MODELING ANXIETY AND DISTRESS MANAGEMENT

JENNIFER M. ERICKSON, DO FAPA
GENERAL DISCLOSURES

The University of Washington School of Medicine also gratefully acknowledges receipt of educational grant support for this activity from the Washington State Legislature through the Safety-Net Hospital Assessment, working to expand access to psychiatric services throughout Washington State.
GENERAL DISCLOSURES

UW PACC is also supported by Coordinated Care of Washington
SPEAKER DISCLOSURES

✓ No conflicts to report
SPEAKER DISCLOSURES

✓ No conflicts of interest

PLANNER DISCLOSURES

The following series planners have no relevant conflicts of interest to disclose:

Mark Duncan MD
Barb McCann PhD
Anna Ratzliff MD PhD
Rick Ries MD
Kari Stephens PhD
Cameron Casey
Betsy Payn
Diana Roll
Cara Towle MSN RN
Niambi Kanye
LEARNING OBJECTIVES

• List the two common symptoms providers experience while treating patients during an complex emergency

• List coping skills and step clinicians can take to support themselves and others complex emergencies
COVID-19 & PROVIDER REACTIONS

• This represents the sum total of literature on this topic
  – YES, I mean nothing
  – NOTHING!
PROVIDERS & OTHER COMPLEX EMERGENCIES*

• Sept 11th
• Turin, 2017
• Fukushima Complex disaster
• Ebola
• SARS

* Complex Emergencies is a term I made up
WHAT HAVE WE LEARNED FROM 9/11?

• Smith et al. 2019
  – Qualitative Research 54 EMTs
  – Delayed Awareness of Needs
  – Preferred physical forms of self care (exercise, etc)
  – Preferred social contact with friend & family or peer support
  – Younger EMTs felt they needed more support
WHAT HAVE WE LEARNED FROM TURIN?

• Caramello et al. 2019
• Emergency Staff
• Stratified by risk by PsySTART-R
• Overall providers did well
  – However, providers without an emergency background did a little worse
  – Low number of nonlethal causatives (87)
  – Short event
  – Providers mostly had issues with the volume & organizational issues
WHAT HAVE WE LEARNED FROM FUKUSHIMA?

• Nukui, et al. 2018

• Narrative Review

• Focused on Nurses

  – Psychosocial setting mattered

  – Job stress played a key role

  – Stigma existed depending on clinical locations

  – Fear for family, children, and ongoing radiation exposure
WHAT HAVE WE LEARNED FROM EBOLA?

- Qualitative study of 35
- Providers described:
  - Loneliness & stigma
  - Physical isolation from colleagues, families, and patients
WHAT HAVE WE LEARNED FROM SARS?

- Lin C-Y et al. 2007
- 92 medical staff in Taiwan
- Psychiatry & ED assessed
- ~94% felt SARS was a Major stressor
- ED > PTSD presentation than Psych
- ED was more likely to have irritability, difficulty with social interactions, and intrusive reoccurrence
WHAT HAVE WE LEARNED FROM SARS?

• Nickell, et al.
• SARS in Toronto
• Surveyed Hospital - 4283 responses
• 2/3 reported SARS concerns
• 29 % showed signs of emotional distress on screeners
• Masks were the most complained about PPE
WHAT HAVE WE LEARNED FROM SARS?

• Maunder, 2004
• Looked at factors for the 29-35% Hospital Workers with distress
• 3 came to the top
  – Working in Nursing
  – Working directly with SARS patients
  – Having young children at home
WHAT HAVE WE LEARNED FROM SARS?

• Beyond PTSD, other psychiatry symptoms/diagnoses can occur too
  – Depression (Chan et al)
  – Increased substance use (Wu et al)
WHAT CAN WE LEARN FROM OTHER COMPLEX EMERGENCIES?

1. Frequently providers can become distressed in these situations
   a. ...But Not ALL of them. (ie in some cases 70% are not showing signs on distress scales)

2. Common contributing factors include working directly with effected patients, social isolation, personal isolation, stigma, job stress, and the providers personal life

3. Providers may not be great at recognizing their own distress/need for self care
WHAT DO WE DO ABOUT IT?

• Lessons of Resiliency
  – learned from Mass Causality Events
  – learned from Ebola
  – learned from SARS
LEARNED FROM MASS CAUSALITY EVENTS

• “One size fits all” is ineffective
• Early brief individual interventions with the goal of reducing distress seems to help
• Early interventions or Group interventions that are focused on detailing trauma are not liked & maybe damaging
• Open follow-up should be offered & people who are initially more symptomatic

Mental Health & Mass Violence Consensus, 2002
LESSONS FROM EBOLA

• Schreiber et al, 2019.

• Assessed a pre-deployment intervention that included:
  – Providers perceptions of potential stressors
  – Their usual self care routine
  – Their emergency self care routine when stressed
  – Identified a person to help check in with the providers when they experienced a stressor

• Found that it allowed people to identify stress events. Also most reported events fell below PTSD thresholds
Maximizing the Resilience of Healthcare Workers in Multi-hazard Events

**Step 1 - Anticipate**
Understand Your Stress Reactions

There are two main kinds of responder stressors you can expect. Planning your response to these stressors will maximize your resilience during disasters.

"Traumatic Response Stress" can include exposure and loss factors such as:
- Witnessed severe burns, dismemberment or mutilation
- Witnessed pediatric death(s) or severe injuries
- Witnessed an unusually high number of deaths
- Responsible for expectant triage decisions
- Injury, death or serious illness of coworkers
- At work, you were treated for injury or illness
- Felt as if your life was in danger

These current stressors may also be "Trauma Triggers" activating memories of other past experiences or losses. "Cumulative Response Stress" can include factors such as:
- Exposure to patients screaming in pain/fear
- Forced to abandon patient(s)
- Unable to meet patient needs (such as patient surge, crisis standards of care)
- Direct contact with grieving family members
- Asked to perform duties outside of current skillset
- Hazardous working conditions (such as extreme shift length, compromised site/safety or security or lack of PPE)
- Unable to return home
- Worried about safety of family members, significant others or pets
- Unable to communicate with family members or significant others
- Health concerns for self due to agent/toxic exposure (infectious disease, chemical, radiological nuclear, etc.)

These current stressors may also be "Trauma Triggers" that activate memories of past experiences or losses.

**Step 2 - Plan**
Plan for Your Response Challenges

**Your Expected Stress Reactions**
List your stress reactions. These may include thoughts, feelings, behaviors, and physical symptoms.
- 1.
- 2.
- 3.
- 4.
- 5.

**Your Expected Response Challenges**
List what you think the most stressful aspects of working on a disaster will be for you. (If you are unsure what you might find stressful, review situations typically experienced by healthcare workers shown on the PsySTART Staff Self Triage System in this brochure.)
- 1.
- 2.
- 3.
- 4.
- 5.

**Your Social Support Plan**
Who is in your social support system? List people who can support you and who you can provide support to during and after a disaster:
- 1.
- 2.
- 3.
- 4.

**Your Positive Coping Plan**
Everyone has different ways of coping with stress. What positive ways of managing stress work best for you every day? What positive ways of managing stress do you think will work for you following a disaster? Strategies you might consider include limiting your exposure to media reports, focusing beyond the short term, taking frequent short breaks. List your healthy coping plan here:
- 1.
- 2.
- 3.
- 4.

**Your Resilience Factors**
People often find that there are some positive things working about a disaster. For example, people might feel good about being able to "make a difference" when their community needs them most. Positive resilience factors help you as a healthcare worker to cope better with the stressors associated with responding to a disaster in your facility or community. Below please list positive factors that might give you a sense of mission or purpose following a disaster:
- 1.
- 2.
- 3.
- 4.

**Step 3 - Deter**
Monitor your stress reactions and activate your Coping Plan (see step 2) early to maximize your resilience during a disaster response. Fill out and review the PsySTART Staff Self Triage form at the end of the disaster (for a one day disaster response) or at the end of your shift each day (for a disaster response that occurs over many days). If you have any of the PsySTART stress factors present:

Review your Personal Resilience Plan, including activating your positive coping plan. If you have not already done so, consider your co-workers as part of your Social Support Plan. Know who to call in your facility if you find that you are dealing with a particular stressor(s) or your reactions to the stressors are intense, disruptive, or lasts longer than a few days or weeks.

Consider visiting Bounce Back Now™ a confidential internet

**Building Your Responder Personal Resilience Plan™**

**Listen, Protect, and Connect**
Below are the three steps of "Psychological First Aid" that you
LESSONS FROM SARS

• Chan et al. 2004.

• 177 health care participants from clinical areas in Singapore

• Areas associated with greater coping
  – Clear directives/Precautionary Measures
  – Ability to give feedback/obtain support
  – Family support
  – Colleague support
  – Religion
HOW DO WE MODEL DISTRESS MANAGEMENT?

• Take your own pulse
  – Not everyone in any of these emergencies had distress
  – Knowing where you are is going to help you help others

• Create an anticipation list for yourself
  – What are your break points? (School remains closed? THEY CLOSE ALL THE COFFEE SHOPS!?!?!)”

• Review your self care plans & what you need to do to escalate them when you hit a break point.
HOW DO WE MODEL DISTRESS MANAGEMENT?

• Create your social support network
  – Get creative about social contact
  – Schedule it if possible

• Re-review your plan as you hit those break points

• Reach out your support network when you need help
HOW DO WE MODEL DISTRESS MANAGEMENT?

• After you have your plan, help others create theirs
  – Help them explore where they are
  – What there concerns/break points maybe
  – What they are doing/going to do to take care of themselves
  – When it is time for them the reach out & what their options are
HOW DO WE MODEL DISTRESS MANAGEMENT?

• As clinical leaders remember all eyes are on us
  – Communicate clearly with the team
  – Reach out with concerns to supervisors
  – Find creative ways to connect with colleagues to make it feel less lonely as we continue to work of social distancing
REFERENCES


