



UW PACC

Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

MODELING ANXIETY AND DISTRESS MANAGEMENT

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GENERAL DISCLOSURES

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GENERAL DISCLOSURES

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SPEAKER DISCLOSURES

✓ No conflicts to report

SPEAKER DISCLOSURES

- ✓ No conflicts of interest

PLANNER DISCLOSURES

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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

September 11 attacks



From Wikipedia, the free encyclopedia

"9/11" redirects here. For other uses, see [911](#) and [September 11 attacks \(disambiguation\)](#).

The **September 11 attacks** (also referred to as **9/11**)^[a] were a series of four coordinated terrorist attacks by the Islamic terrorist group al-Qaeda^{[3][4][5]} against the United States on the morning of Tuesday, September 11, 2001. The attacks **resulted in 2,977 victim fatalities, over 25,000 injuries**, and caused at least \$10 billion in infrastructure and property damage.^{[6][7]} Additional people have died of 9/11-related cancer and

September 11 attacks

Part of terrorism in the United States



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

2017 Turin stampede

From Wikipedia, the free encyclopedia

Coordinates: 45.06773°N 7.68259°E﻿ / ﻿

The **2017 Turin stampede** occurred on 3 June 2017 when panic emerged in the **Piazza San Carlo** after a robbery attempt during a screening of the **UEFA Champions League Final in Turin, Italy** between Torinese club **Juventus** and **Real Madrid**. Two women died, and at least 1,526 people were injured.

Contents [hide]

- Stampede
- Casualties
- Reactions and investigations
- References

Stampede [[edit](#)]

The incident occurred at approximately 10:30 p.m. local time, about 10 minutes before the end of the match, when panic

2017 Turin stampede



Location of Turin in Italy

Date	3 June 2017
Time	10:30 p.m.
Location	Turin, Italy
Cause	Robbery attempt and a loud bang
Deaths	2
Non-fatal injuries	1,526

WHAT HAVE WE LEARNED FROM FUKUSHIMA?

- Nukui, et al. 2018
- Narrative Review
- Focused on Nurses

The Fukushima Daiichi nuclear disaster (福島第一原子力発電所事故, *Fukushima Dai-ichi* (pronunciation) *genshiryoku hatsudensho jiko*) was a nuclear accident at the Fukushima Daiichi Nuclear Power Plant in Ōkuma, Fukushima Prefecture. The disaster was the most severe nuclear accident since the 26 April 1986 Chernobyl disaster and the only other

Fukushima Daiichi nuclear disaster

Part of the 2011 Tōhoku earthquake and tsunami



Image on 16 March 2011 of the four damaged reactor buildings. From left to right: Unit 4, 3, 2, and 1.

- 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?

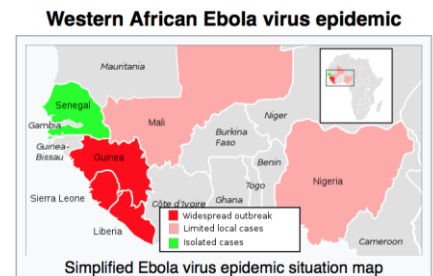
- McMahan, et al. 2016
- Qualitative study of 35
- Providers described:
- Loneliness & stigma
- Physical isolation from colleagues, families, and patients

Western African Ebola virus epidemic

From Wikipedia, the free encyclopedia
(Redirected from Ebola virus epidemic in West Africa)

This article is about the Ebola virus epidemic in West Africa in 2013–2016. For the ongoing Ebola virus epidemic in the Democratic Republic of the Congo and Uganda, see [Kivu Ebola epidemic](#).

The **Western African Ebola virus epidemic** (2013–2016) was the most widespread outbreak of [Ebola virus disease](#) (EVD) in history—causing major loss of life and socioeconomic disruption in the region, mainly in [Guinea](#), [Liberia](#), and [Sierra Leone](#). The first cases were recorded in Guinea in December 2013; later, the disease spread to neighboring Liberia



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

Severe acute respiratory syndrome coronavirus

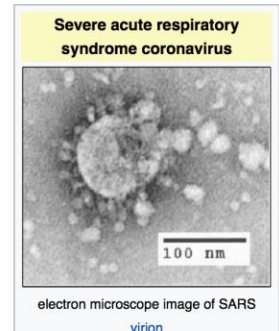
From Wikipedia, the free encyclopedia

This article is about the virus strain that causes SARS. For the strain that causes COVID-19, see Severe acute respiratory syndrome coronavirus 2. For the species to which both strains belong, see Severe acute respiratory syndrome-related coronavirus.

Severe acute respiratory syndrome

coronavirus (SARS-CoV) is the strain of virus that causes severe acute respiratory syndrome (SARS).^[2] It is an enveloped, positive-sense, single-stranded RNA virus which infects the epithelial cells within the lungs.^[3] The virus enters the host cell by binding to the ACE2 receptor.^[4] It infects humans, bats, and palm civets.^{[5][6]}

On April 16, 2003, following the outbreak of SARS in Asia and secondary cases elsewhere in the world, the World Health Organization (WHO) issued a press release stating that the coronavirus identified by a number of laboratories



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

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 skills
- 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 works 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 about working on 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 a number of 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

Know whom to call for additional support such as mental health, spiritual care or Employee Assistance Program resources. In the space below, write the contact information for the person or program in your facility that is responsible for providing mental health support for healthcare workers following disasters:

- 1.
- 2.
- 3.
- 4.

Listen, Protect, and Connect

Below are the three steps of "Psychological First Aid" that you

Building Your Responder Personal Resilience Plan™



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 their concerns/break points maybe
 - What they are doing/going to do to take care of themselves
 - When it is time for them to 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

1. Smith, E., Walker, T., & Burkle, F. M. (2019). Lessons in post-disaster self-care from 9/11 paramedics and emergency medical technicians. *Prehospital and disaster medicine*, 34(3), 335-339.
2. Caramello, V., Bertuzzi, L., Ricceri, F., Albert, U., Maina, G., Boccuzzi, A., ... & Schreiber, M. C. (2019). The Mass Casualty Incident in Turin, 2017: A Case Study of Disaster Responders' Mental Health in an Italian Level I Hospital. *Disaster medicine and public health preparedness*, 1-9.
3. Schreiber, M., Cates, D. S., Formanski, S., & King, M. (2019). Maximizing the Resilience of Healthcare Workers in Multi-hazard Events: Lessons from the 2014–2015 Ebola Response in Africa. *Military medicine*, 184(Supplement_1), 114-120.
4. McMahan, S. A., Ho, L. S., Brown, H., Miller, L., Ansumana, R., & Kennedy, C. E. (2016). Healthcare providers on the frontlines: a qualitative investigation of the social and emotional impact of delivering health services during Sierra Leone's Ebola epidemic. *Health Policy and Planning*, 31(9), 1232-1239.
5. Lin, C. Y., Peng, Y. C., Wu, Y. H., Chang, J., Chan, C. H., & Yang, D. Y. (2007). The psychological effect of severe acute respiratory syndrome on emergency department staff. *Emergency Medicine Journal*, 24(1), 12-17.
6. Nickell, L. A., Crighton, E. J., Tracy, C. S., Al-Enazy, H., Bolaji, Y., Hanjrah, S., ... & Upshur, R. E. (2004). Psychosocial effects of SARS on hospital staff: survey of a large tertiary care institution. *Cmaj*, 170(5), 793-798.
7. Maunder, R. (2004). The experience of the 2003 SARS outbreak as a traumatic stress among frontline healthcare workers in Toronto: lessons learned. *Philosophical Transactions of the Royal Society of London. Series B: Biological Sciences*, 359(1447), 1117-1125.
8. Wu, P., Liu, X., Fang, Y., Fan, B., Fuller, C. J., Guan, Z., ... & Litvak, I. J. (2008). Alcohol abuse/dependence symptoms among hospital employees exposed to a SARS outbreak. *Alcohol & Alcoholism*, 43(6), 706-712.
9. National Institute of Mental Health. (2002). Mental health and mass violence: Evidence-based early psychological intervention for victims/survivors of mass violence. A workshop to reach consensus on best practices.
10. Schreiber, M., Cates, D. S., Formanski, S., & King, M. (2019). Maximizing the Resilience of Healthcare Workers in Multi-hazard Events: Lessons from the 2014–2015 Ebola Response in Africa. *Military medicine*, 184(Supplement_1), 114-120.
11. Chan, A. O., & Huak, C. Y. (2004). Psychological impact of the 2003 severe acute respiratory syndrome outbreak on health care workers in a medium size regional general hospital in Singapore. *Occupational Medicine*, 54(3), 190-196.