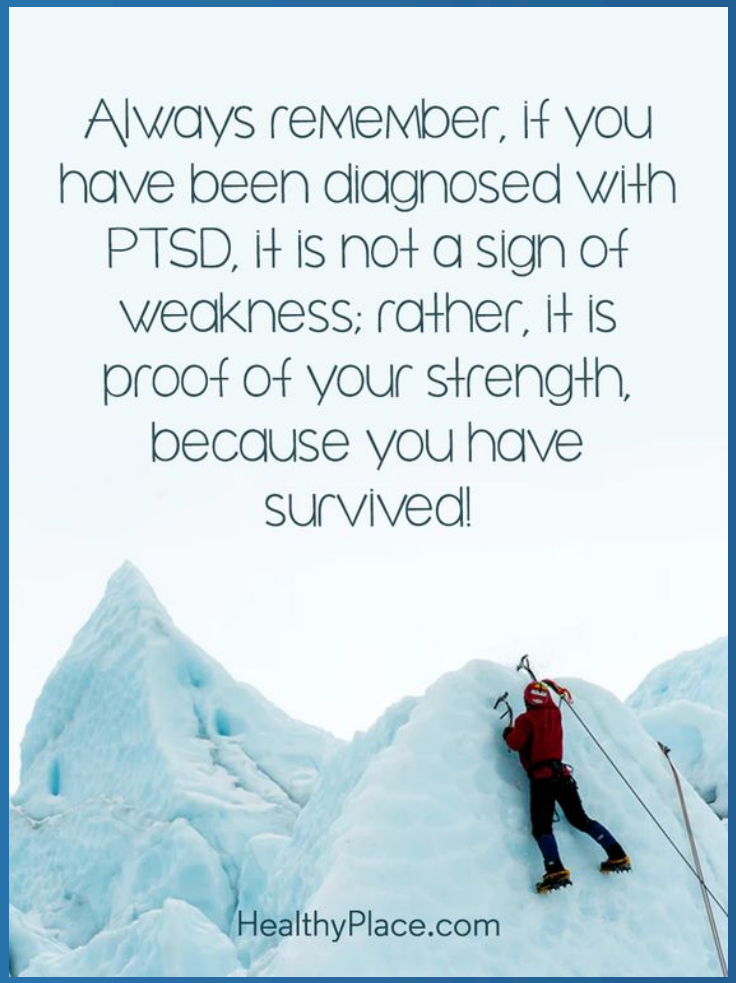
Trauma- and Stressor-Related Disorders: ASD and PTSD



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Awareness of Post-Traumatic Stress Disorder (PTSD)

Posttraumatic Stress Disorder (PTSD) 309.81 Diagnostic Criteria from DSM 5

A. Stressor: The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: (1 required)

1. Direct exposure.
2. Witnessing, in person. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
3. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.

B. Intrusion symptoms: The traumatic event is persistently re-experienced in the following way(s): (1 required)

1. Recurrent, involuntary, and intrusive memories. Note: Children older than 6 may express this symptom in repetitive play.
2. Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).
3. Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may reenact the event in play.
4. Intense or prolonged distress after exposure to traumatic reminders.
5. Marked physiologic reactivity after exposure to trauma-related stimuli.

C. Avoidance Persistent effortful avoidance of distressing trauma-related stimuli after the event: (1 required)

1. Trauma-related thoughts or feelings.
2. Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).

D. Negative alterations in cognitions and mood Negative alterations in cognitions and mood that began or worsened after the traumatic event: (2 required)

1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol or drugs).
2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous.").
3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
4. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt or shame).
5. Markedly diminished interest in (pre-traumatic) significant activities.
6. Feeling alienated from others (e.g., detachment or estrangement).
7. Constricted affect: persistent inability to experience positive emotions.

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Awareness of Post-Traumatic Stress Disorder (PTSD)

E. Alterations in arousal and reactivity Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: (2 required) 1. Irritable or aggressive behavior. 2. Self-destructive or reckless behavior. 3. Hypervigilance. 4. Exaggerated startle response. 5. Problems in concentration. 6. Sleep disturbance.
F: Duration Persistence of symptoms (in Criteria B, C, D and E) for more than one month.
G: Functional significance Significant symptom-related distress or functional impairment (e.g., social, occupational).
H: Exclusion Disturbance is not due to medication, substance use, or other illness.
Specify if: With dissociative symptoms. In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli: 1. Depersonalization: experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream). 2. Derealization: experience of unreality, distance, or distortion (e.g., "things are not real").
Specify if: With delayed expression. Full diagnosis is not met until at least 6 months after the trauma(s), although onset of symptoms may occur immediately.

Source: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association

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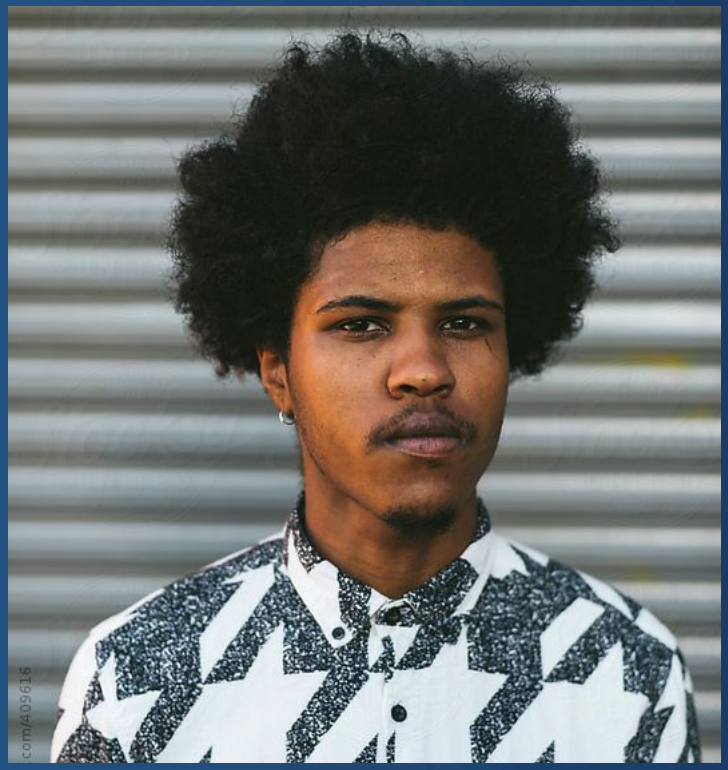
Awareness of Post-Traumatic Stress Disorder (PTSD)

“PTSD affects approximately 3.5 percent of U.S. adults, and an estimated one in 11 people will be diagnosed with PTSD in their lifetime. Women are twice as likely as men to have PTSD.”

- **American Psychiatric Association**



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Awareness of Post-Traumatic Stress Disorder (PTSD) in Preschool Children (under age 6 years)

Posttraumatic Stress Disorder (PTSD) 309.81 Diagnostic Criteria in children (under the age of 6 years)

A. Children under the age 6 have been exposed to an event involving real or threatened death, serious injury, or sexual violence in at least one of the following ways:

1. The child directly experienced the event.
2. The child witnessed the event, but this does not include events that were seen on television, in movies or some other form of media.
3. The child learned about a traumatic event that happened to a caregiver.

B. The presence of at least one of the following intrusive symptoms that are associated with the traumatic event and began after the event occurred:

1. Recurring, spontaneous, and intrusive upsetting memories of the traumatic event.
2. Recurring and upsetting dreams about the event.
3. Flashbacks or some other dissociative response where the child feels or acts as if the event were happening again.
4. Strong and long-lasting emotional distress after being reminded of the event or after encountering trauma-related cues.
5. Strong physical reactions, like increased heart rate or sweating, to trauma-related reminders.

C. The child exhibits at least one of the following avoidance symptoms or changes in his or her thoughts and mood. These symptoms must begin or worsen after the experience of the traumatic event.

1. Avoidance of or the attempted avoidance of activities, places, or reminders that bring up thoughts about the traumatic event.
2. Avoidance of or the attempted avoidance of people, conversations, or interpersonal situations that serve as reminders of the traumatic event.
3. More frequent negative emotional states, such as fear, shame, or sadness.
4. Increased lack of interest in activities that used to be meaningful or pleasurable.
5. Social withdrawal.
6. Long-standing reduction in the expression of positive emotions.

D. The child experiences at least one of the below changes in his or her arousal or reactivity, and these changes began or worsened after the traumatic event:

1. Increased irritable behavior or angry outbursts. This may include extreme temper tantrums.
2. Hypervigilance, which consists of being on guard all the time and unable to relax.
3. Exaggerated startle response.
4. Difficulties concentrating.
5. Problems with sleeping.

Duration: Persistence of symptoms (in Criteria B, C, D) for more than one month.

Functional significance : result in considerable distress or difficulties in relationships or with school behavior.

Exclusion: The symptoms also cannot be better attributed to ingestion of a substance or to some other medical condition.

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Psychoeducation and Support within TSN services

In my role as TSN Coordinator, what can I do to help?

Inpatient Services	Outpatient Services
Rounding on Trauma Patients/Families	Support Groups for Survivors & Families
TSN Patient & Family Handbook	In-Person 6-session NextSteps Groups
Family Class/Snack n Chat	Online 6-session NextSteps Groups
Peer Visitation for Patients & Families	Peer Visitation for Patients & Families
ASD/PTSD Support/Resources	ASD/PTSD Support/Resources
	TSN Website Resources for Survivors& Families

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Psychoeducation and Support within TSN services

Case Examples from Inpatient and Outpatient TSN Services:

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Using a Trauma-Informed Approach to Empower Survivors and Families

Trauma-Informed Approach

According to SAMHSA's concept of a trauma-informed approach, "A program, organization, or system that is trauma-informed:

1. *Realizes* the widespread impact of trauma and understands potential paths for recovery;
2. *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeks to actively resist *re-traumatization*."

- A trauma-informed approach can be implemented in any type of service setting or organization and is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing.

SAMHSA
Substance Abuse and Mental Health Services Administration

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Using a Trauma-Informed Approach to Empower Survivors and Families

SAMHSA's Six Key Principles of a Trauma-Informed Approach

A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific:

1. **Safety**
2. **Trustworthiness and Transparency**
3. **Peer support**
4. **Collaboration and mutuality**
5. **Empowerment, voice and choice**
6. **Cultural, Historical, and Gender Issues**

From SAMHSA's perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA's definition of recovery, services and supports that are trauma-informed build on the best evidence available and consumer and family engagement, empowerment, and collaboration.

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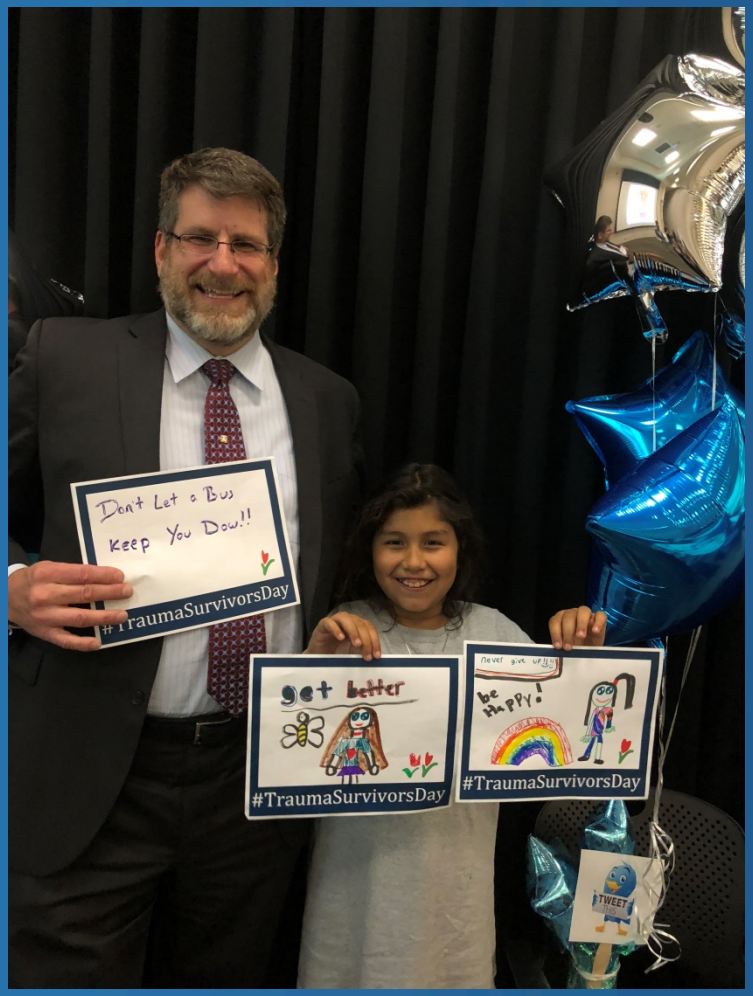
Using a Trauma-Informed Approach to Empower Survivors and Families



Trauma-Specific Interventions

Trauma-specific intervention programs generally recognize the following:

- The survivor's need to be respected, informed, connected, and hopeful regarding their own recovery
- The interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety
- The need to work in a collaborative way with survivors, family and friends of the survivor, and other human services agencies in a manner that will empower survivors and consumers

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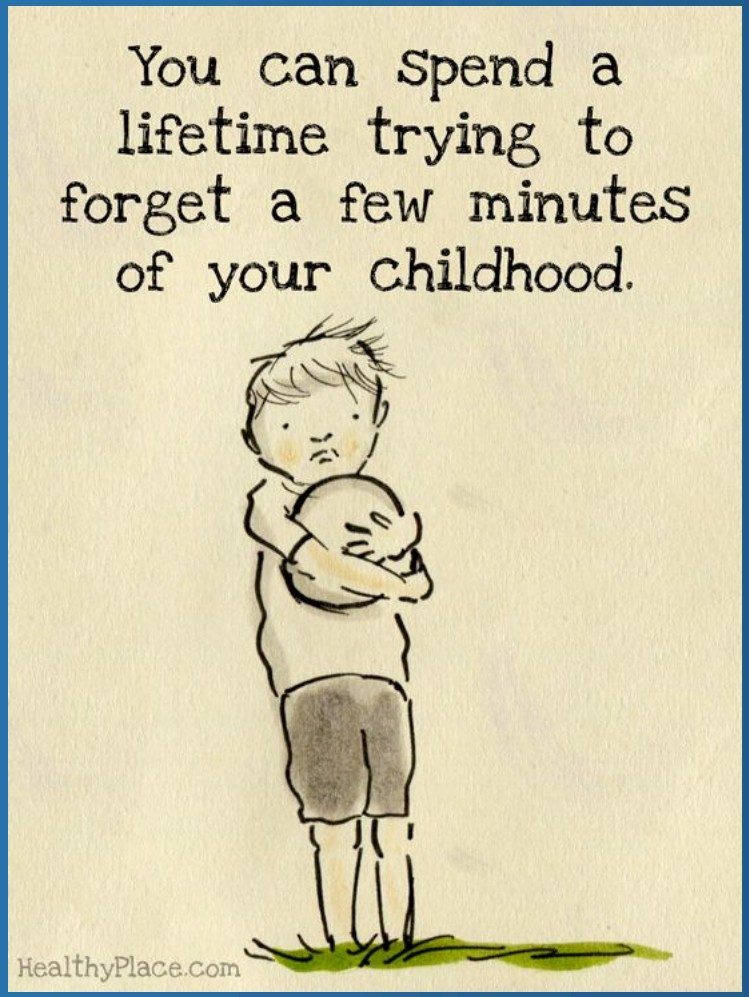

Adverse Childhood Experiences have been linked to:

- risky health behaviors,
- chronic health conditions,
- low life potential, and
- early death.

As the number of ACEs increases, so does the risk for these outcomes.

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Sources and Resources

- **International Society for Traumatic Stress Studies**
  - www.istss.org
- **Trauma Center at Justice Resource Institute**
  - www.traumacenter.org
- **National Child Traumatic Stress Network**
  - www.nctsn.org
- **National Center for PTSD**
  - www.ptsd.va.gov
- **American Counseling Association**
  - https://www.counseling.org/knowledge-center/mental-health-resources/trauma-disaster#
- **Substance Abuse and Mental Health Services Association**
  - https://www.samhsa.gov/nctic/trauma-interventions
- **Centers for Disease Control and Prevention**
  - https://www.cdc.gov/violenceprevention/acestudy/about_ace.html
- **International Society for the Study of Trauma and Dissociation**
  - http://www.isst-d.org/
- **American Psychiatric Association**
  - www.psychiatry.org/patients-families/ptsd/what-is-ptsd

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Supporting Trauma Survivors and Loved Ones:

Psychoeducation and Screening

Alisha Bowker, LCSW

A proud member of
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Who is on our Trauma Psychology Team?

- Clinical Psychologist
- LCSW
- Psychiatry Residents and Fellows
- Psychology Interns
- Social Work Intern

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What do we do?

- Administer PTSD/Depression Screens to all trauma activated patients
- Administer the AUDIT to any patient with a positive toxicology screen
- Provide brief interventions to patient's and loved ones: psychoeducation, grounding, resources
- Follow for bedside therapy for the duration of the patient's stay

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The screens we use

PC-PTSD 5

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?
YES (1) / NO (0)

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
YES (1) / NO (0)

3. Were constantly on guard, watchful, or easily startled?
YES (1) / NO (0)

4. Felt numb or detached from others, activities, or your surroundings?
YES (1) / NO (0)

5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?
YES (1) / NO (0)

Total PC-PTSD Score: _____ (positive if ≥ 3)

PHQ-2/PHQ-9

PHQ-2

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things
(0) Not at all
(1) Several days
(2) More than half the days
(3) Nearly everyday

2. Feeling down, depressed, or hopeless
(0) Not at all
(1) Several days
(2) More than half the days
(3) Nearly everyday

Total PHQ-2 Score: _____ (if ≥ 3, administer PHQ-9)

PHQ-9

3. Trouble falling asleep, staying asleep, or sleeping too much 0 1 2 3
4. Feeling tired or having little energy 0 1 2 3
5. Poor appetite or overeating 0 1 2 3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down 0 1 2 3
7. Trouble concentrating on things, such as reading the newspaper or watching television 0 1 2 3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual 0 1 2 3
9. Thoughts that you would be better off dead or of hurting yourself in some way 0 1 2 3

Total PHQ-9 Score: _____ (5-9 mild, 10-14 moderate, ≥ 15 severe depression)Q-9

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How we administer screens

- Introduce ourselves and our role at the hospital *(normalize the 'Psych' part)*
- Ask questions from screens conversationally + provide psychoeducation throughout
- Normalize any symptoms the pt might be reporting
- Provide resources and next step options

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What to do about family + loved ones?

1. Always ask if patient is comfortable with folks staying in the room during the screens

   (Pros and Cons to both)

2. If patient is unable to communicate or has a poor prognosis, we can offer support and education to others impacted

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Resources provided

- Local Mental Health Centers for therapy/medication management
- Trauma Recovery Clinic (at UMC)
- Housing
- Mindfulness Tools
- Substance Abuse Resources (inpatient and outpatient)

Soon hope to include:

- TSN Booklet
- TSN Survivor's Group
- TSN Website

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Trauma Recovery Clinic

- **Location:** 5th floor of our clinic building, embedded in trauma surgery clinic
- **Population:** Any person 13+ who was a UMCNO trauma activation, or their family member/loved one
- **Providers:** Psychologist, LCSW, Psychiatry

Services:

- CBT, Prolonged Exposure Therapy
- Medication Management
- Clinic-based consultations: we can see patients in their clinic room during Trauma Surgery clinic to assess symptoms and provide brief interventions

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Any Questions?