PTSD

Trainer's Guide

COURSE TITLE PAGE

Program:	Crisis Intervention Training
Block:	Special Focus
Course#/Title:	*Posttraumatic Stress Disorder*
Accreditation#:	NM170753
Course Level:	Advanced Training
Prerequisites:	None
Instructional Method:	Lecture, Power Point, Discussion
Time Allotted:	.5 Hour
Target Group:	New Mexico Law Enforcement Basic and Certified Officers; Basic and Certified Telecommunicators
Instructor/Student Ratio:	1/40
Evaluation Strategy:	Pre-Test/Post-Test, Class discussion
Required Instructor Materials:	Lesson Plan, Power Point, Handouts, Discussion,
Required Student Materials:	Note-taking materials, Student Manual
Suggested Instructor Certification:	☒ General Instructor ☒ Professional Lecturer ☒ Specialized Instructor ☒ CIT Instructor ☒ Master Instructor

Source Document/Bibliography:

Friedman, M. J., Keane, T. M., & Resick, P. A. (2014). *Handbook of PTSD : Science and practice* (Second edition.). New York: The Guilford Press. http://public.eblib.com.libproxy.unm.edu/choice/publicfullrecord.aspx?p=1691133

Kessler, R. C., & Üstün, T. B. (2004). The World Mental Health (WMH) Survey Initiative version of the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI). *International Journal Of Methods In Psychiatric Research*, *13*(2), 93-121. doi:10.1002/mpr.168

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Sadock, B. J., Sadock, V. A., & Ruiz, P. (2015). *Kaplan & Sadock's synopsis of psychiatry : Behavioral sciences/clinical psychiatry* (Eleventh edition /). Philadelphia: Wolters Kluwer.

Kessler RC, Sonnega A, Bromet E, Hughes M, & Nelson CB. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives Of General Psychiatry*, *52*(12), 1048-60.

Stein MB, Kessler RC, Heeringa SG, Jain S, Campbell-Sills L, Colpe LJ, ... Army STARRS collaborators. (2015). Prospective longitudinal evaluation of the effect of deployment-acquired traumatic brain injury on posttraumatic stress and related disorders: results from the Army Study to Assess Risk and Resilience in Service members (Army STARRS). *The American Journal Of Psychiatry*, *172*(11), 1101-11. doi:10.1176/appi.ajp.2015.14121572.

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COURSE GOAL:

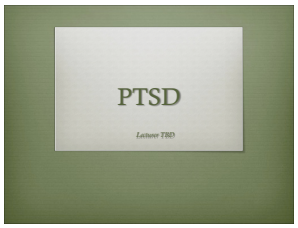
The goal is to help law enforcement to become familiar with some key aspects of PTSD, including symptoms, causes, risks, treatments, and tips on how to communicate with people living with PTSD. The knowledge is aimed to help law enforcement relate more easily people living with PTSD and to help humanize their experience.

LEARNING OBJECTIVE(S):

Upon completion of training, the participant will be able to demonstrate the following measurable learning objectives:

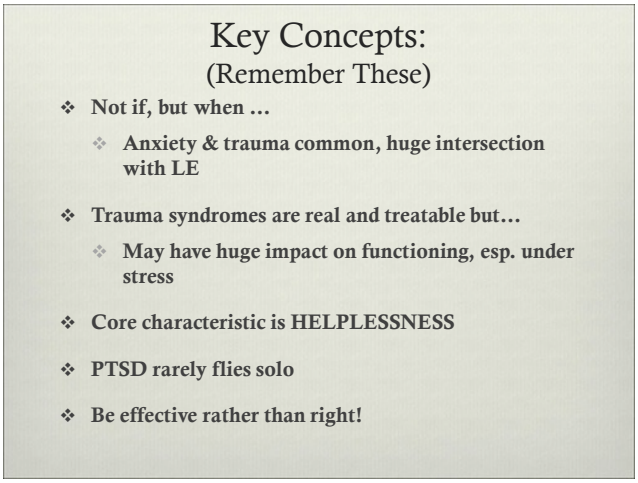
1. Be able to identify some key aspects of PTSD:
    a. Be able to identify at least 3 key symptoms.
2. Learn a basic overview de-escalating with people with PTSD:
    a. Be able to name two strategies that need extra attention when working with people displaying PTSD.
    b. Be able to identify a counterproductive thing to avoid saying to people with PTSD.

c. **Welcome (Slide 1)**



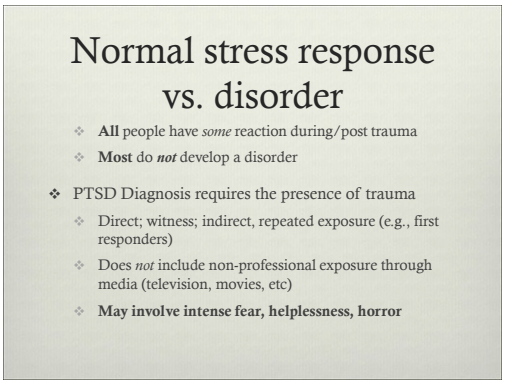
- Welcome students and introduce yourself. You may want to include your name on this PowerPoint or write it on a whiteboard or flip chart.
- Remind students of training rules (no phone or computers).

Key concepts (Slide 2)



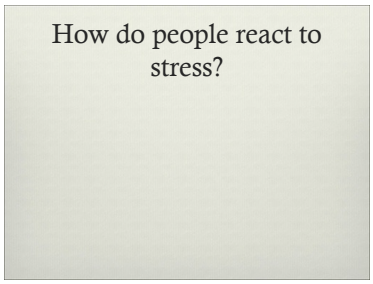
1. "Not if, but when …"
    a. All people experience anxiety. Without the experience of anxiety, life would be even more dangerous, though it might be more fun. It would be as if we were all drunk all the time.
    b. Police encounter violence and trauma daily, it's unavoidable.
2. A core characteristic is HELPLESSNESS
    a. Trauma causes people to feel their life is out of control and that the world is continuously dangerous.
3. PTSD rarely flies solo
    a. Most people with PTSD have other illnesses, such as substance use disorders, brain injuries, and personality disorders.
4. Be effective rather than right!
    a. Don't try to win arguments, or even have arguments. This desire to be right can destroy rapport and any show of compassion.

Normal stress response vs. disorder (Slide 3)



- Go over points on the slide.
- All people react to trauma. Most at minimum have some mild symptoms associated with PTSD such as hyper-vigilance, hyper-arousal, avoiding, numbing, and anger.
- The DSM-V criteria require longer than a month, and like all disorders it must cause significant distress or impairment in the individual's social interactions, capacity to work, or other important areas of functioning.
- This is a photo of Sylvester Stallone playing the character John Rambo in the 1982 film Rambo. He portrays a Vietnam vet with many symptoms of PTSD.

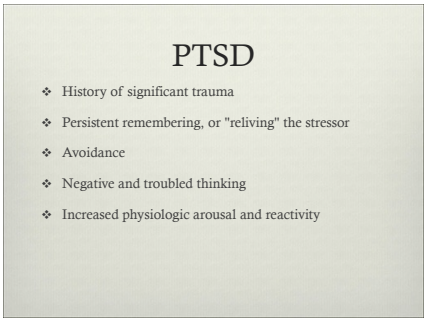
How do people react to stress? (Slide 4)



- Ask audience how people generally react to stress.
- Give a story about someone who was otherwise a normal healthy person who was then brutally traumatized. He was jumped while pumping gas, dragged into a nearby alleyway, beaten and raped, then left for dead.
- **Discussion**. Ask how he might be affected by this trauma. Try to cover all the symptoms of PTSD from the DSM.
    - Reliving (intrusion symptoms) – eg intrusive distressing memories, physical and psychological discomfort when reminded of the event, flashbacks, nightmares,
    - Avoidance – which can include avoiding thoughts, feelings, conversations, places and people associated with the trauma. Withdrawal from friends and family, blunted show of emotions, and memory trouble.
    - Negative thinking.
    - Persistently increased arousal – trouble sleeping, anger, difficulty concentrating, hyper-vigilance, exaggerated startle response. Hyper-vigilance

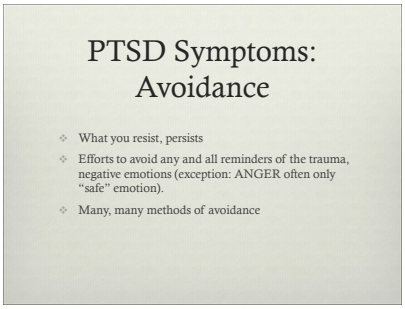
- Use prompts for discussion, ask:
    - Would he avoid gas stations? If so why? What will his body feel like when going by that particular gas station? What about the song that was playing on the radio just before he was attacked?
    - Will he be able to easily put this event out of his mind or will he relieve it, have intrusive memories of it?
    - Will he be just as happy and interactive with friends and family?
    - Will he be on edge and jumpy?

PTSD Symptoms for Dx (Slide 5)



- **Review points on slide simply to reinforce the previous discussion**.
- **Intrusion** (reliving symptoms)
    - intrusive distressing memories
    - physical and/or psychological discomfort when reminded of the event
    - flashbacks
    - nightmares.

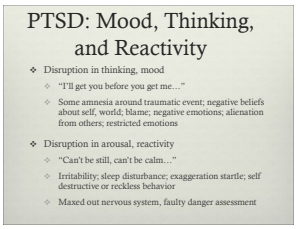
PTSD Symptoms: Avoidance (Slide 6)



- **Review points on slide**
- **Avoidance**, which can include avoiding …
    - thoughts, feelings, conversations, places and people associated with the trauma.
    - Withdrawal from friends and family, blunted show of emotions, and memory trouble.

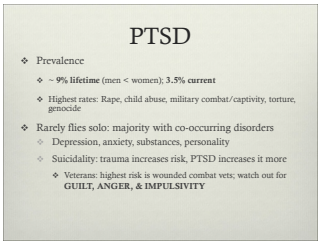
- **Anger** is a more masculine and "acceptable" emotion for men than depression and/or anxiety.

PTSD Dx (Slide 7)



- Review points on slide
- **Negative and troubled thinking** -
  - Poor memory around the time of trauma
  - Negative beliefs about oneself and others, or the world
  - Distorted thoughts about cause or consequence of the trauma
  - **Persistent negative emotional state**
  - Diminished interest in activities and/or feelings of detachment from others
  - Persistent inability to experience positive emotions
- **Persistently increased arousal and reactivity** –
  - trouble sleeping, anger, difficulty concentrating, hyper-vigilance, exaggerated startle response, hyper-vigilance.

PTSD Provenance (Slide 8)



- **Review Points on the slide**
- **Optional Information:**
  - PTSD can develop at any age
  - Develops in one third to one half of people exposed to rape military combat or captivity, and genocide
  - About 50% of people recover from trauma within 3 months

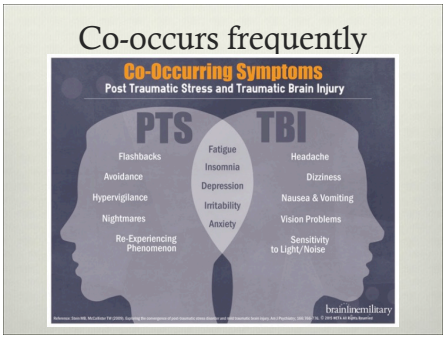
Optional Video discussion

- **Watch video about Chris Malarchuck,** an NHL goalie who suffered one of the most brutal sports injuries ever.
- **The video is 11 minutes:**

http://espn.go.com/video/clip?id=9255400

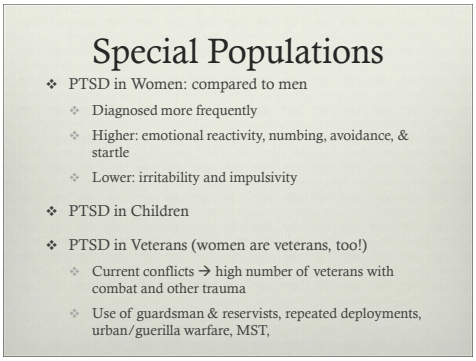
- After video, lead brief discussion about PTSD as it relates to the symptoms mentioned above under slides seven and 8.

Rarely Flies Solo (Slide 9)



- Review points on slide.
  - **Review Points on the slide**
  - **Other psych disorders**
    - **~ 80% more likely to have a (second) psych disorder than general population is of having one.**
    - **Depressive, anxiety, substance abuse, personality**
    - **Among Vets from Afghanistan and Iraq, co-occurrence of PTSD and mild TBI is 48%**
  - **Suicidality**
    - **Trauma increases risk, bigger increases with PTSD dx**
    - **Veterans: highest risk is wounded combat vets; watch out for GUILT, ANGER, & IMPULSIVITY**

Special Populations (Slide 10)

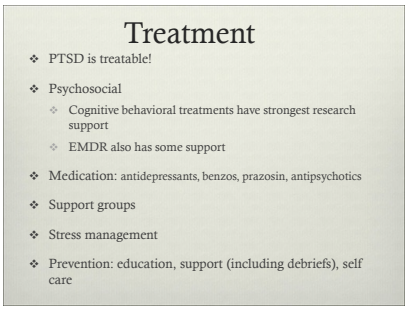


- **PTSD in Veterans (women are veterans, too!)**
  - Current conflicts → high number of veterans with combat and other trauma
  - Use of guardsman & reservists, repeated deployments, urban/guerilla warfare
- **Women are exposed to more rape and other interpersonal violence than men**, but when men are faced with the same trauma, the rates for development of PTSD are about the same
  - **Optional Info:** Rape, in both men and women, carries one of the highest risks for producing PTSD. Approximately 0.7% of men in the United States reported being raped as compared with 9.2% of women.[Sptizberg BH]
  - **Kids may develop new onset nightmares**
    - Dreams often without content specific to the trauma
    - Young children express re-experienceing through play.
  - **Veterans**
    - **highest risk is wounded combat vets;**
    - **watch out for GUILT, ANGER, & IMPULSIVITY**

- **Optional Info:**
  - **Women are more likely to have**
    - numbing and avoidance
    - mood and anxiety disorders
  - **Men are more likely to have**
    - irritability and impulsiveness.
    - comorbid substance use disorders
  - **Suicidality**
    - **Trauma increases risk, bigger increases with PTSD dx**
    - **Veterans: highest risk is wounded combat vets; watch out for GUILT, ANGER, & IMPULSIVITY**

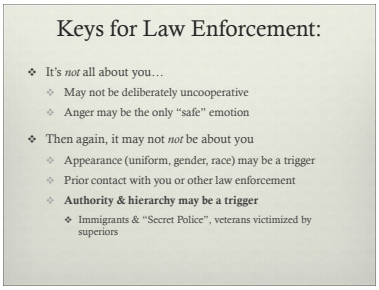
Spitzberg BH. An analysis of empirical estimates of sexual aggression victimization and perpetration. Violence Vict. 1999;14:241-260.
http://www.medscape.org/viewarticle/418733

Treatment (Slide 11)



- Review points on slide.
    - PTSD is treatable!
        - Rememeber the normal course of the illness is to recover
    - Psychosocial
        - Cognitive behavioral treatments have strongest research support
    - Medication: antidepressants, prazosin, antipsychotics
        - Medication is considered second line and adjuctive treatment.
    - Support groups
    - Stress management
        - Behavioral interventions, relaxation techniques.
    - Pevention after a trauma:
        - Prevention: education and support
        - Spend time with people you love and care about, especially those who understand what you've been through (like fellow officers).
        - The worst is isolation and substance use.
        - I is generally not helpful to force people to talk about the trauma, simply be there for them and either draw them out slowly or allow them to talk at their own pace.
        - Optional Information about debriefs:
            - Studies about structured debriefs after trauma have mixed relsults.
            - Those that do best offer guidance to help people feel safe and to reconnect with people they love.

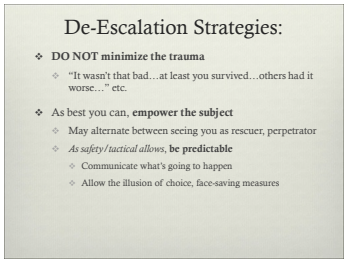
Keys for Law Enforcement (Slide 12)



- **Review points on slide**
- **Don't personalize bad behaviors.** LEO should use knowledge about PTSD to help them avoid personalizing bad behaviors of those living with PTSD:
    - May not be deliberately uncooperative, they may simply be overwhelmed by anxiety or other symptoms of PTSD.
    - Anger may be the only "safe" emotion
    - Police presence may trigger PTSD symptoms.

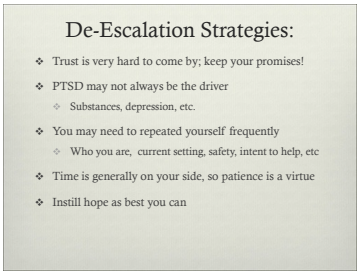
- **Optional discussion:**
    - Ask: "What symptoms of PTSD may make it appear that someone is uncooperative?"
    - In addition to anger and triggers from uniforms:
        - Lack of sleep, avoidance of anything that is a reminder of trauma, medication side effects, withdrawal and numbing, poor memory, negative thinking and beliefs.

De-Escalation Strategies (Slide 13)



- **Review points on slide**
- **Minimization is usually inadvertent and intended to help.**
- **Optional Information, also avoid:**
    - **Moralizing,** "This is your opportunity to grow and be stronger."
    - **Accusations,** "How can you not remember?"
    - **Minimization when talking about guilt,** "You have nothing to feel guilty about." People with PTSD feel guilty, trying to minimize that too soon can lead to withdrawal, lack of trust, or an argument, "It was my fault." It's not like the movies.
- **Optional** examples of empowerment. If the person has to be brought to the hospital, let them know what to expect. Hand cuffs may be very triggering:
    - "For safety, try to avoid sudden movements, let the person know what to expect as much as possible, "Though I'm taking you to the hospital, we have to put cuffs on you, we do this with everyone who rides in a police car, it's our safety protocol."

De-Escalation Strategies Continued (Slide 14)



- Review points on the slide.
- **Trust** is very difficult because their trauma has taught them not to trust people.
- Remember, PTSD rarely flies alone
- People with PTSD often have trouble thinking.
- **Optional information about instilling hope**:
    - It is a much more difficult task than you may expect.
    - Try to give objective comforting information:

        - Examples:
            - "There are treatments for PTSD, and I've been taught that they really can work."
            - "The plan is that you'll go to your therapist tomorrow to talk about this."
    - **A sense of safety is key.** Focus on, and use the word, "Safety." A loss of a sense of safety is a fundamental problem in PTSD.
    - **Optional Information:**
        - **But be careful not to moralize or minimize!** Avoid statements like, "Why would you think about hurting yourself, your wife loves you, you have so much to live for" He may believe his wife hates him, or maybe she actually does, either way, you'll get into an argument.

Thanks! (Slides 15)

- Ask for and answer questions as best you can.

Acknowledgements:
This course was created with collaborations from the following people and organizations:

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Matthew Tinney

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