Managing Traumatic Stress: Evidence-Based Guidance for Organizational Leaders

A Compassion in Action Webinar
April 21, 2020
Your Moderator

Stephanie Adler Yuan, MS
Director, Education & Training
The Schwartz Center for Compassionate Healthcare
The Schwartz Center for Compassionate Healthcare

Putting compassion at the heart of healthcare through programs, education and advocacy

Through national and international partnerships, the Schwartz Center’s coalition of caregivers, patients, families and other leaders work together to make compassion a vital element in every aspect of healthcare.
Please Note

• This webinar is funded in part by a donation in memory of Julian and Eunice Cohen, whose generosity inspired others to give and to learn.

• You may submit your questions via the “Questions” pane to the right of your screen at any time.

• We appreciate your feedback! Please take a moment to complete our very brief survey following the webinar.
Today’s Host

Beth Lown, MD
Chief Medical Officer
The Schwartz Center for Compassionate Healthcare
Today’s Speaker

Professor Neil Greenberg, BM, BSc, MMedSc, FHEA, MFMLM, DOccMed, MEWI, MInstLM, MFFLM, MD, FRCPsych
Professor of Defence Mental Health
King’s College London
Who am I?

• Psychiatrist and Professor at King’s College London
• RC Psychiatrists Chair of Occupational Psychiatry SIG
• Served in the Royal Navy for 23+ years
• Managing Director of March on Stress Ltd
• Provide psychological clinical support, advice, training and assessments for organisations such as:
  • FCO
  • BBC,
  • Emergency Services,
  • PSCs
Intro

• Why is this topic important
• Type 1 and type 2 trauma
• Stigma and help-seeking
• Prevent
• Detect
• Treat
• Snake oil
Main Sources of www. Information

http://www.ukpts.co.uk

http://www.kcl.ac.uk/kcmhr

www.marchonstress.com/

http://epr.hpru.nihr.ac.uk/

http://epr.hpru.nihr.ac.uk/

Traumatic Stress Management Guidance
For Organisations Whose Staff Work In High Risk Environments

the schwartz center
FOR COMPASSIONATE HEALTHCARE
What is Traumatic Stress???
What is a Potentially Traumatic Event (DSM-5)

• Being exposed to:
  • Death
  • Threatened death
  • Actual or threatened serious injury
  • Actual or threatened sexual violence

• By
  • Direct exposure
  • Witnessing in person
  • Indirectly learning of a close relative/friend’s trauma
  • Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties
Type 1 and type 2 traumas

Sudden “Type I” trauma

Type II – ‘the final straw’
The PTSD Diagnosis

• Experience a Potentially Traumatic Event
  (often causing intense helplessness, horror or fear)

• Symptoms (for more than a month)
  • Intrusion symptoms
  • Avoidance
  • Negative alterations in cognitions and mood
  • Alterations in arousal and reactivity

• Symptoms must be functionally significant
What is the natural history of PTSD?

Important Caveat

• PTSD is not the only post incident psych health problem related to trauma

• Depression, anxiety, adjustment disorders and substance misuse also common

• NICE refer to “clinically important Post Traumatic Stress Symptoms”
Organisational Traumatic Stress Management

- Prevent
- Detect
- Treat

http://www.ukpts.co.uk

Traumatic Stress Management Guidance
For Organisations Whose Staff Work In High Risk Environments

Produced in association with the European Society for Traumatic Stress Studies
Prevent

• Robust operational stress policy
  • Philosophy of the organisation
    • “they have to know you care, before they care what you know”

• Duties of individuals and managers
  • Especially important in safety critical roles
Prevent

- Robust operational stress policy
  - Philosophy
  - Duties of individuals and managers
- ‘Build’ supportive teams and ensure effective (caring) supervisory level leaders
Cohesion – Iraq 2009

High cohesion: 3+ of:

a. ‘sense of comradeship with others in my unit’
b. ‘able to go to most people in unit with personal problems’
c. ‘my seniors are interested in what I do or think’
d. ‘I feel well informed about unit matters’

Mulligan et al, BJPsych, 2010
Supervisory leadership and PTSD – Afghanistan 2010

Good leadership 3+ of:

‘my leaders never or seldom...
  a. ‘embarrass unit members in front of others’
  b. ‘accept extra unit duties in order to impress their seniors’
‘my leaders often or always...
  c. ‘treat all members of the unit fairly’
  d. ‘show concern about the safety of unit members’

Prevalence of probable PTSD*
Prevent

• Robust operational stress policy
  • Philosophy
  • Duties of individuals and managers

• ‘Build’ supportive teams and ensure effective (caring) supervisory level leaders

• Training
  • On the job training is important
    • E.g. Iversen et al, Psych Med, 2008
Prevent

• Robust operational stress policy
  • Philosophy
  • Duties of individuals and managers

• ‘Build’ supportive teams and ensure effective (caring) supervisory level leaders

• Training
  • On the job training is important
  • Psychoeducation/mental health training
Psychoeducation/mental health training

• Evidence that it has an effect for those on the job
  • [e.g. troops on deployment; Mulligan et al. BJPsych 2010]

• No evidence that it has a sustained long term impact

• May be useful in helping to shift attitudes over time
  • [stigma change; Osório et al. Mil Med. 2013 Aug;178(8):846-53]

• Benefits from training managers
  • [£1 for £10; Milligan-Saville, Lancet Psychiatry, 2017]
House Passes New Recruit Mental Health Screening

WASHINGTON -- New mental health screening that supporters say could help stem the high rate of military suicides or even stop shooting rampages passed the House on Thursday as part of the massive 2015 defense budget.

The House bill, sponsored by Rep. Glenn Thompson, R-Pa., orders the National Institutes of Health to create a universal mental health evaluation for potential recruits that would catch past suicide attempts and psychiatric disorders. The data could be used by the services to weed out candidates with potentially dangerous mental health issues.

Army Mental Health: Better Screening Yields Better Results

By Mark Thompson @MarkThompson_DC | April 17, 2011

Just how closely should the nation be screening its troops for mental illnesses before they're shipped off to war? We are seeing, again and again, that bad things — depression, divorce, suicide, murder — can happen in combat's wake.

If there is a way to weed out — that may not be the right word — the folks who might be driven to such ends by war, is it the government's job to keep them at home?

You bet, say five Army mental-health experts in the April issue of The American Journal of Psychiatry:

This predeployment screening process was associated with a decreased need for clinical care for combat stress, psychiatric and behavioral disorders, and suicidal ideation. This systematic screening activities provides the first direct evidence to support the use of a center-wide approach.
Psychological ‘Pre-’ Screening

• Seductive

• Psychometric, personality, ‘lie detecting’/validity scales….. (e.g. MMPI)

• Grandmother test is good
King’s College London – Screening research

Data collected in 2002 → Troops sent to Iraq in 2003 → Follow up in 2004
Post incident screening

• Survey and/or face to face to identify MH problems

• For those with problems – advisory or mandatory MH referral

• Many forces (US, CAN, ADF, NLD) routinely use post deployment screening

• BUT worrying 2009 JAMA paper (US focused)
Post Operational Screening Trial (POST)

- Part of the 2010 Murrison Report on MH; US funded ~ $3M RCT
- Involved ~9000 troops returning from Afghanistan (Herrick 14-16)
- Computer based screening vs. control group
- Tailored feedback offered to screened troops
- 6-12 weeks (initial); 10-24 months (follow up; mean 15 months)
- Outcomes: Primary: Mental Health; Secondary: Help-seeking
POST Screening outcomes - MH

Post-deployment screening for mental disorders and tailored advice about help-seeking in the UK military: a cluster randomised controlled trial

Outcome comparisons of those screened and controls

- PTSD-C
- PHQ-9 / GAD-7
- Any mental disorder
- AUDIT
- SF-36

Primary & Secondary Outcomes

Screened
Control
POST Screening outcomes - behaviour

![Bar chart showing effects of screening on help-seeking and pharmaceutical use - Prevalence.](chart)

- Any health visit: 60% screened, 61% control
- Medical service use: 58% screened, 61% control
- Welfare service use: 14% screened, 15% control
- Mental health service use: 19% screened, 12% control
- Antidepressant use: 3% screened, 3% control
- Sleeping pill use: 3% screened, 5% control
So....

• People do not tell the truth in an organisational context

• Even when ‘reassured’ that no personal outcome will occur

• Thus, however well intentioned....psychological monitoring/screening is unlikely to work in organisational settings
Detect

• Screening?

• Peer led ‘trauma awareness’ training
  • ‘Psychological first aid’
  • Available wherever incidents happen
  • Non medical therefore less stigmatising
Peer support

Guidelines for Peer Support in High-Risk Organizations: An International Consensus Study Using the Delphi Method

Mark C. Creamer,1,2 Tracey Varker,1,2 Jonathan Bisson,3 Kathy Darte,4 Neil Greenberg,5 Winnie Lau,1,2 Gill Moreton,6 Meaghan O’Donnell,1,2 Don Richardson,7 Joe Ruzek,8 Patricia Watson,9 and David Forbes1,2

1Australian Centre for Posttraumatic Mental Health, Melbourne, Victoria, Australia
2Department of Psychiatry, University of Melbourne, Melbourne, Victoria, Australia
3School of Medicine, Cardiff University, Cardiff, Wales, United Kingdom
4Veterans Affairs Canada, Charlottetown, Prince Edward Island, Canada
5Institute of Psychiatry, King’s College, London, England, United Kingdom
6Rivers Centre for Traumatic Stress, Edinburgh, Scotland, United Kingdom
7Parkwood Operational Stress Injury Clinic-St. Joseph’s Health Care, London, Ontario, Canada
8National Center for PTSD, VA Palo Alto Health Care System, Menlo Park, California, USA
9UCLA/Duke University National Centre for Child Traumatic Stress, Los Angeles, California, USA

Peer supporters should:

• (a) provide an empathetic, listening ear;
• (b) provide low level psychological intervention;
• (c) identify colleagues who may be at risk to themselves or others;
• (d) facilitate pathways to professional help.
TRiM – Trauma Risk Management
Trauma Risk Management (TRiM)-What is it?

- Peer group support and risk assessment strategy
- Set up within the Royal Marines in late ’90s – now – all Services (since 2007). FCO, BBC, Em Serv, PSC etc.
- ‘Human resource’ initiative
- TRiM is not a cure - assesses psychological risk & suggests management and signposts
- Trained practitioners at all levels/grades
Who do deployed staff talk to?

- Military peer group same deployment
- Spouse or partner
- Another family member
- Military peer group not on same deployment
- Civilian friends/peer group
- Chain of command
- Medical services
- Welfare services

Greenberg et al, JMH, 2003
TRiM risk factors checklist

1. The person thought that they were out of control during the event
2. The person thought that their life was threatened during the event
3. The person blamed others or what happened
4. The person is ashamed about their behaviour during the event
5.* The person experienced acute stress following the event
6. The person has been exposed to substantial stress since the event
7. The person has had problems with day to day activities since the event
8. The person has been involved in previous traumatic events
9. The person has poor social support, (family, friends, unit support)
10. The person has been drinking alcohol excessively to cope with distress
What Peer Practitioners are not!

- Counsellors
- Therapists
- Pseudo-psychologists
- Group Huggers
- Scented Candle users
Promoting organizational well-being: a comprehensive review of Trauma Risk Management

D. Whybrow¹, N. Jones¹ and N. Greenberg²

¹Academic Department of Military Mental Health, King’s College London, Weston Education Centre, London SE5 9RJ, UK,
²Department of Psychological Medicine, King’s College London, Weston Education Centre, London SE5 9RJ, UK.

Correspondence to: D. Whybrow, Academic Department of Military Mental Health, King’s College London, Weston Education Centre, Cutcombe Road, London SE5 9RJ, UK. Tel: +44 (0)20 7848 5351; fax: +44 (0)20 7848 5408;
e-mail: deanwhybrow@hotmail.com

www.kcl.ac.uk/kcmhr under Publications
What does the evidence show?

- TRiM may help spot people who are in need (FCO)
- TRiM may help mobile social support (RM/Infantry)
- TRiM may help with occupational functioning (RCT)
- TRiM appears acceptable to service personnel (RN)
- TRiM use associated with less sickness absence (Police)
- TRiM improves help-seeking (up to 3x; linkage)
- TRiM does not cause harm (RCT)
Treat

- National Guidelines
- Evidence based
- Delivered by trained, experienced mental health professionals
Psychological Debriefing
“Hard to tell from here. Could be buzzards. Could be grief counsellors.”
How to deal with PTSD

What isn’t recommended...

- “Psychological Debriefing”
- For PTSD, drug treatments NOT a first line treatment (different for depression)
- Not Benzodiazepines

What is recommended...

- “Watchful Waiting” / “Active monitoring”
- Checking in after a month
- Trauma-focused treatments (CBT and EMDR) for adults and children if unwell
  [EMDR slightly less evidenced than TF-CBT]
Novel treatment approaches

- Intensive CBT
- Remote delivery
- Training paraprofessionals
- Novel approaches (3MDR, MDMA, VR)
- Conjoint therapy
- ‘Early’ treatment before secondary losses occur!

Training peers to treat Ebola centre workers with anxiety and depression in Sierra Leone

Samantha Waterman1, Elaine Catherine Margaret Hunter1, Charles L Cole2, Lauren Jayne Evans1, Neil Greenberg2, G James Rubin3 and Alison Beck1
And sellers of *Bad Science* often will say they have ‘the answer’
Summary

• Most people exposed to traumatic events will cope
• However, some will become ill and are unlikely to seek help
• Evidence based prevent, detect and treat options available
• Overall best early interventions approaches are to
  • i. improve support
  • ii. reduce pressure
• Post incident support ideally comes ‘from within’ organisations (peer support/good leadership & camaraderie)
• Within (most) organisations resilience does not lay within individuals but between them
Any Questions? Fire Away!

Neil.greenberg@kcl.ac.uk
www.marchonstress.com
www.kcl.ac.uk/kcmhr
Q & A

Dr. Neil Greenberg
Dr. Beth Lown

Please type your questions in the “Questions” pane on your screen.
Next Up

April 28
“Supporting Patients and Families in a Crisis”
Dr. Patricia Watson and Dr. Richard Westphal

May 5
“Communication in the Age of COVID”
Dr. Tony Back

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JUNE 16-OCTOBER 16, 2020

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