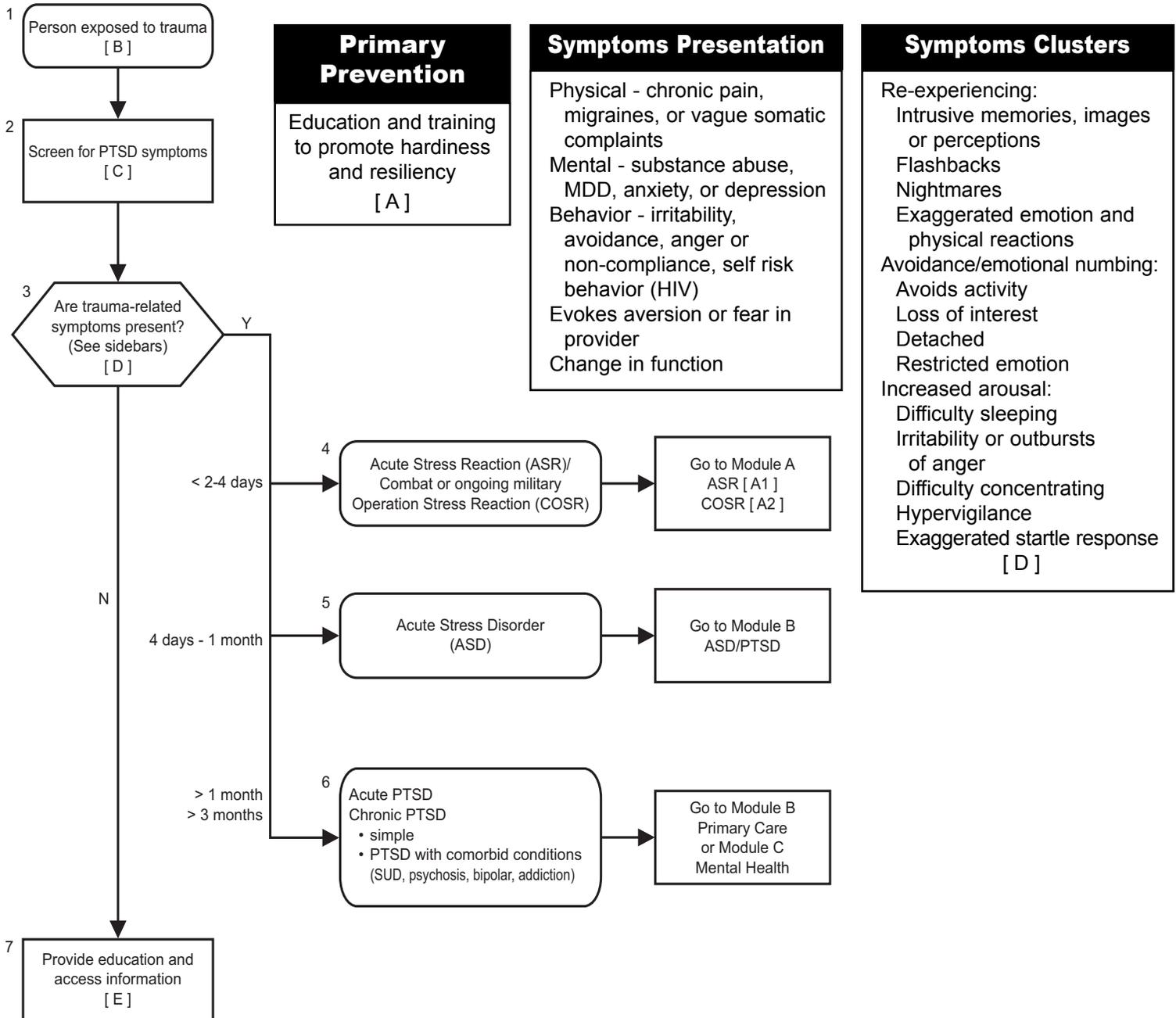


# VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF POST TRAUMATIC STRESS

## Core Module Summary

### INITIAL EVALUATION AND TRIAGE



## ANNOTATIONS

### PRIMARY PREVENTION

#### A. Education And Training to Promote Hardiness and Resiliency

##### OBJECTIVE

Prepare individuals and groups for exposure to traumatic experiences in ways that minimize the likelihood of development of PTSD and other trauma-related problems.

##### BACKGROUND

Because exposure to traumatic stressors is part of the expected work experience of some occupations (e.g., military personnel and emergency services workers), it is sensible to make efforts to prepare individuals in these professions for their encounter with traumatic events. This preparation is not explicitly undertaken in most workplaces, with some exceptions (e.g., some military training environments). To date, research has not examined our capacity to prepare individuals or communities for trauma exposure. However, general principles of preparation can be outlined that are consistent with theoretical models of the development of PTSD, research on risk factors for development of PTSD, and emerging concepts of resilience and hardiness.

##### RECOMMENDATIONS

1. In high-risk occupations for which probability of trauma exposure is moderate or high, efforts should be undertaken to increase psychological resilience of workers to the negative effects of trauma exposure.

##### DISCUSSION

Although little is directly known about our capacity to prepare individuals or communities for trauma exposure, it is possible to identify principles of preparation that are consistent with empirical research on risk and resilience factors and with current theories of PTSD development. Such pre-trauma preparation can include attention to both the ability to cope during the trauma itself and to shaping the post-trauma environment so that it will foster post-trauma adaptation.

Some influential theories of PTSD posit that a process of classical conditioning can lead to development of chronic PTSD symptomatology. In this process, stimuli associated with the traumatic experience can elicit responses similar to those experienced during the trauma itself (e.g., intense anxiety). Other theories suggest that individuals who develop negative trauma-related beliefs (e.g., about personal guilt) will be more likely to experience continuing trauma reactions because such beliefs will maintain a sense of threat. Research on risk factors for PTSD indicates that post-trauma social support and life stress affect the likelihood of development of the disorder. Protective factors have also been identified that mitigate the negative effects of stress. Research is beginning to delineate the psychological processes that moderate an individual's response to stress and to explore training programs for increasing resilience to stress. Hardiness is one personality factor that has been demonstrated to buffer against traumatic stress and PTSD in military veterans. Hardiness is characterized by three key attributes: ability to perceive *control* over life's events; ability to make strong *commitment* to tasks; and ability to see stressful experiences as a *challenge* to be overcome. Training programs, personnel policies, and leadership strategies that promote hardiness may thereby increase an individual's ability to resist the negative effects of traumatic stress.

Such findings and theories are consistent with the following principles of preparation:

1. *Provide realistic training* that includes vicarious, simulated, or actual exposure to traumatic stimuli that may be encountered. Examples of application of this principle in military training include exposure to live weapons fire, survival training or, for subgroups of military personnel, mock captivity training. This principle can be applied to many work roles, e.g., those likely to be involved in body handling might be trained in mortuary environments. It is consistent with classical conditioning theories in that this can help reduce arousal or anxiety associated with particular traumatic stimuli.

2. *Strengthen perceived ability to cope* during the trauma and with the aftermath. Realistic training contributes to this goal. Instruction and practice in use of a variety of coping skills (e.g., stress inoculation training, problem-solving, assertion, and cognitive restructuring) may be helpful in enabling workers to tolerate stressful work environments. In addition, individuals can be trained to cope with acute stress reactions that are common following trauma exposure. Such training experiences help to maximize expectations of mastery of traumatic situations and their physical and emotional sequelae. The training must include specific, practical actions in order to change the threatening or horrifying situation for the better. Without such positive action learning, "simulated" terrifying or horrifying situations and stimuli can induce feelings of helplessness that make the training itself traumatizing.
3. *Create supportive interpersonal work environments* that are likely to provide significant social support during and after traumatic events. Efforts to build teams and establish group cohesion among work group members are important in this regard. Identification and training of peer stress management resource persons, and training and practice in the provision of peer social support may also be useful. Families are crucial in post-trauma support and can be given information about and training in ways of providing social support. Finally, competent, ethical leadership at all levels of the organization helps protect against traumatization.
4. *Develop and maintain adaptive beliefs* about the work role and traumatic experiences that may be encountered within it. Key beliefs will be related to realistic expectancies about the work environment, confidence in leadership, confidence in the meaningfulness or value of the work role, positive but realistic appraisals of own coping ability, and knowledge about the commonness and transitory nature of most acute stress reactions. It may be useful to identify and discuss negative beliefs that sometimes arise in the specific work environment, in order to "inoculate" against such beliefs.
5. *Develop workplace-specific, comprehensive traumatic stress management programs.* Such programs can be

a significant source of post-trauma support (e.g., via mental health professionals) that can minimize trauma-related problems among workers. It is important to take steps to increase awareness of such services and to de-stigmatize and reduce potential negative consequences of their use. For example, employees should be helped to understand that seeking help in confronting symptoms and problems early in their development is likely to be more effective than avoiding them or keeping them secret from others, but that even long hidden or persisting PTSD can be treated.

Comprehensive preparation programs that target and integrate these principles and that are, themselves, integrated into existing unit/community support systems may be expected to be most helpful.

## **POPULATIONS AT-RISK FOR DEVELOPING PTSD**

### **B. People At-Risk For Developing Stress Symptoms After Trauma**

#### **OBJECTIVE**

Identify persons at risk for developing a traumatic stress disorder (PTSD) after trauma exposure.

#### **BACKGROUND**

Although exposure to trauma is common, several risk factors for the development of PTSD have been identified. Risk factors for developing PTSD can be grouped as characteristics related to the trauma itself, pre-trauma factors and post-trauma factors.

- *Trauma*-related risks include the nature, severity, and duration of the trauma exposure. For example, life-threatening traumas such as physical injury or rape pose a high risk of PTSD. A prior history of trauma exposure conveys a greater risk of PTSD from subsequent trauma.
- *Pre-trauma* risk factors include adverse childhood, younger age, female gender (not in military cohorts), minority race, and low socioeconomic or educational status.
- *Post-trauma* risks include poor social support and life stress. A greater risk for developing PTSD may be conveyed by post-trauma factors (e.g., lack of social support and additional life stress) than pre-trauma factors.

The development of Acute Stress Disorder (ASD) at the time of the trauma is also a risk for developing PTSD. Similarly, dissociation at the time of the trauma appears to be an important predictor for the establishment of chronic PTSD.

## RECOMMENDATIONS

1. Persons exposed to trauma should be assessed for known risk factors for developing PTSD – both pre-trauma risks and post trauma risks.
2. The trauma type, nature and severity should be assessed.
3. Assessment of existing social supports and ongoing stressors is important.
4. Patients with Acute Stress Disorder (ASD) warrant careful clinical attention, as they are at high-risk for developing PTSD.
5. Patients with dissociative symptoms may also warrant careful clinical attention.

## SECONDARY PREVENTION – SURVEILLANCE SCREENING

### C. Screen For PTSD Symptoms

#### OBJECTIVE

Identify possible cases of PTSD.

#### BACKGROUND

Patients don't often self-identify as suffering with PTSD, and patients with unrecognized PTSD are often difficult to treat because of poor patient/provider rapport, anger and distrust, somatization, and other trauma-related problems. Research supports the utility of brief screening tools for identifying undiagnosed cases of PTSD. Identification of PTSD may help facilitate development of rapport, suggest treatment options and potentially improve outcomes for these patients.

#### RECOMMENDATIONS

1. All new patients should be screened for symptoms of PTSD initially and then on an annual basis or more frequently if clinically indicated due to clinical suspicion, recent trauma exposure (e.g., major disaster) or history of PTSD.

2. Patients should be screened for symptoms of PTSD using paper and pencil or computer-based screening tools.
3. No studies are available that compare the benefits of one PTSD screening tool versus another. However, the following screening tools have been validated and should be considered for use:
  - Primary Care PTSD Screen (PC-PTSD)
  - PTSD Brief Screen
  - Short Screening Scale for DSM IV PTSD
4. There is, as yet, insufficient evidence to recommend special screening or differing PTSD treatment for members of any cultural or racial groups

### D. Are Trauma Related Symptoms Present?

#### OBJECTIVE

Identify people exposed to trauma who are at risk for developing acute stress reaction (ASR) acute stress disorders (ASD) or Post-Traumatic Stress Disorder (PTSD).

#### BACKGROUND

##### *Warning Signs of Trauma Related Stress (APA)*

Individuals who have experienced a traumatic event oftentimes suffer psychological stress related to the incident. In most instances, these are normal reactions to abnormal situations. Individuals who feel they are unable to regain control of their lives or who experience the following symptoms for more than a month, should consider seeking outside professional mental health assistance. The American Red Cross is now working with mental health professionals trained in trauma. For information or a referral, contact the local American Red Cross chapter or the American Psychological Association at 202-336-5800.

The symptoms to watch out for include:

- Recurring thoughts, mental images or nightmares about the event
- Having trouble sleeping or changes in appetite
- Experiencing anxiety and fear, especially when exposed to events or situations reminiscent of the trauma

- Being on edge, being easily startled or becoming overly alert
- Feeling depressed, sad and having low energy
- Experiencing memory problems including difficulty in remembering aspects of the trauma
- Feeling "scattered" and unable to focus on work or daily activities
- Having difficulty making decisions
- Feeling irritable, easily agitated or angry and resentful
- Feeling emotionally "numb," withdrawn, disconnected or different from others
- Spontaneously crying, feeling a sense of despair and hopelessness
- Feeling extremely protective of, or fearful for, the safety of loved ones
- Not being able to face certain aspects of the trauma and avoiding activities, places, or even people that remind you of the event

## RECOMMENDATION

1. Individuals who are presumed to have symptoms of PTSD or who are positive for PTSD on the initial 4-item screening should receive specific assessment of their symptoms.
2. Useful information may include details such as time of onset, frequency, course, severity, level of distress, functional impairment, and other relevant information.
3. The elapsed time since the exposure to trauma is very important in assessing the risk of developing PTSD and determining the appropriate intervention. The following definition will help providers select the appropriate treatment algorithm.

## STRESS RELATED DISORDERS & SYNDROMES DEFINITIONS

**Trauma:** an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced

by a family member or other close associate. The person's response to the event must involve intense fear, helplessness, or horror

**Acute Stress Reaction (ASR) during an Ongoing Military Operation or, Combat and Operational Stress Reactions (COSR):** broad group of physical, mental and emotional signs, which result from heavy mental and emotional work during difficult conditions. Onset of at least some signs and symptoms may be simultaneous with the trauma, itself or may follow the trauma after an interval of hours or days. Symptoms include depression, fatigue, anxiety, decreased concentration/memory, hyperarousal or any of the four clusters above that have not resolved within 4 days after the event, after a rule-out of other disorders.

**Acute Stress Disorder (ASD):** clinically significant (causing significant distress or impairment in social, occupational, or other important areas of functioning) symptoms >2 days, but <1 month after exposure to a trauma as defined above (may progress to PTSD if symptoms last >1 month).

- Exposure to trauma as defined above.
- Either while experiencing or after experiencing the distressing event, the individual has at least three of the following *dissociative* symptoms:
  1. A subjective sense of numbing, detachment and/or absence of emotional responsiveness.
  2. A reduction in awareness of his/her surroundings (e.g., "being in a daze").
  3. Derealization (the feeling that familiar surroundings or people are unreal or have become strange).
  4. Depersonalization (the feeling in an individual that (s)he is no longer him/herself. His/Her personality, body, external events, the whole world may be no longer appear real).
  5. Dissociative amnesia (i.e., the inability to recall an important aspect of the trauma)
- The traumatic event is persistently *re-experienced* in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.

- Marked *avoidance* of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people, sounds, smells, etc.)
- Marked symptoms of anxiety or *increased arousal* (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, and motor restlessness)

**Post Trauma Stress Disorder (PTSD):** clinically significant (causing significant distress or impairment in social, occupational, or other important areas of functioning) symptoms more than 1 month after exposure to a trauma. Symptoms include:

- Exposure to trauma as defined above
- The traumatic event is persistently re-experienced in one (or more) of the following ways:
  1. Recurrent and intrusive recollections of the event, including images, thoughts, or perceptions
  2. Recurrent distressing dreams of the event
  3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated)
  4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
  5. Physiologic reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- Persistent **avoidance** of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three or more of the following:
  1. Efforts to avoid thoughts, feeling, or conversations associated with the trauma
  2. Efforts to avoid activities, places, or people that arouse recollections of the trauma
  3. Inability to recall an important aspect of the trauma
  4. Markedly diminished interest or participation in significant activities
  5. Feeling of detachment or estrangement from others
  6. Restricted range of affect (e.g., unable to have loving feelings)

7. Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

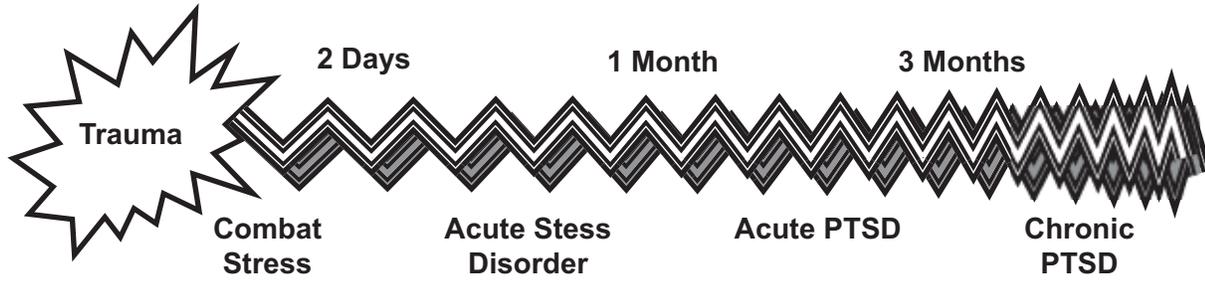
- Persistent symptoms of *increased arousal* (not present before the trauma) as indicated by at least two of the following:
  1. Difficulty falling or staying asleep
  2. Irritability or outbursts of anger
  3. Difficulty concentrating
  4. Hypervigilance
  5. Exaggerated startle response

**Acute PTSD:** above clinically significant (causing significant distress or impairment in social, occupational, or other important areas of functioning) symptoms lasting >1 month, but <3 months after exposure to trauma.

**Chronic PTSD:** above clinically significant (causing significant distress or impairment in social, occupational, or other important areas of functioning) symptoms lasting >3 months after exposure to trauma.

- Simple chronic PTSD – consist of symptoms from the above clusters
- Complex – persistent difficulties in interpersonal relations, mood, somatization, and profound identity problems. Complex PTSD is often associated with sustained or repeated trauma during childhood or adolescence (such as longstanding incest or physical abuse), but it may also be associated with sustained trauma in later life or may appear as a late consequence of chronic PTSD, even if the original traumatic stressor was a single event.
- Comorbid – also meeting DSM criteria for another disorder such as substance abuse, depression or anxiety disorder

**PTSD with Delayed Onset:** onset of above clinically significant (causing significant distress or impairment in social, occupational, or other important areas of functioning) symptoms at least 6 months after exposure to trauma.



**Table 1: Common Signs After Exposure to Trauma or Loss**

Physical <input type="checkbox"/>	Cognitive/Mental <input type="checkbox"/>	Emotional <input type="checkbox"/>	Behavioral <input type="checkbox"/>
<ul style="list-style-type: none"> <li>• Chest pain</li> <li>• Chills</li> <li>• Difficulty breathing</li> <li>• Dizziness</li> <li>• Elevated blood pressure</li> <li>• Fainting</li> <li>• Nausea</li> <li>• Fatigue</li> <li>• Grinding teeth</li> <li>• Headaches</li> <li>• Muscle tremors</li> <li>• Profuse sweating</li> <li>• Rapid heart rate</li> <li>• Shock symptoms</li> <li>• Thirst</li> <li>• Twitches</li> <li>• Visual difficulties</li> <li>• Vomiting</li> <li>• Weakness</li> </ul>	<ul style="list-style-type: none"> <li>• Blaming someone</li> <li>• Change in alertness</li> <li>• Confusion</li> <li>• Difficulty identifying familiar objects or people</li> <li>• Hyper-vigilance</li> <li>• Increased or decreased awareness of surroundings</li> <li>• Intrusive images</li> <li>• Loss of orientation to time, place, person</li> <li>• Memory problems</li> <li>• Nightmares</li> <li>• Poor abstract thinking</li> <li>• Poor attention</li> <li>• Poor concentration</li> <li>• Poor decisions</li> <li>• Poor problem solving</li> </ul>	<ul style="list-style-type: none"> <li>• Agitation</li> <li>• Anxiety</li> <li>• Apprehension</li> <li>• Denial</li> <li>• Depression</li> <li>• Emotional shock</li> <li>• Fear</li> <li>• Feeling overwhelmed</li> <li>• Grief</li> <li>• Guilt</li> <li>• Inappropriate emotional response</li> <li>• Irritability</li> <li>• Loss of emotional control</li> <li>• Severe pain</li> <li>• Uncertainty</li> </ul>	<ul style="list-style-type: none"> <li>• Alcohol consumption</li> <li>• Antisocial acts</li> <li>• Change in activity</li> <li>• Change in communication</li> <li>• Change in sexual functioning</li> <li>• Change in speech pattern</li> <li>• Emotional outbursts</li> <li>• Erratic movements</li> <li>• Hyper-alert to environment</li> <li>• Inability to rest</li> <li>• Loss or increased appetite</li> <li>• Pacing</li> <li>• Somatic complaints</li> <li>• Startle reflex intensified</li> <li>• Suspiciousness</li> <li>• Withdrawal</li> </ul>

## **NORMALIZATION FOR ASYMPTOMATIC SURVIVORS AND RESPONDERS**

### **E. Normalization For Asymptomatic Survivors And Responders**

#### **OBJECTIVE**

Help trauma survivors and responders who are NOT themselves experiencing signs or symptoms recognize that these reactions in others are common in the aftermath of trauma and do not signify personal inadequacy, health problems, mental illness, or other enduring negative consequences.

#### **BACKGROUND**

Contemporary approaches to early intervention following trauma exposure emphasize the importance of “normalization” of acute stress reactions. This means that survivors or responders who show distressing symptoms or disturbed behavior are helped to understand that their reactions are “normal responses to the abnormal events.” Such an approach follows from the common clinical observation that individuals experiencing acute stress reactions often interpret their reactions as “personal weakness” or “going crazy,” which increases their demoralizations and distress. Normalization is undermined if survivors or responders who are not feeling disruptive distress (yet) show a derogatory or punitive attitude to others who are. Also, the persons who most strongly deny or dissociate from their distress may be at increased risk for developing ASD and subsequent PTSD. The education that should go with normalization may therefore help them recognize how to protect themselves better and to seek care early if symptoms do start getting the better of their “self-control.” Even although who go on to develop PTSD may benefit from an understanding that their symptoms do not represent “personal weakness” and that although their symptoms may be severe and painful, they are not losing control of their minds.

## **RECOMMENDATIONS**

1. Pre- and post-trauma education should include helping asymptomatic trauma survivor or responder understand that the acute stress reactions of other people are common and do not indicate personal failure or weakness, mental illness, or health problems. Responders should be taught the simple words and measures that will support quick recovery, rather than push survivors toward a persisting disorder.
2. Education should include sufficient review of the many ways that post-traumatic problems can present, including symptoms in the ASD/PTSD spectrum, behavioral problems with family and friends, occupational problems, and alcohol or other substance misuse/abuse.
3. Provide education and access information to include the following:
  - Begin with clear statement about normal ASRs, self- and buddy-management, plus available resources if stress symptoms persist or worsen
  - Maximize positive expectation of mastery
  - Demystify PTSD (before listing symptoms) and emphasize the human brain and mind’s natural resiliency, e.g., our forefathers/mothers, generations ago, survived very bad situations or we wouldn’t be here, and we can survive also
  - Painful memories sometimes get stuck, through no fault of the sufferer. Such memories cause real biological changes that can cause physical change and illness elsewhere in the body. Many of these changes can be reversed. All can be compensated for by developing new brain skills, aided by medication when appropriate
  - Professionals with special skills and capabilities (including some religious pastors, mental health professionals, other medical people and others with special training and supervision) can intervene to reverse the process.
  - Resolving developing symptoms and problems.