Post Traumatic Stress: An organisational perspective

Professor Neil Greenberg

Academic Centre for Defence Mental Health
King's College London

Who am I

- Defence Professor of Mental Health
- Royal Navy Surgeon Captain
- Consultant Psychiatrist
- Varied military career – ships, submarines, Royal Marines


Eric Feferbe

Plan for my talk

- What is trauma and what is PTSD
- Organisational Prevention
  - Primary
  - Secondary
  - Tertiary
- Summary and Conclusions

Prof Richard Layard 2005

"Worklessness caused by anxiety and depression is the single largest contributor to the national incapacity benefit bill"

Dame Carol Black's Review of the health of Britain's working age population

Working for a healthier tomorrow

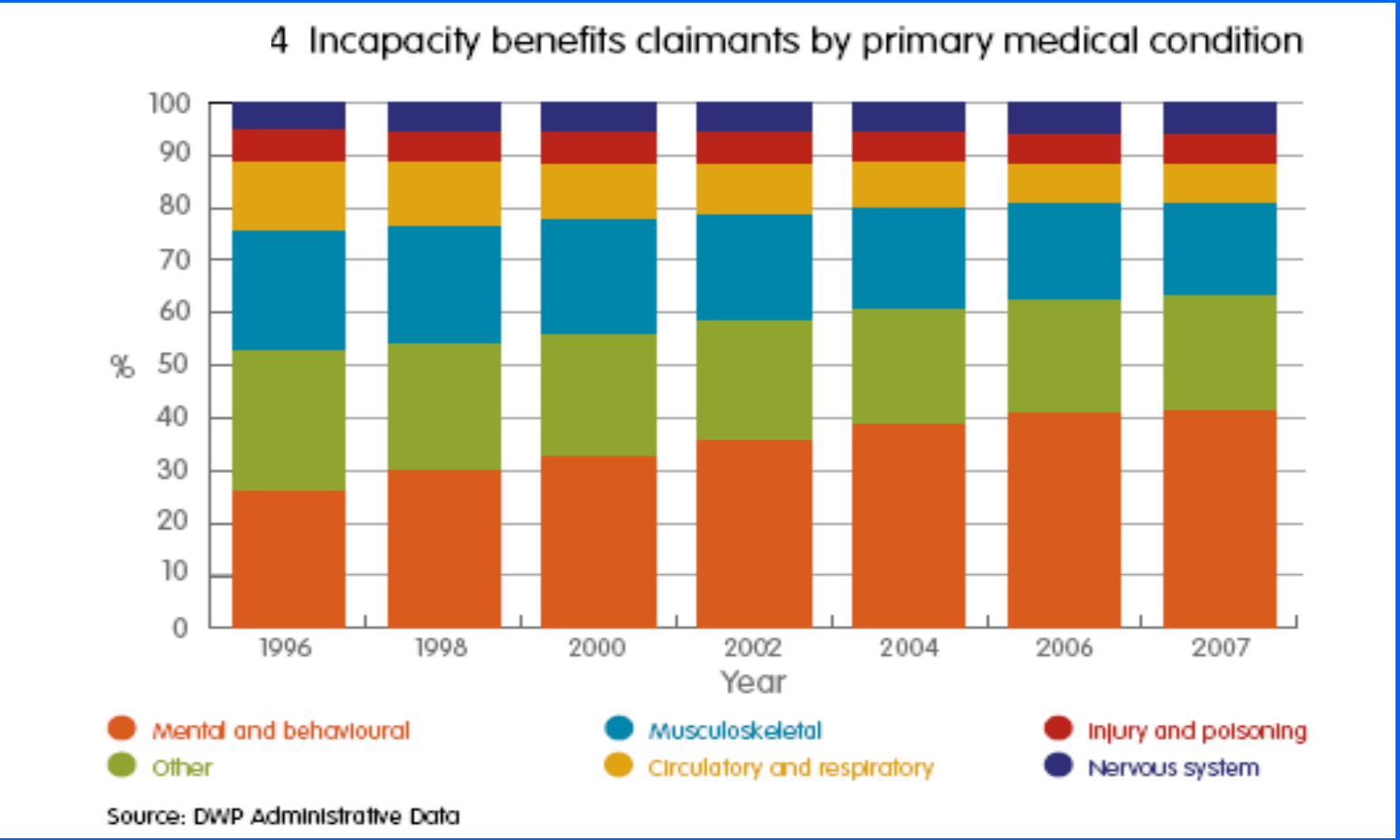
Presented to the Secretary of State for Health and the Secretary of State for Work and Pensions

17th March 2008

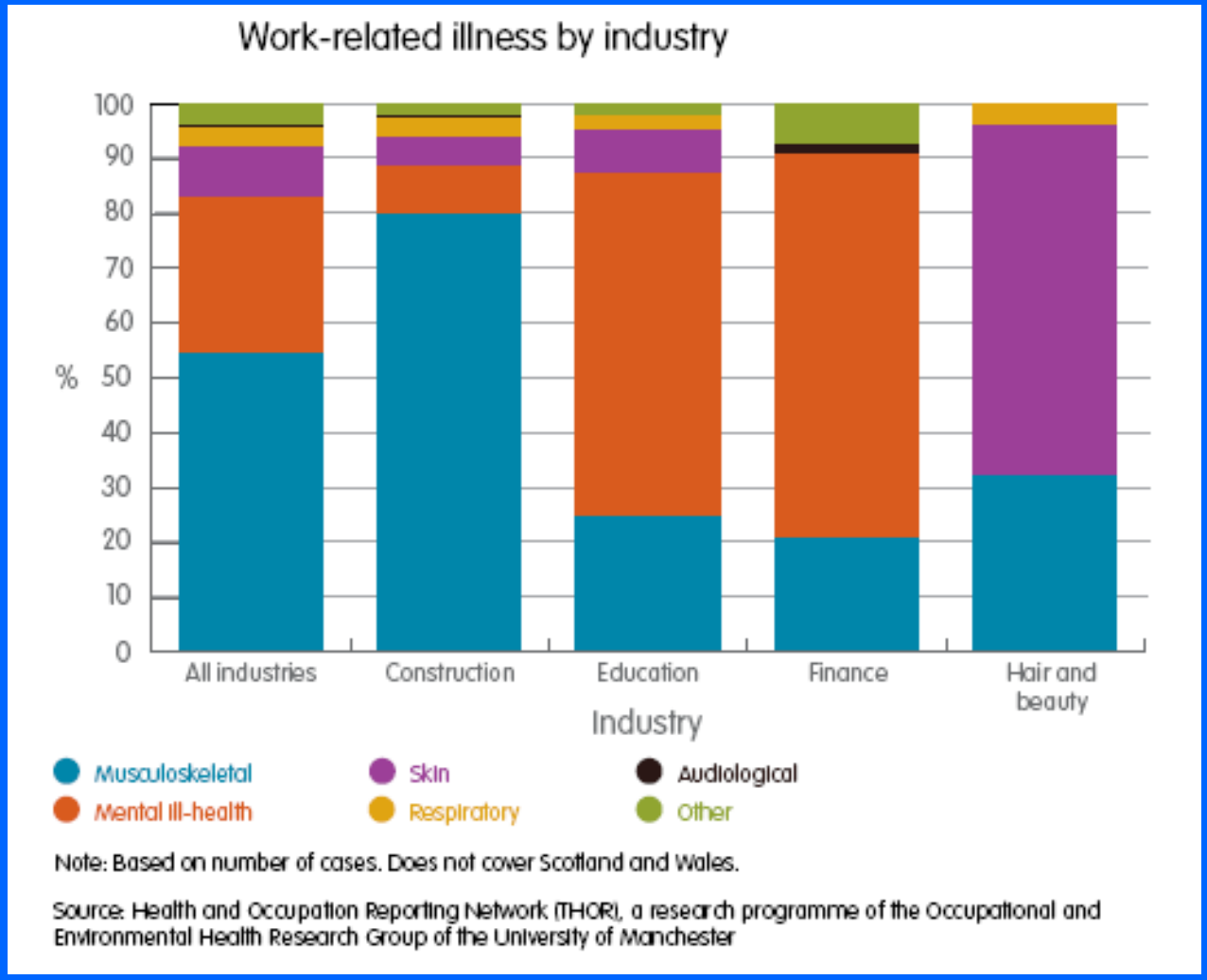
Why is mental health (MH) important?

- In 2008 ~ 13.5 million days were lost to work-related stress in the UK
- With MH conditions, reduced productivity accounts for 1.5 X as much working time lost as SA
- Mean time certified for a person with MH problems (15/52) nearly twice as long as the mean for all conditions (8/52)

MH and Incapacity benefit



Not all industries are the same



What is Traumatic Stress???

Lockerbie

Kings Cross Fire

Herald of Free Enterprise

Bradford F.C. Fire

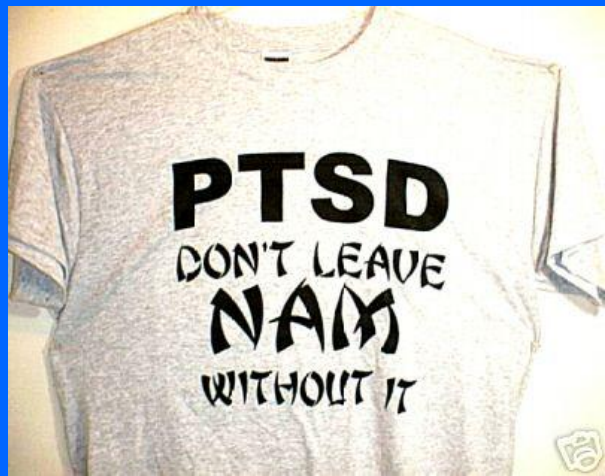
Hillsborough

But don’t forget…

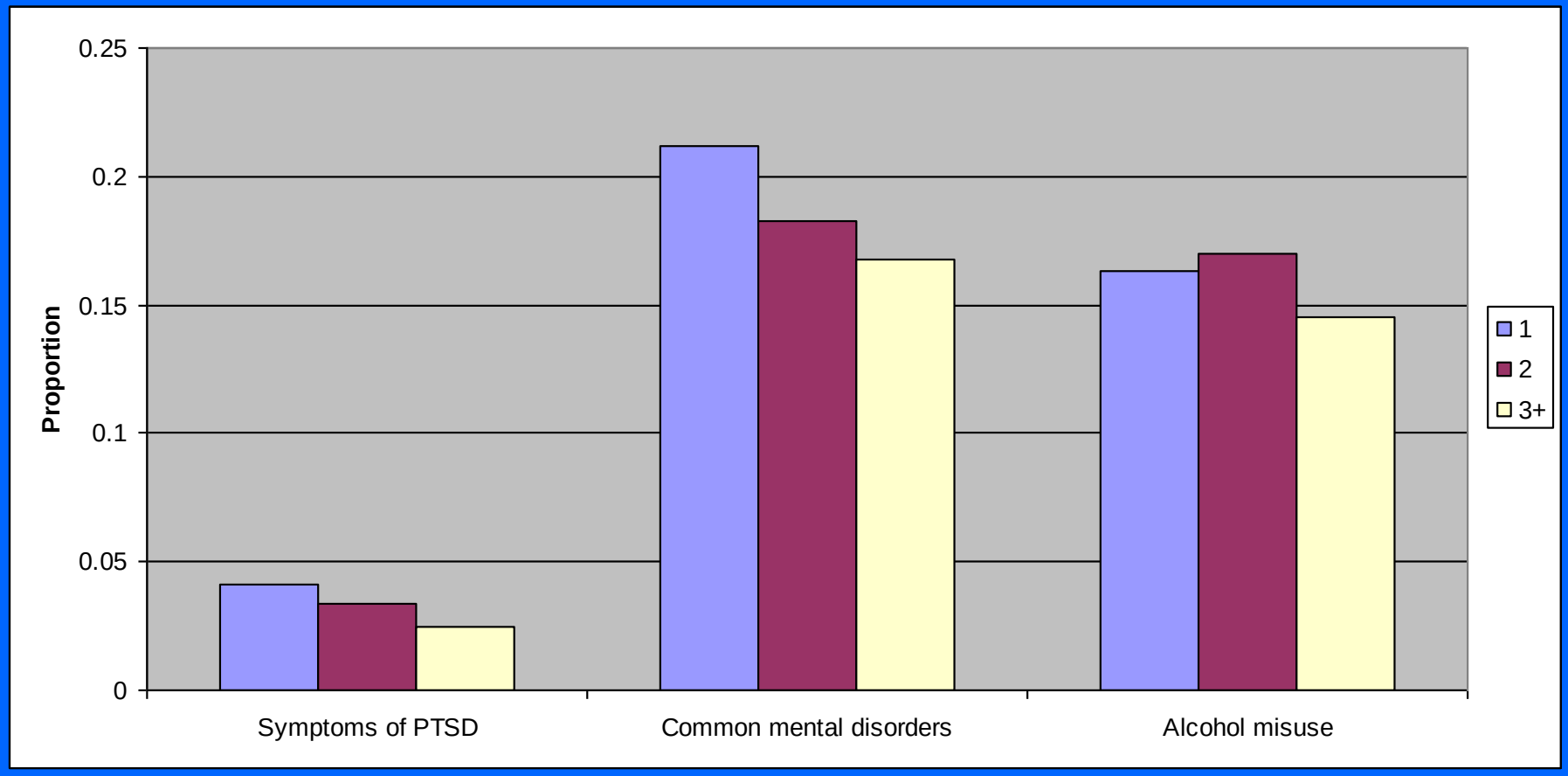
- Journalists
- Emergency services personnel
- Train drivers
- Diplomats
- Private security contractors
- **Healthcare professionals**
- and so on….

Important Caveat

- PTSD is not the only post incident psychological health problem
- Depression, Anxiety, adjustment disorders and substance misuse common



PTSD is not the most common MH disorder in UK AF who have deployed



Number of deployments – currently serving Army regulars

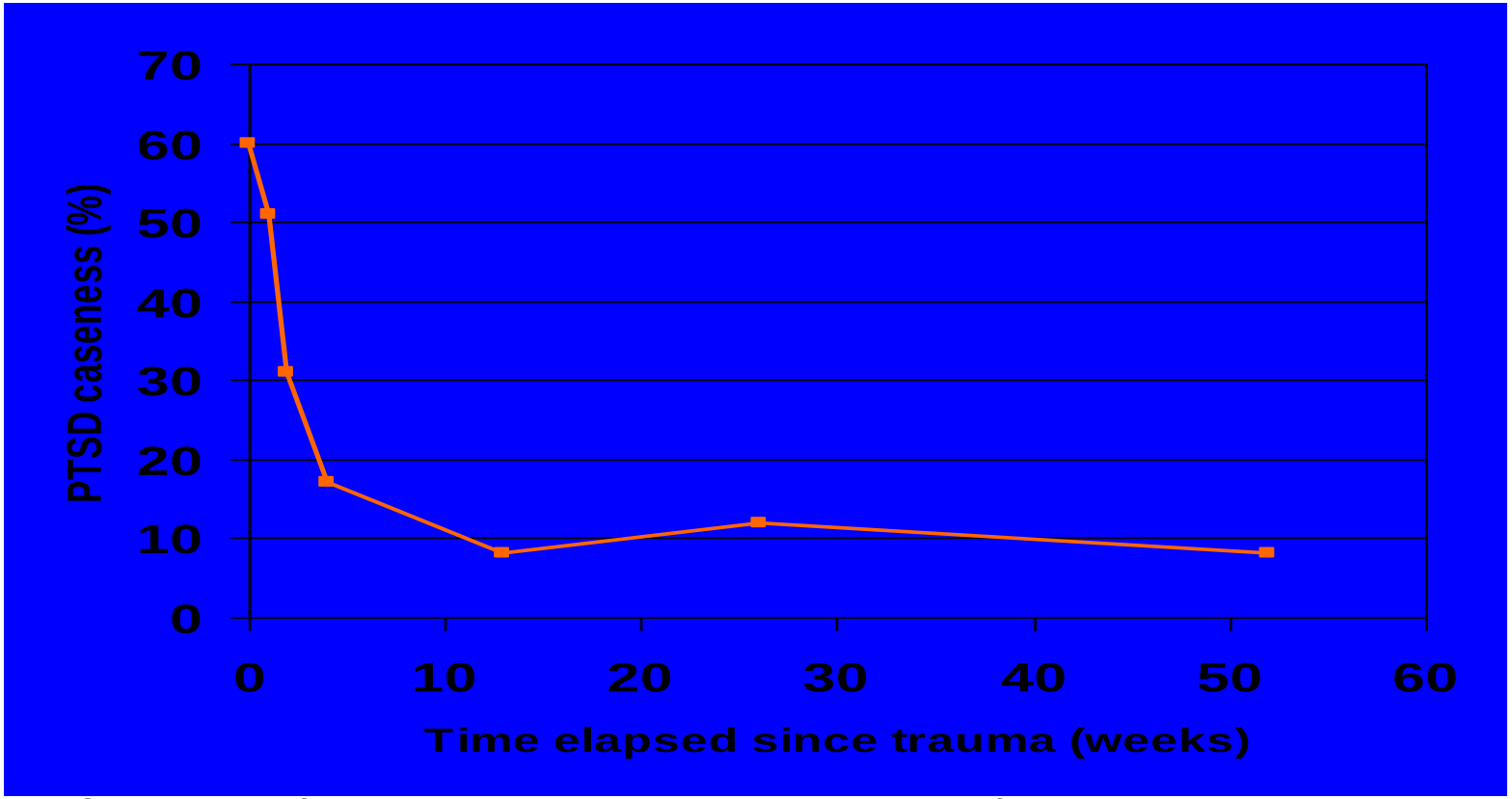
Fear et al, Lancet, 2010

What is PTSD?

The PTSD Diagnosis

- Experience or witness an event which causes:
  - intense helplessness
  - intense horror
  - intense fear
- Symptoms (for more than a month)
  - Re-experiencing
  - Avoidance
  - Arousal
- Impairment of function

What is the natural history of PTSD?



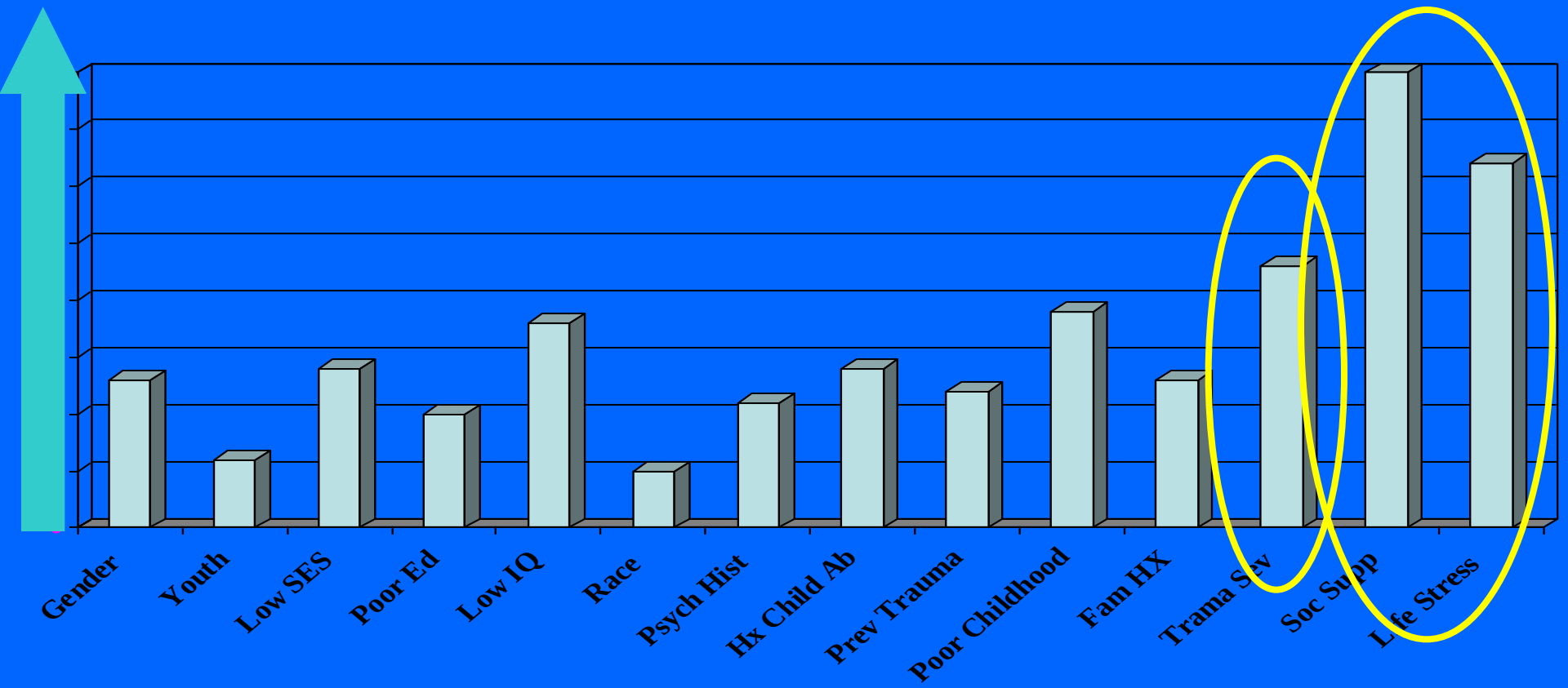
PTSD 'caseness' of patients directly involved in a raid over time. Data from Richards (1997) The Prevention of PTSD after armed robbery: the impact of a training programme within Leeds Permanent Building Society.

How common is PTSD?

- 3% in the general “English Population”
- 7.5% in the US population
- 4% in UK military personnel (7% combat pers)
- Up to a 1/3 of US military personnel

- 4% of London Amb Personnel post 7/7
- Up to 50% of rape victims

Why do people develop PTSD



Primary Prevention Strategies

- Training
- “Mental Health Training”
- Good leadership and social support or “cohesion”
- Selection
- (Reducing exposure)

Training

- Realistic
- Hard (enough)
- Pass/fail – plus option to leave
- (training is selection of sorts)

Training….. Mental disorders - 1/12 post Madrid train bombs

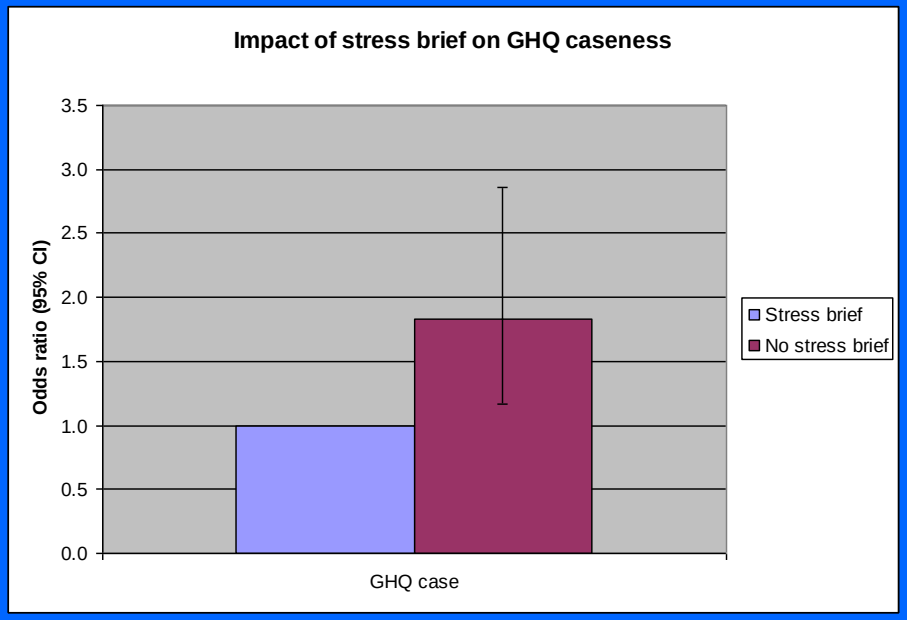
	Injured	Alcalá	Police
PTSD	44.1 (35.3-53.2)	12.3 (9.6-15.6)	1.3 (0.2-4.6)
Major depression	31.5 (23.5-40.3)	8.5 (6.1-11.3)	1.3 (0.2-4.6)
Agoraphobia	23.8 (16.5-32.0)	10.5 (7.9-13.6)	0.7 (0.2-3.6)
GAD	13.4 (8.0-20.6)	8.6 (6.3-11.5)	0.7 (0.2-3.6)
Panic	9.4 (5.0-15.9)	2.1 (1.0-3.8)	0.7 (0.2-3.6)
Any mental disorder	58.3 (49.2-67)	29.4 (25.4-33.7)	6.7 (4.6-8.0)
Any mood disorder	34.0 (25.7-42.8)	9.7 (7.2-12.7)	2.0 (0.7-5.0)
Any anxiety disorder	55.9 (46.8-64.7)	25.1 (21.3-29.2)	3.4 (1.9-6.1)

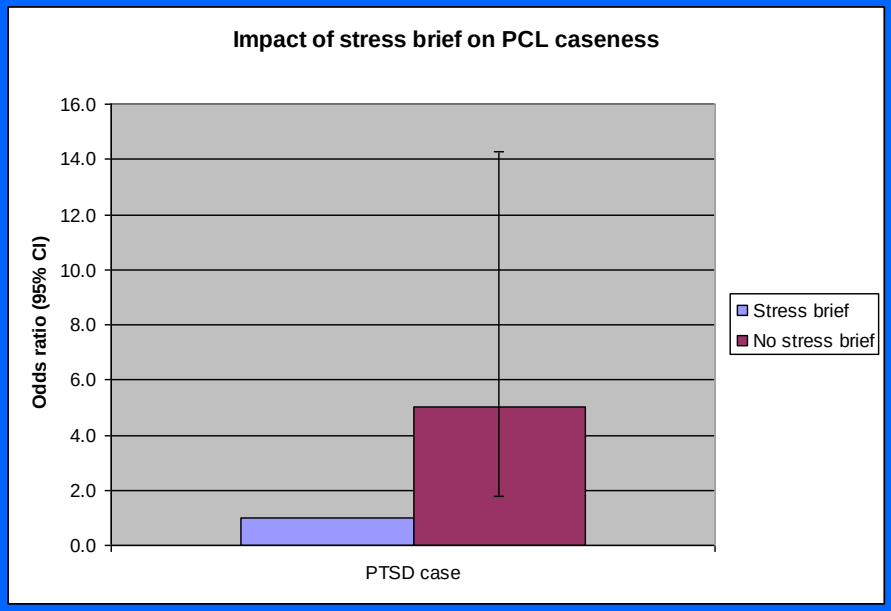
Pre-incident Mental Health Training

- Organisation and context specific intervention
- Education plus actions
- Timing (plus continuation)

Pre-deployment Stress Briefings (I)

Personnel who had received a P-D stress brief were less likely to be mental health cases (GHQ, PCL) even taking quality of leadership into account





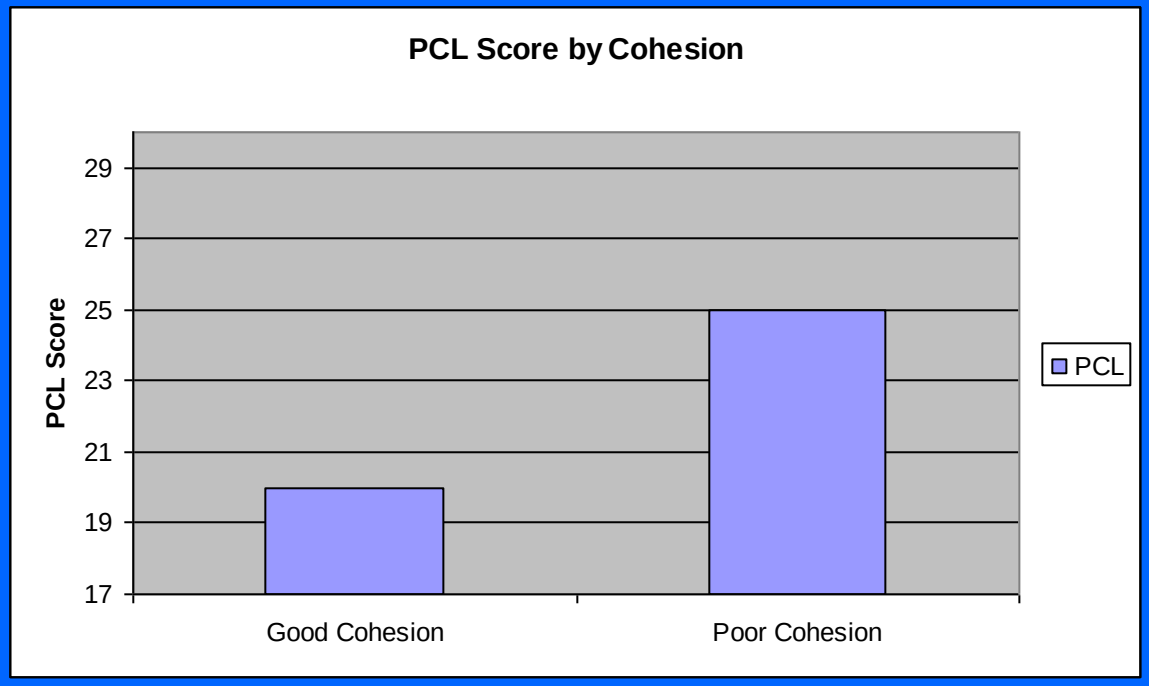
Cohesion, Social Support and Leadership

- Good leader 3+ of:
  - *'my leaders never or seldom…*
    - 'embarrass unit members in front of others'
    - 'accept extra unit duties in order to impress their seniors'
  - *'my leaders often or always…'*
    - 'treat all members of the unit fairly'
    - 'show concern about the safety of unit members'

- High cohesion: 3+ of:
  - 'feel a sense of comradeship with others in my unit'
  - 'able to go to most people in unit with personal problem'
  - 'my seniors are interested in what I do or think'
  - 'I feel well informed about unit matters'

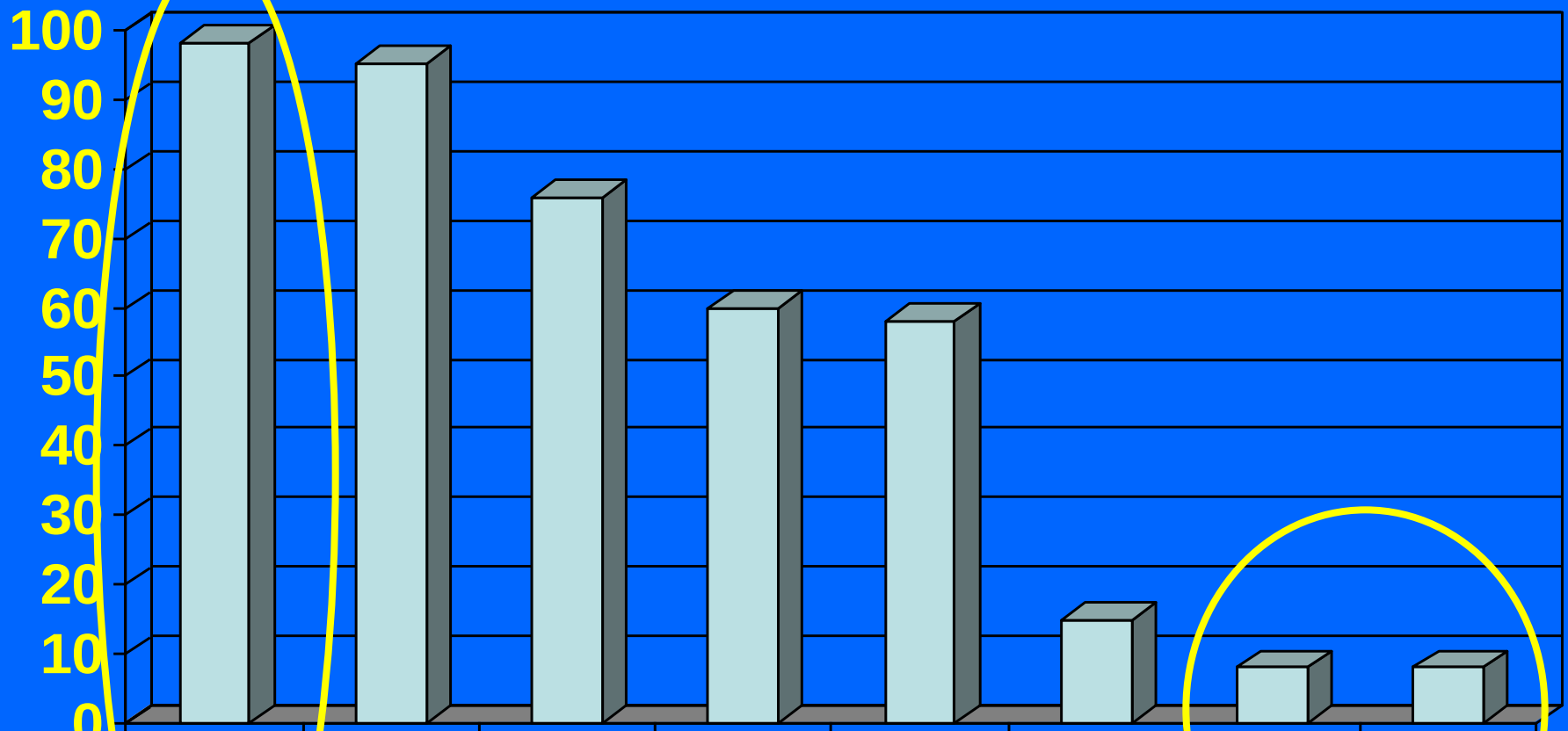
Cohesion – Iraq 2009

Highly cohesive units enjoyed better psychological health **(GHQ and PCL, PCL shown below)**



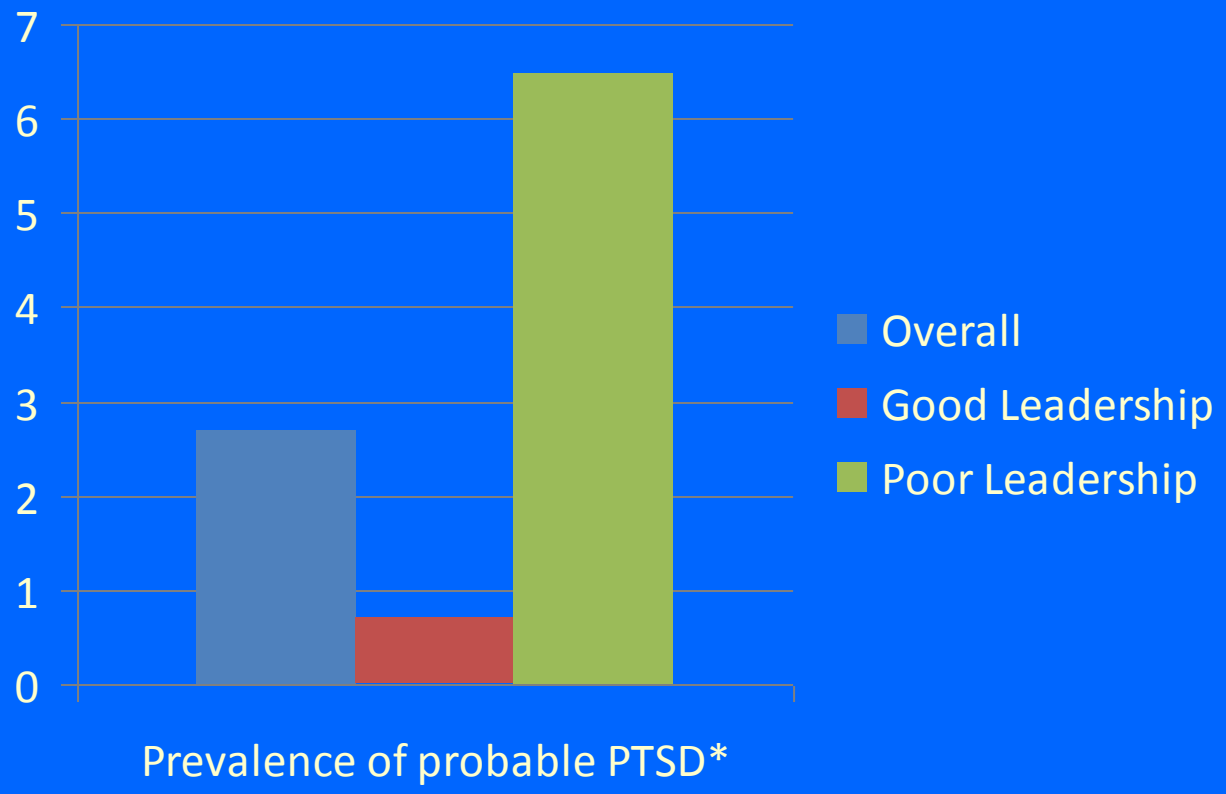
Mulligan et al, BJPsych, 2010

Where does cohesion/social support come from?



Greenberg et al, JMH, 2003

Leadership and PCL caseness – Afghanistan 2010



Jones et al, Psychiatry, 2011

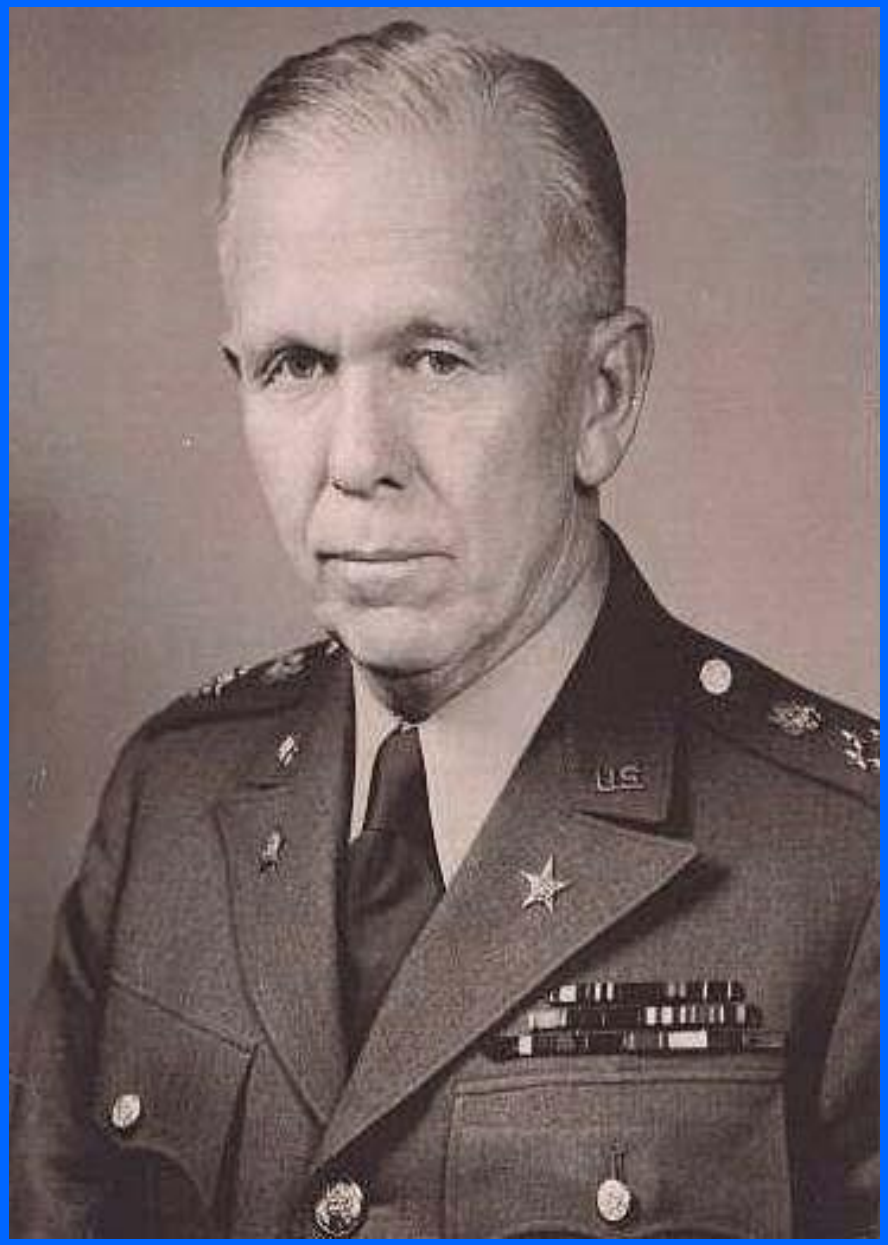
Cohesion and Leadership

- Both moderate MH impact of traumatic events
- Both (esp cohesion) are part of social support
- both are not “owned” by Healthcare Professionals (unless managers!)

Selection Screening

Screening - definitions

- Selection Screening (primary)
- Health screening (secondary)
- Surveillance (for research)



Selection Screening UK military

Before and After Iraq War 2003

Pre Deployment Selection/Screening: PTSD Cases

		After Iraq Invasion (04)		
		+	-	Total
Before Iraq Invasion (02)	+	6	27	33
	-	41	1540	1581
	Total	47	1567	1614

PPV 18% (5-31%); NPV 97% (96-98%)

Last Updated: Tuesday, 28 August 2007, 22:32 GMT 23:32 UK

E-mail this to a friend Printable version

US ex-astronaut to plead insanity

By Andy Gallacher
BBC News, Florida

Lawyers for former Nasa astronaut Lisa Nowak say they are planning to pursue a defence of temporary insanity when she stands trial in Florida next month.

Capt Nowak was said to be suffering from depression and insomnia

The 44-year-old mother of three is charged with attempted kidnap, assault and burglary.

Police say she confronted a woman she believed was a rival for the affections of a space shuttle pilot.

Capt Nowak made headlines after police said she drove across the US wearing adult nappies to avoid toilet breaks.

She was arrested at Orlando airport here in Florida after

VIDEO AND AUDIO NEWS
Lisa Nowak's fall from grace
Watch

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Selection Screening

- Seductive idea…however
- Grandmother test is good
- Health records check may be useful (DDA?)
- But psych selection screening is a non-starter (including personality profiling)

Secondary Prevention Strategies

- Post incident health screening
- Debriefing
- Peer group support/Risk Assessment
- Mental Health training
- Reduction of stigma

Post incident screening

- Many AF use PD screening
- Aims to identify those at risk and provide them with treatment
- Administered on return and again a few months later (face to face + surveys)

Program Evaluation of PDHA Screening for PTSD, Army Active Component

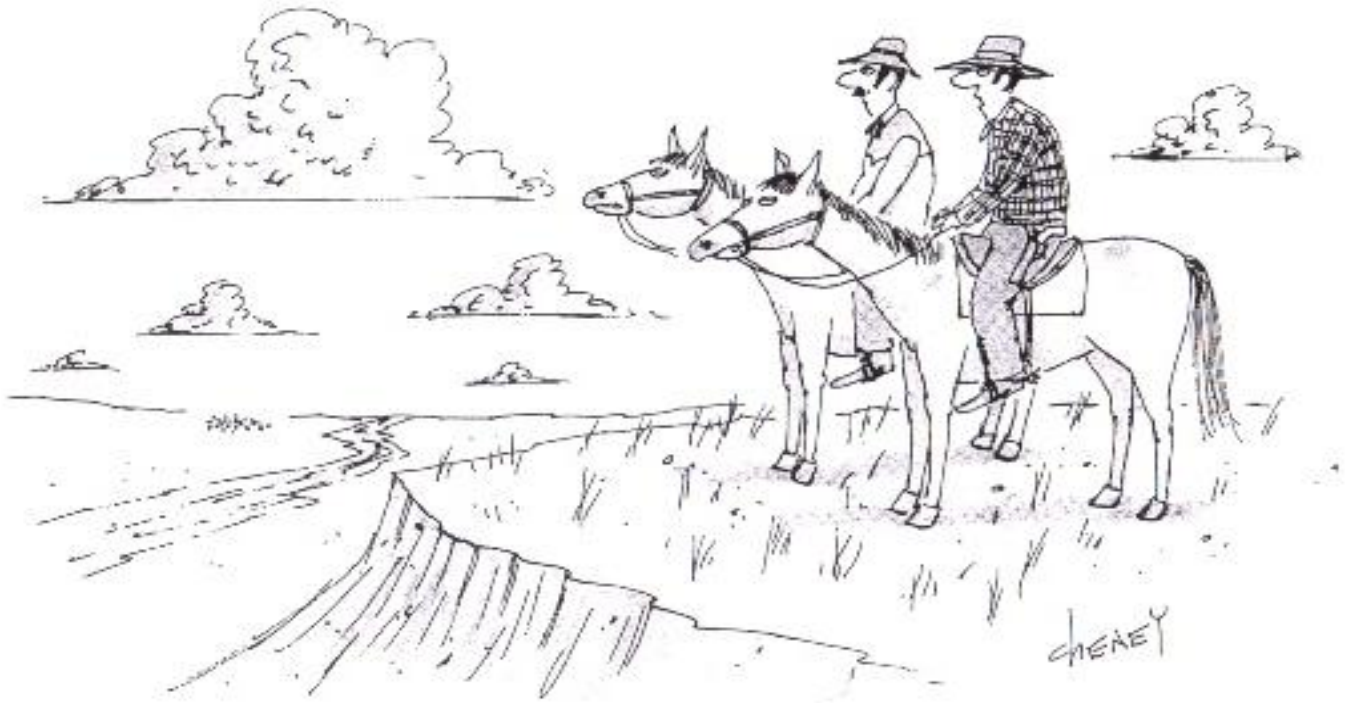
Milliken, et. al., Table 4, JAMA 2007 (N=56,350)

PTSD Screen Positive (PC-PTSD ≥ 3) n=3474 (6.2%)	Number (%) Who Received Mental Health Treatment and Number of MH Sessions	Number (%) Recovered 6 Months Post-Iraq (PC-PTSD < 3)
Referred to Mental Health n=804	None, 349 (43.4)	205 (58.7)
	1 Session, 128 (15.9)	69 (53.9)
	2 Sessions, 70 (8.7)	36 (51.4)
	≥3 Sessions, 257 (32.0)	96 (37.3)
Not Referred to Mental Health n=2670	None, 1721 (64.5)	1181 (68.6)
	1 Session, 419 (15.7)	254 (60.6)
	2 Sessions, 129 (4.8)	67 (51.9)
	≥3 Sessions, 401 (15.0)	150 (37.4)

Post Incident Health Screening

- Again a seductive idea
- No easy to administer ‘test’
- Concerns about implications of positive result (? Realistic)
- Resource heavy (UK RCT underway)

Psychological Debriefing



"Hard to tell from here. Could be buzzards. Could be grief counsellors."

NHS
National Institute for Clinical Excellence

How to deal with PTSD (NICE slide edited)

Peer Group support/risk assessment – TRiM (Trauma Risk Management)


RIFLE DRILLS
LOAD
1. POINT WEAPON INTO UNLOADING BAY
2. ENSURE SAFETY CATCH IS AT "S"
3. TILT WEAPON TO THE RIGHT
4. CHECK THAT THE TOP ROUNDS ARE SEATED CORRECTLY
5. PUSH THE MAGAZINE FIRMLY INTO THE MAGAZINE HOUSING, MAKING CERTAIN IT IS SECURE
UNLOAD
1. POINT WEAPON INTO UNLOADING BAY
2. ENSURE SAFETY CATCH IS AT"S"
3. REMOVE MAGAZINE
4. TILT THE WEAPON TO THE RIGHT, COCK THE WEAPON, AND APPLY THE HOLDING OPEN DEVICE
5. ENSURE THE BODY, CHAMBER AND FACE OF THE BOLT IS CLEAR AND THAT THE MAGAZINE HOUSING IS CLEAR OF ROUNDS. AGAIN CHECK THE BODY, CHAMBER AND FACE OF THE BOLT IS CLEAR
6. RELEASE THE WORKING PARTS, FORWARD ASSIST, SET SAFETY CATCH TO "F" AND OPPERATE THE TRIGGER
7. REPLACE SAFETY CATCH TO "S", CLOSE DUST COVER AND CHECK SIGHTS
PISTOL DRILLS
LOAD
1. POINT WEAPON INTO
UNLOAD
1. POINT WEAPON INTO LOADING BAY
2. REMOVE MAGAZINE
3. COCK WEAPON AND APPLY THE SLIDE LOCKING LEVER
4. ENSURE BODY CHAMBER AND MAGAZINE HOUSING ARE CLEAR OF ROUNDS
5. RELEASE THE SLIDE UNDER CONTROL
6. REPLACE AN EMPTY MAGAZINE AND OPERATE THE TRIGGER
7. REMOVE MAGAZINE

Trauma Risk Management (TRiM)- What is it?

- Non professional peer support psychological first aid process
- Started in the UK 12 AF years ago; now used by diplomats, emergency services, NHS, PSC, media companies
- ‘Human resource’ initiative – not health led
- TRiM aims to assess psychological risk & manage it

How to filter an event?

Filtering Groups

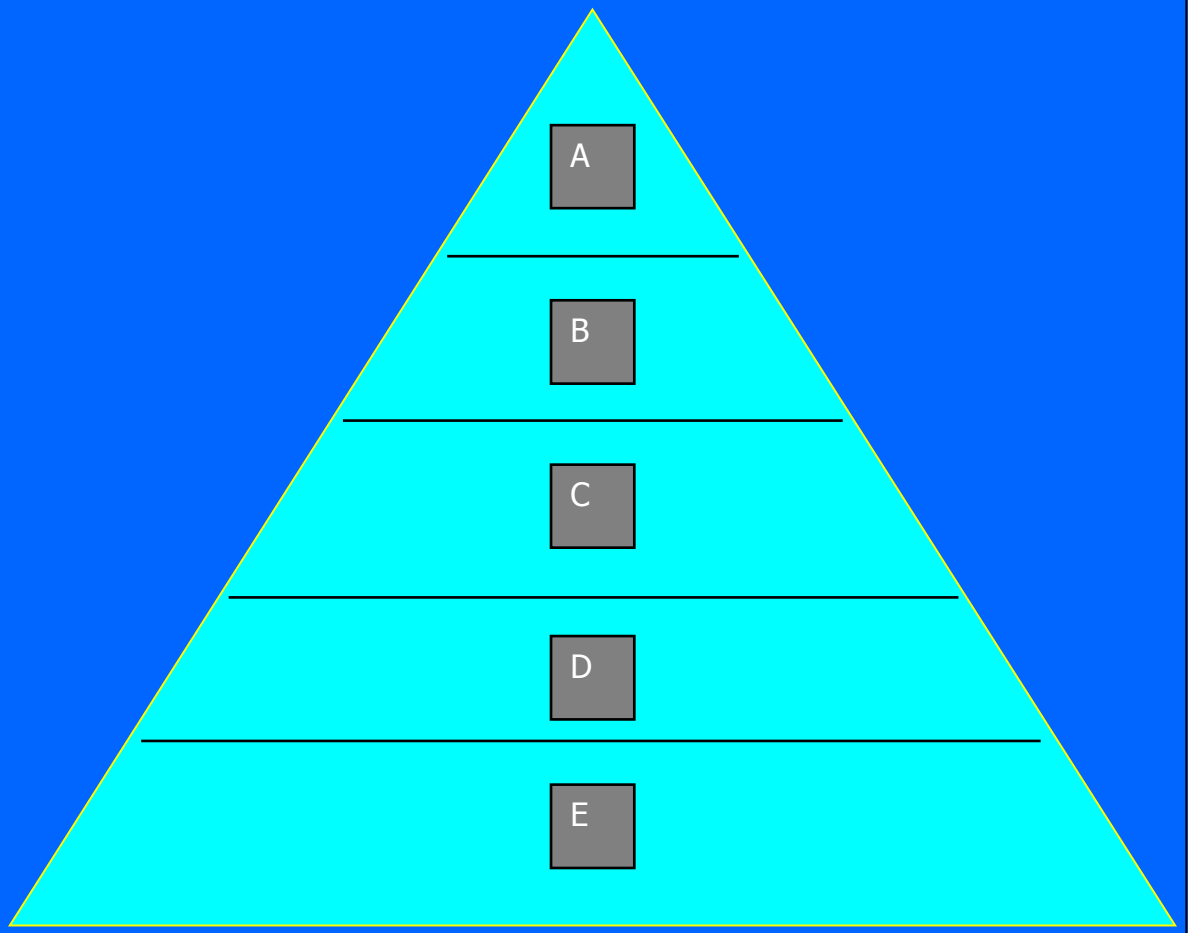
A – Directly involved (primary victims)

B – Rescuers and helpers (secondary victims)

C – Onlookers/involved at a distance

D – Those who could have been there but were not

E – Vulnerable people, who may be affected by the event



How to filter an event?

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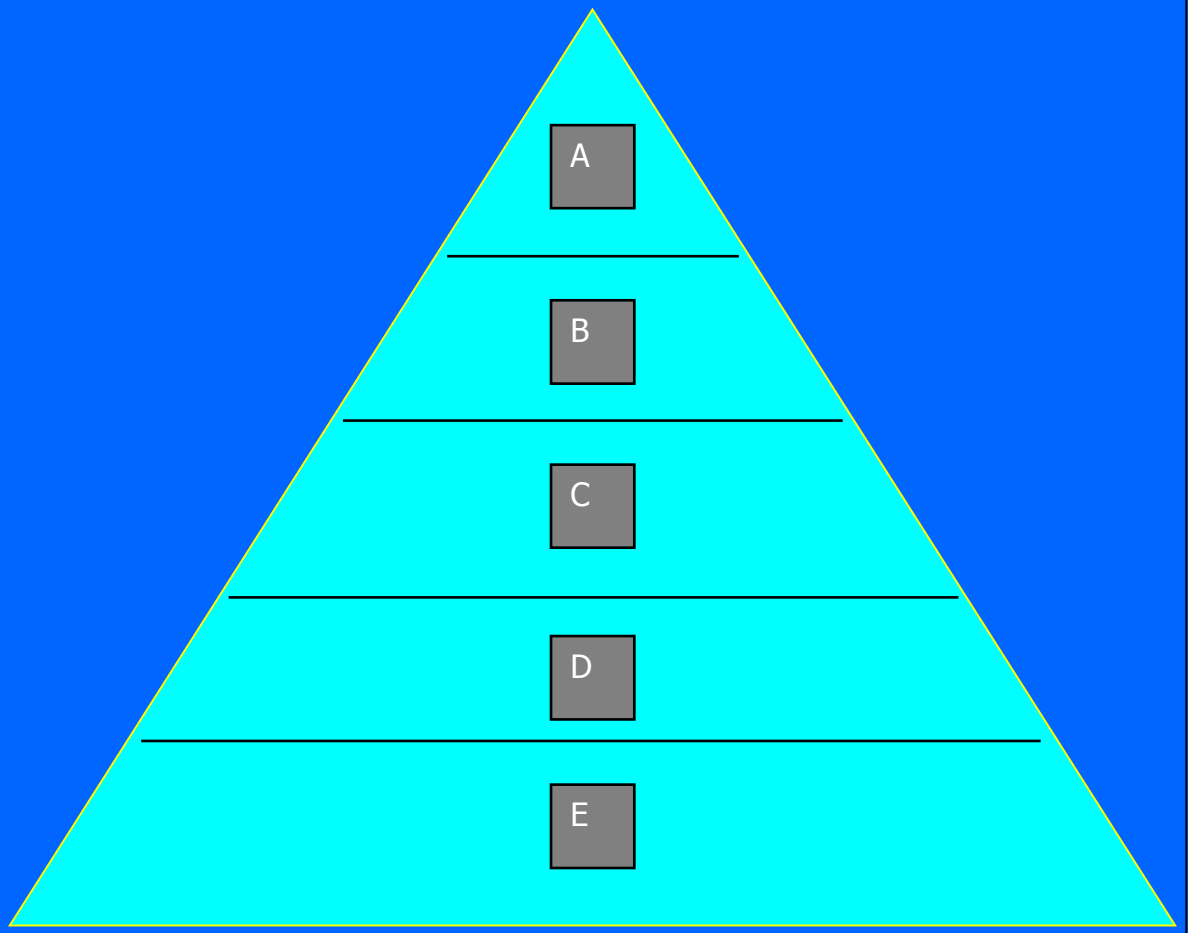


TRiM Interview

Facts Thoughts Future	Before	During	After
Facts (5W&H)	1	4	7
Thoughts	2	5	8
Future	3	6	9

Risk Assessment Checklist Initial

1. The person felt that they were out of control during the event
2. The person felt that their life was threatened during the event
3. The person blamed others or what happened
4. The person feels 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

TRiM publications

Journal of Mental Health,
June 2009; 18(3): 216–223

informa
healthcare

Peer-group risk assessment: management strategy for hie organizations

N. Jones[1], P. Roberts[2] and N. Greenberg[3]

Background Organizations have moral an their workforce following ex workplace. Additionally, it ma to the effects of psychological of psychological intervention events, but recent evidence

Journal of Traumatic Stress, Vol. 20, No. 4, August 2007, pp. 1–11 (© 2007)

InterScience

ORIGINAL PAPERS

TRAUMA RISK MANAGEMENT (TRiM) IN THE UK ARMED FORCES

N Greenberg[1], V Langston[2], N Jones[3]

[1]Association

Abstract

Management (TRiM) is a novel system of post incident management which intend to allow commanders to
opriate support to their subordinates in the aftermath of traumatic events
operational tempo being experienced by the majority of the UK Armed F
as been in use in both Iraq and Afghanistan. Although TRiM originated f
y used in both the Royal Navy and Army; there are also plans to introduc
r Force such as for the RAF Regiment. This paper aims to explore the bas

Psychological risk assessment following the terrorist attacks in New York in 2001

NEIL GREENBERG[1], C. DOW[2], & DUNCAN BLAND[1]

[1]*King's Centre for Military Health Research, Weston Education Centre, London, and* [2]*Health and Welfare Department, Foreign and Commonwealth Office, London, UK*

Abstract

Background: Trauma Risk Management (TRiM) is a post-traumatic psychological management model utilizing peer support/assessment, developed by the UK military. Following September 11th, 2001, the UK Foreign & Commonwealth Office (FCO) deployed TRiM personnel to New York.

Aims: This report describes the use of TRiM by the FCO in New York and examines the correlation validity of the TRiM assessments.

Method: Assessments were conducted among personnel shortly after the event and again after a

Journal of Traumatic Stress, Vol. 23, No. 4, August 2010, pp. 430–436 (© 2010)

Stigma and the Military: Evaluation of a PTSD Psychoeducational Program

Matthew Gould
Department of Clinical Psychology, Royal Holloway, University of London, Egham, Surrey, TW20 0EX, UK

Neil Greenberg
King's Centre for Military Health Research, Weston Education Centre, Cutcombe Road, London, SE5 9RJ, UK

Jacquie Hetherton
Department of Clinical Psychology, Royal Holloway, University of London, Egham, Surrey, TW20 0EX, UK

Trauma risk management (TRiM) is an intensive posttraumatic stress disorder (PTSD) psychoeducational management strategy based on peer-group risk assessment developed by the UK Royal Navy (RN). TRiM seeks to modify attitudes about PTSD, stress, and help-seeking and trains military personnel to identify at-risk individuals and refer them for early intervention. This quasiexperimental study found that TRiM training significantly improved attitudes about PTSD, stress, and help-seeking from TRiM-trained personnel. There was a nonsignificant effect on attitudes to seeking help from normal military support networks and on general health. Within both the military and civilian populations, stigma is a serious issue preventing help-seeking and reducing quality of life. The results suggest that TRiM is a

A Cluster Randomized Controlled Trial to Determin the Efficacy of Trauma Risk Management (TRiM) in Military Population

Neil Greenberg, Victoria Langston, Brian Everitt, Amy Iversen, Nicola T. Fear, Norman Jones, and Simon Wessely
King's College London and Institute of Psychiatry, London

Trauma Risk Management is a peer-support program that aims to promote help-seeking in the aftermath of traumatic events. Prior to its implementation, the British military conducted a randomized controlled trial of Trauma Risk Management against standard care in 12 warships; 6 were randomized to use Trauma Risk Management after collecting baseline measurements. Follow up after 12–18 months found no significant change in psychological health or stigma scores in either group; however, the studied vessels only encountered low numbers of critical incidents. Additionally, measurements of organizational functioning were modestly better in the Trauma Risk Management ships. The authors conclude that within organizations using Trauma Risk Management may be beneficial and may, in time, lead to a valuable cultural shift.

Occupational Medicine Advance Access published April 5, 2011

Occupational Medicine
doi:10.1093/occmed/kqr022

The acceptability of 'Trauma Risk Management' within the UK Armed Forces

N. Greenberg[1], V. Langston[2], A. C. Iversen[2] and S. Wessely[2]

[1]Academic Centre for Defence Mental Health, Weston Education Centre, Cutcombe Road, London SE5 9RJ, UK, [2]King's Centre for Military Health Research, Weston Education Centre, Cutcombe Road, London SE5 9RJ, UK.

Correspondence to: N. Greenberg, Academic Centre for Defence Mental Health, Weston Education Centre, Cutcombe Road, London SE5 9RJ, UK. Tel: +44 (0)20 7848 5351; fax: +44 (0)207 848 5397; e-mail: sososanta@aol.com

Background Trauma-support programmes may benefit employees of organizations that routinely expose their staff to traumatic events. However, in order for such programmes to be effective, staff need to find them acceptable.

Aims To investigate whether Trauma Risk Management (TRiM), an example of such a programme, is ac-

Does trauma risk management reduce psychological distress in deployed troops?

W. Frappell-Cooke[1], M. Gulina[2], K. Green[3], J. Hacker Hughes[1] and N. Greenberg[4]

[1]Defence Clinical Psychology Service, HQ Surgeon General, DMS Whittington, Lichfield, Staffordshire WS14 9PY, UK, [2]Department of Psychology, City University, Northampton Square, London EC1V 0HB, UK, [3]Navy Command Headquarters, MP 3-1, Leach Building, Whale Island, Portsmouth PO2 8BY, UK, [4]Academic Centre for Defence Mental Health, London, UK.

Correspondence to: N. Greenberg, Academic Centre for Defence Mental Health, Academic Department of Psychological Medicine (IOP), Weston Education Centre, Cutcombe Road, London SE5 9RJ, UK. Tel: +44 (0)207 848 5351; fax: +44 (0)207 848 5397; e-mail: wfcpsych@talktalk.net

Background Military personnel exposed to potentially traumatic events whilst deployed on operational duties may develop psychological problems. The Royal Marines have made extensive use of Trauma Risk Management (TRiM), a peer-support system that operates through practitioners embedded within operational units. TRiM aims to promote recognition of psychological illness and to facilitate social support.

Post Incident Mental Health Training

- Delivered as a brief
- Evidence from Iraq (2003) conflict showed that non-receipt of a MH brief on return from deployment was associated with a MH diagnosis

Battlemind “training”

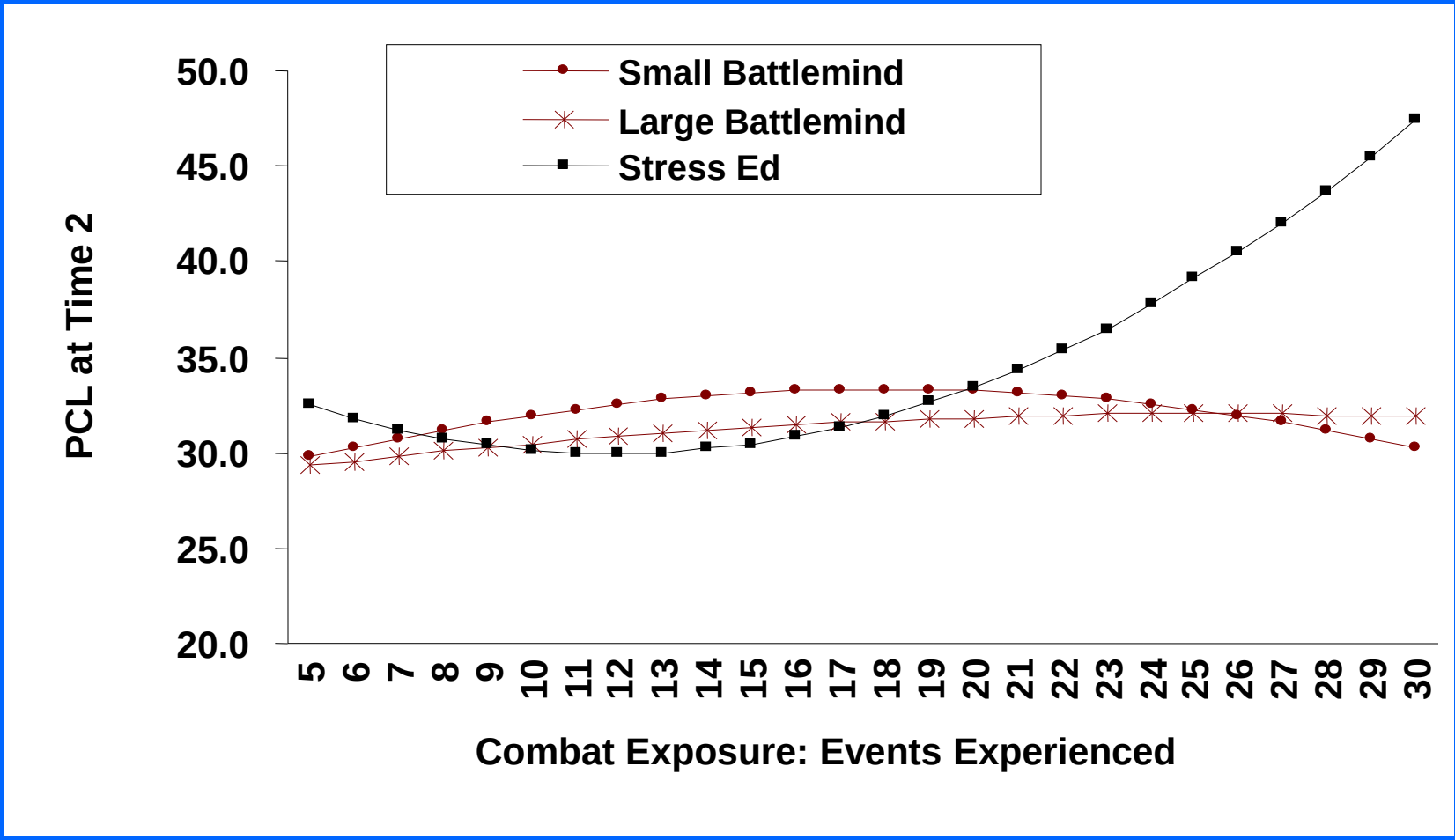
US Training package

- Training at post deployment phase
- Aims to manage operations to home transition
- Uses Service Person’s own experience positively
- Does not use an illness paradigm

BATTLEMIND

Buddies (cohesion)	Withdrawal
Accountability	Controlling
Targeted Aggression	Inappropriate aggression
Tactical awareness	Hypervigilance
Lethally Armed	‘Locked and loaded’ at home
Emotional Control	Anger/Detachment
Mission Security (OPSEC)	Secretiveness
Individual Responsibility	Guilt
Non-Defensive (combat) Driving	Aggressive Driving
Discipline and Ordering	Conflict

US Battlemind Study: Post-Traumatic Stress at 4 months

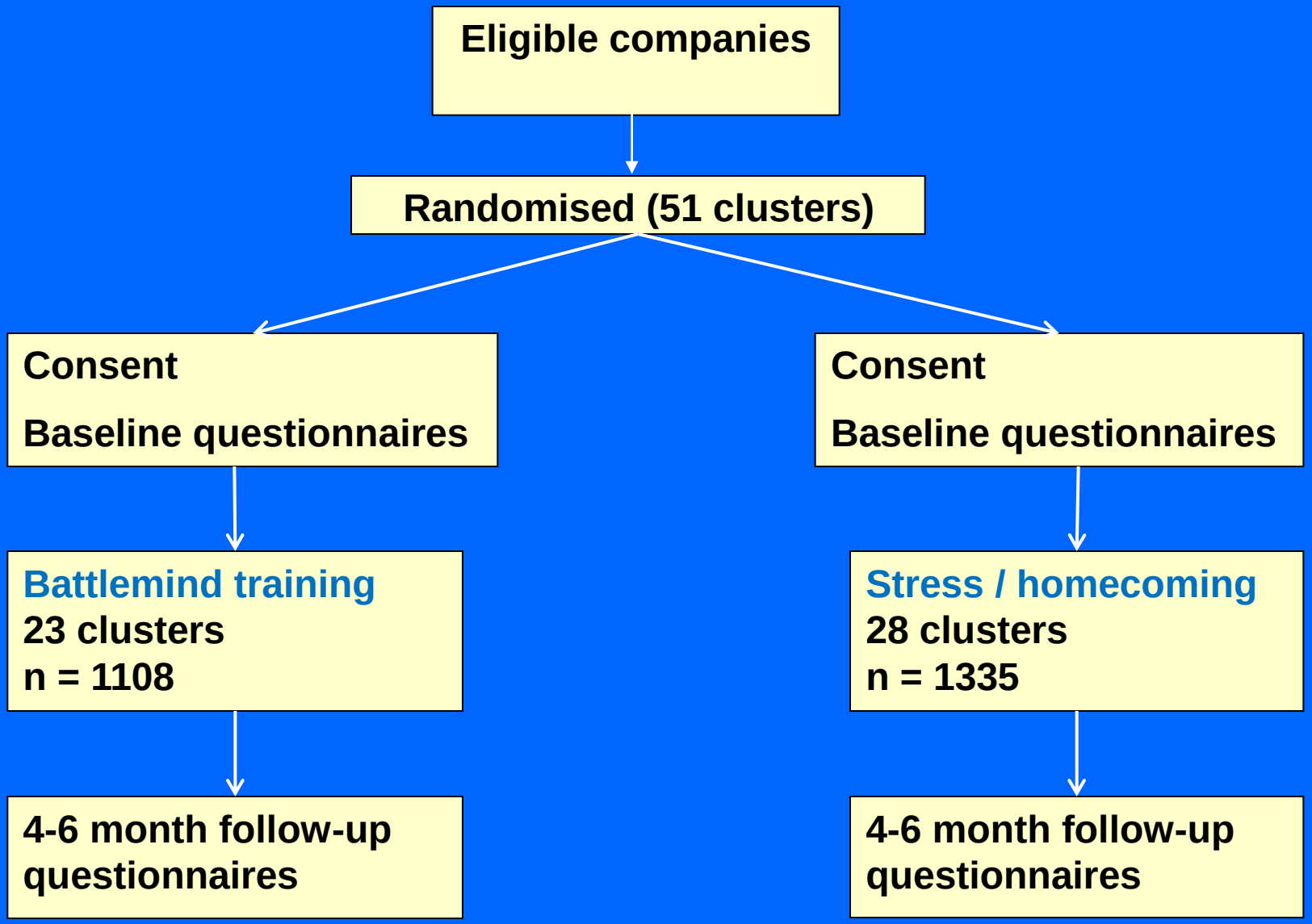


UK Battlemind materials

Deployment BATTLEMIND	Home Front Problems
Buddy Buddy System	Withdrawal
Accountability	Controlling at home
Targeted Aggression	General Aggression
Tactical Awareness	Being on Edge
Limited Alcohol	Lagered up
Emotional Control	Detachment & Numbness
Mission Operational Security	Secretiveness
Individual Responsibility	Guilt
Non-Defensive (Combat) Driving	Unnecessary Risk-taking
Discipline and Ordering	Conflict with Friends & Family

www.battlemind.co.uk

Study design



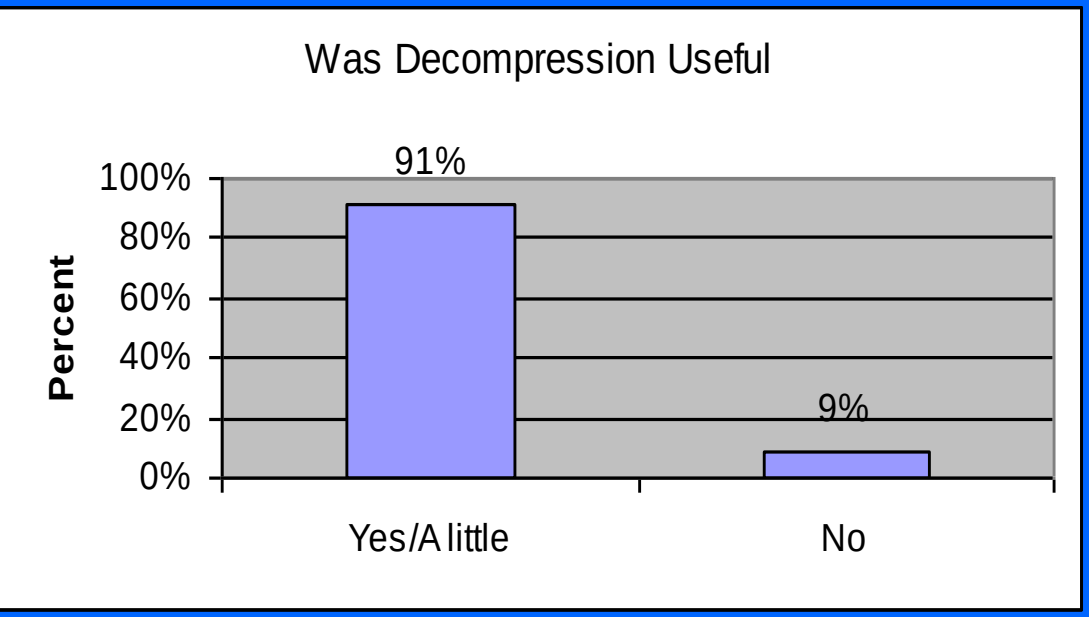
Battlemind Study Summary

- Both briefs received positively

- Battlemind findings:
  - No difference from standard brief on mental health (PCL, GHQ)
  - But some evidence of benefit on alcohol (harm and binging)

Post Deployment - Decompression

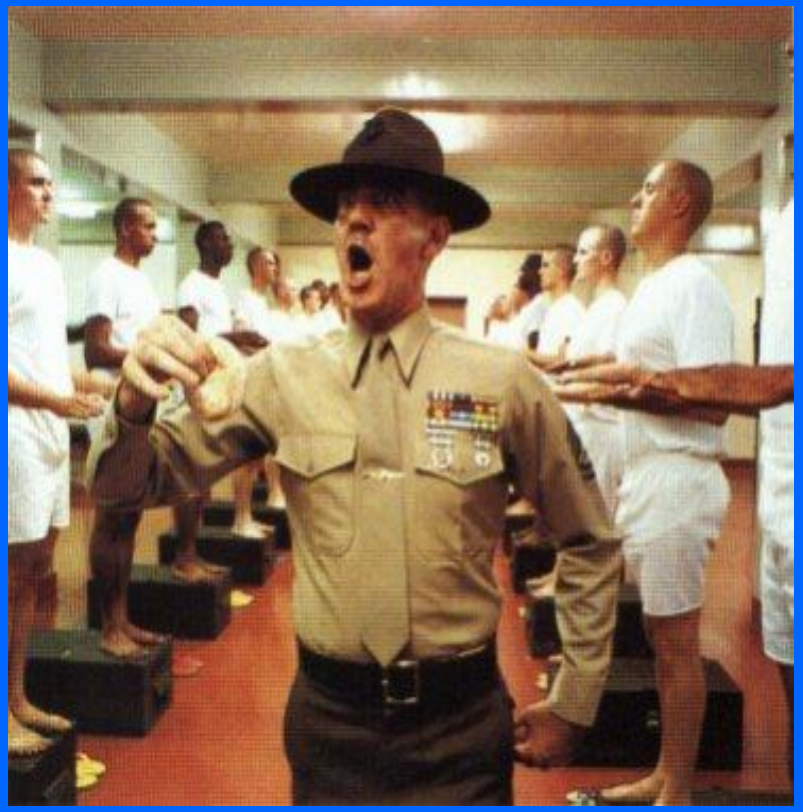
- Prior to attending DcN ~80% did not want to go or were ambivalent
- Having been through DcN…



Mental Health Outcomes TLD Attendees vs Controls

- Data from KCL cohort; 2006-2009 AF personnel did/did not attend TLD
- Propensity score generated to match
- Inverse Probability of Treatment Weights (IPTW) used to adjust outcomes
- Short answer is TLD seems to help!

Stigma



Stigma

- “an attribute that is deeply discrediting” (Goffman, 1963)
- “the bearer of a mark that defines him or her as deviant, flawed, limited, spoiled or generally undesirable” (Jones,1984)
- Long history of stigma in “robust” organisations

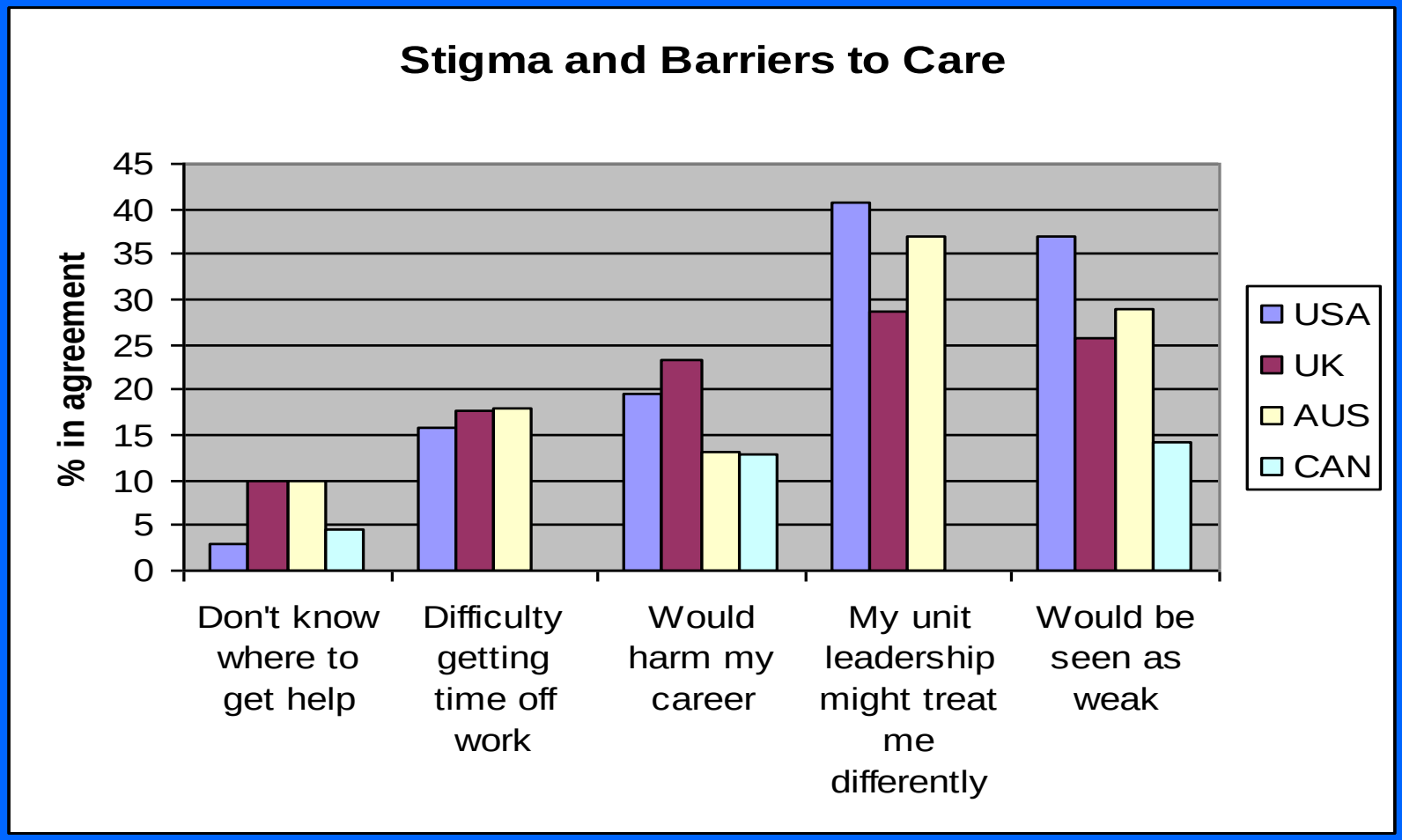
WW1 - Stigma

"It is wholly out of place to show them compassion. People with shell shock are weaklings who should never been allowed to join the Army or tricksters who deserved to be punished"

Captain Dunn, Medical officer, RWF

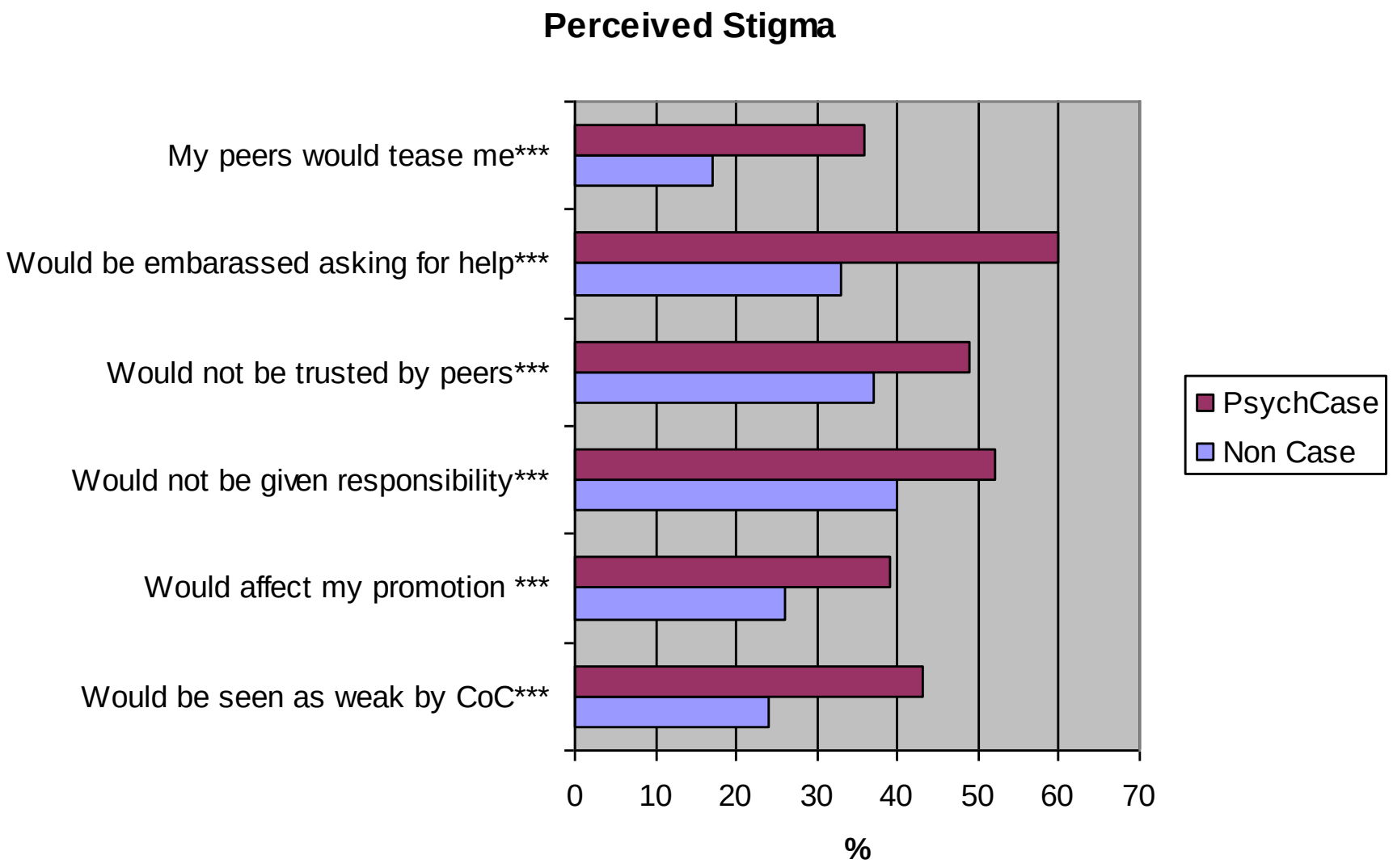
Stigmatising "pan-society" views continue until post WW2 (e.g. LMF)

Stigma and Barriers to Care



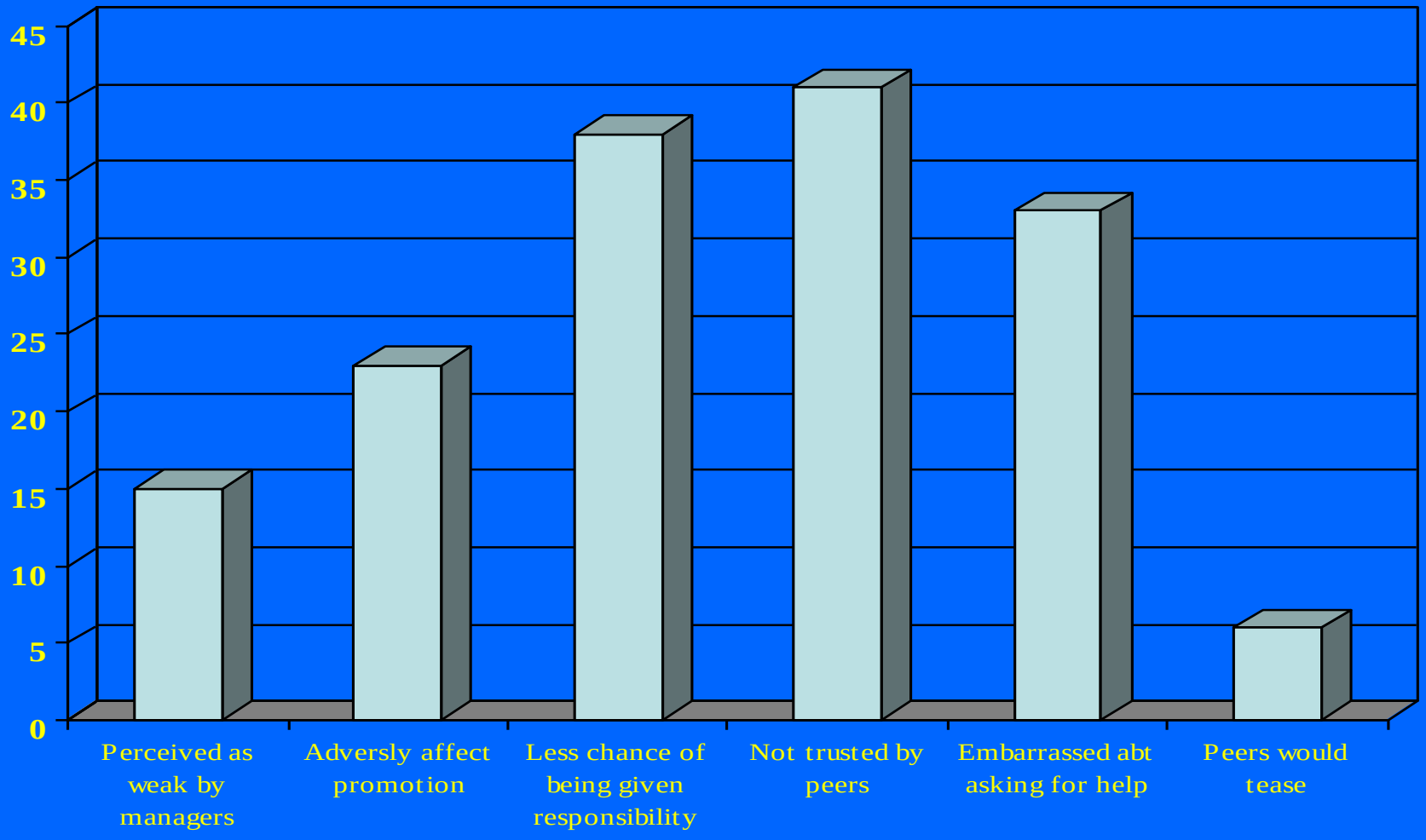
Gould et al, 2010, JRSM

Internal Stigma – Naval Service



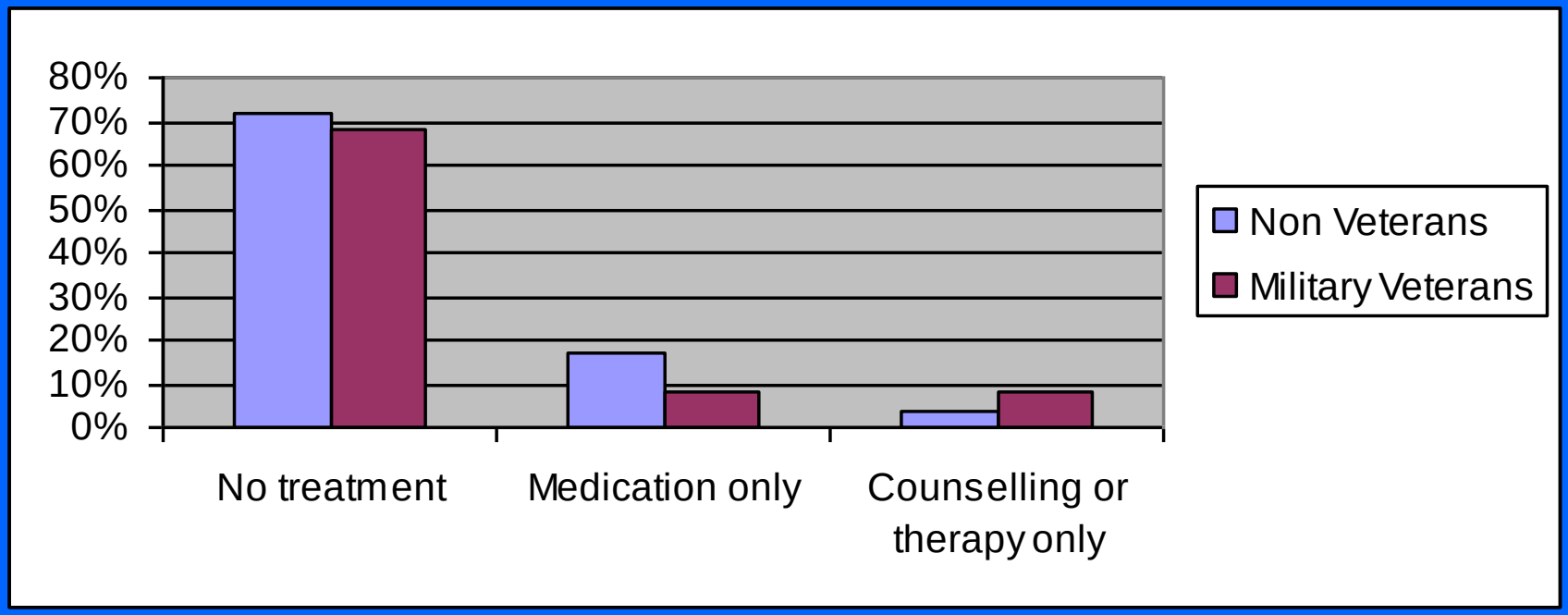
Langston et al, 2010, JMH

“Why might you not seek help after being exposed to a traumatic event?”



Greenberg et al, JMH, 2009

Stigma is a societal issue



Help seeking for PTSD

Woodhead et al, 2010, Soc Sci Med

Stigma summary

- Reducing stigma is difficult
- It involves leadership owning the issue (not healthcare providers)
- Less stigma should mean more not less cases
- What about “no stigma”?

Tertiary Prevention Strategies

- Forward Psychiatry
- Evidence based “NICE” treatments
- Snake oil salesmen

The principles of forward psychiatry

P - Proximity
I - Immediacy
E - Expectancy
S - Simplicity

IDF research (Solomon et al)

Simplicity

- Practical interventions
  - Food
  - Sleep*
  - Shelter
- Communication with loved ones
- Protect from further “stress” (inc media)
- Informal social support
  - “an ear, or shoulder, if needed”
- To get back to “normal” as soon as is practical

NHS
National Institute for Clinical Excellence

How to deal with PTSD (NICE slide edited)

What isn't recommended…

- "Psychological Debriefing"
- Ineffective psychological treatments
- For PTSD, drug treatments NOT a first line treatment (different for depression)

What is recommended…

- "Watchful Waiting"
- Checking in after a month
- Trauma-focused treatments (CBT and EMDR) for adults and children if unwell

Coming soon…

- High intensity tx (CBT, EMDR)
- Telemedicine therapy
- Some evidence of C-CBT
- “New” medications

Snake Oil Salesmen

Snake Oil Salesmen (SOS)

- Will sell you a treatment which sounds “unbelievable”
- Will offer “testimonials” as evidence
- Will tell you that EBM is the wrong tool for dealing with PTS
- (some SOS are well meaning however)
- But…
  - Why use a non-tested tx when we have EBM ones?

Conclusions

- PTSR/PTSD may be considered as a “reducible” consequence of working with psych trauma
- The prevention of psychological injury is a HR not medical
- Early detection (peer support) may prevent longer term issues
- There are plenty of ways to treat established psych injury if people can be convinced to access treatment

Any Questions?- Fire Away!

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