

Worksheet 3.1

Trauma Responses

Read your assigned trauma response (on the following pages). Develop a short presentation, no longer than 5 minutes, to present to the larger group. Follow the directions below and develop the presentation around the fictional case study of a “survivor” who exhibits the symptoms of the disorder. Attempt to make the presentation somewhat interactive.

Appoint a scribe who can write legibly! This worksheet will be exchanged with another group later in the training.

Case Study Instructions Part 1

1. Very briefly, describe the circumstances of the homicide, the victim(s), and the survivor(s).
2. Describe how you first came into contact with the survivor(s), and their initial responses to the homicide.
3. Describe how the survivor(s) responses changed over the days/weeks/months following notification.
4. Describe when and how you first suspected that the survivor(s) was experiencing symptoms of your assigned trauma, and why. Describe what the survivor(s) was doing, and any triggers that might have caused a traumatic reaction.

Case Study Instructions Part 2 (to be completed in Module 8)

1. Very briefly, describe the actions you would like to take to assist the survivor.
2. Describe a problem, why it would be difficult for you to provide the services or referrals the survivor needs, or why the survivor would have trouble accessing them.

Case Study Instructions Part 3 (to be completed in Module 8)

1. In the narrative you have been given, explain what you would do to resolve the problem described in Part 2 (above).
2. Describe any additional resources or collaborative efforts that would be necessary.

1. Posttraumatic Stress Disorder (PTSD)

PTSD is an anxiety disorder recognized and defined by the DSM-V. Formal diagnostic criteria require that the symptoms last more than 1 month and cause significant impairment in social, occupational, or other important areas of functioning. If a survivor shows signs of PTSD, it is critical that he or she receive treatment as soon as possible. This disorder rarely resolves on its own.

PTSD can develop after exposure to a frightening or terrifying event or ordeal in which serious physical harm occurred or was threatened. Traumatic events that may trigger PTSD include violent personal assaults, natural or human-caused disasters, accidents, and military combat.

The National Institute of Mental Health estimates that over the average lifetime, 6.8 percent of adults in the U.S. will experience PTSD. Within any given year, approximately 3.5 percent of adults in the U.S. are affected. Of those, about 36 percent of cases are classified as severe. Many more survivors of homicide may not meet the full criteria of PTSD but suffer specific categories of PTSD (Zinzow, Rheingold, et al., *Journal of Traumatic Stress*, Volume 24, Issue 6, pages 743–746, December 2011). On the basis of this high rate, the researchers recommended that all survivors of homicide victims be screened for PTSD, especially those having contact with the criminal justice system. According to the DMS-IV, PTSD symptoms can be grouped into three categories, or clusters.

Re-experiencing	Avoidance	Hyperarousal
<ul style="list-style-type: none"> ▪ Flashbacks – reliving the trauma over and over, including physical symptoms like a racing heart or sweating ▪ Intrusive images of the traumatic event ▪ Bad dreams/nightmares (of the actual event or of fearful things in general) ▪ Frightening thoughts <p>Symptoms can be generated from the person’s own thoughts and feelings or from other reminders of the event, such as words, objects, or situations. Re-experiencing symptoms may impact a survivor’s everyday life.</p>	<ul style="list-style-type: none"> ▪ Avoiding thoughts, feelings, or conversations about the traumatic event ▪ Avoiding places, events, or objects that are reminders ▪ Feeling emotionally numb and detached from others ▪ Losing interest in activities that were once enjoyable ▪ Having difficulty remembering the event ▪ Having a sense of a foreshortened future <p>Any situation that recalls the traumatic event can trigger avoidance symptoms. For example, a homicide survivor may refuse to say the word “homicide” or avoid the hospital where the loved one died.</p>	<ul style="list-style-type: none"> ▪ Being easily startled ▪ Feeling tense or “on edge” ▪ Having difficulty sleeping ▪ Having angry outbursts ▪ Having difficulty concentrating <p>Hyperarousal symptoms usually are not triggered; rather, they are constant in the survivor’s life. Hyperarousal can make a survivor feel stressed and angry, which in turn makes it difficult to perform daily tasks such as sleeping, eating, or concentrating.</p>

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2. Traumatic Grief

Traumatic grief is an emotional response that is sometimes referred to as complicated grief. It also is identified by other names, such as prolonged grief, separation distress, unresolved grief, maladaptive bereavement, or complicated bereavement. The differences arise because there is no consensus on the terminology, and the disorder is not included in the DSM-V.

Traumatic grief encompasses a general set of symptoms that reflect an extended grief period that obsessively focuses on separation from the victim. Painful emotions are so long lasting and severe that individuals have trouble accepting the death and resuming their own lives (Mayo Clinic, 2003, Harvard Medical School Family Health Guide, 2006). About 20 percent of survivors are at high risk for developing traumatic grief (Rynearson, 2011).

Traumatic grief is very different from PTSD. Rather than re-experiencing or avoiding the event, or living in a constant state of fear, someone with traumatic grief longs to re-establish a psychological and physical connection with the deceased. Symptoms of both PTSD and traumatic grief reflect a survivor's fundamental effort to master the effects of both death and homicide. However, these two disorders are also at odds: traumatic grief pulls toward the loved one, PTSD pushes away the memory of the deceased (Rynearson, 2001). Interestingly, some people develop both disorders.

The most characteristic symptoms of traumatic grief are intrusive thoughts and images of the deceased person, a painful yearning for his or her presence, fantasies of reunion, or "searching" for the deceased (Rynearson, 2001). However, other symptoms may include:

- Numbness or detachment
- Preoccupation with one's own sorrow
- Bitterness about your loss
- Inability to enjoy life
- Difficulty accepting the loss
- Difficulty moving on with life
- Trouble carrying out normal routines
- Withdrawing from social activities
- Feeling that life holds no meaning or purpose
- Irritability or agitation
- Lack of trust in others.
- Feeling stunned, dazed or shocked

(Harvard Medical School Family Health Guide, 1999.)

In order to meet the criteria for this disorder, these symptoms are to persist for 6 months after the loss.

3. Major Depressive Disorder

Major depressive disorder (MDD) is characterized by an all-encompassing low mood accompanied by low self-esteem, and by loss of interest or pleasure in normally enjoyable activities. Other symptoms vary widely. For example, insomnia and weight loss are considered to be classic signs, even though many depressed patients gain weight and sleep excessively. Anxiety symptoms such as panic attacks, phobias, and obsessions also are not uncommon.

At some point in our lives, almost all of us become depressed for one reason or another. Survivors of homicide victims are certainly at risk for depression in the aftermath of the event (although it is possible to grieve without depression). For most survivors, the depressive state diminishes over time. For others, though, depression continues to disrupt everyday life. This may indicate MDD.

According to the DSM-V, indications of MDD include:

- Persistent sadness
- Markedly diminished interest or pleasure in all, or almost all activities
- Sleep disturbance
- Changes in appetite
- Tearfulness
- Irritability
- Psychomotor agitation or retardation (fewer movements)
- Fatigue or loss of energy
- Feelings of worthlessness
- Excessive guilt
- Difficulty concentrating
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

An individual with MDD may also have myriad physical symptoms such as fatigue, headaches, or digestive problems.

MDD is a disabling condition that adversely affects a person's family, work or school life, sleeping and eating habits, and general health.

One difference between depression and grief is that with grief the sadness and feelings of guilt are focused around the loss. With MDD, sadness is more universal across domains and excessive guilt relates to the person, and not the loss.

Worksheet 3.1, continued

4. Substance Abuse and Dependence

The two disorders in this category refer to either the abuse or dependence on a substance. A substance can be anything that is ingested in order to produce a high, alter one's senses, or otherwise affect functioning. According to the DSM-V, a diagnosis of substance abuse or dependence is based on clusters of behaviors and physiological effects occurring within a specific time frame. The diagnosis of dependence always takes precedence over that of abuse, e.g., a diagnosis of abuse is made only if DSM-V criteria for dependence have never been met.

The table below outlines the symptoms between the two disorders.

Substance Abuse <i>(One or more of the following occurrences in a 12-month period)</i>	Substance Dependence <i>(Three or more of the following occurrences in a 12-month period)</i>
<ul style="list-style-type: none"> ▪ Recurring substance use resulting in a failure to fulfill major role obligations at work, school, or home (such as repeated absences or poor work performance, suspensions from school, or child neglect). ▪ Recurring substance use in potentially hazardous situations, such as driving or operating machinery. ▪ Recurrent substance-related legal problems (such as arrests for substance-related disorderly conduct). ▪ Continued substance use despite having persistent or recurrent social or interpersonal problems caused by the effects of the substance (for example, physical fights and arguments with family about the substance abuse). 	<ul style="list-style-type: none"> ▪ Tolerance (increase in amount used, with marked decrease in effect). ▪ Characteristic withdrawal symptoms; substance taken to relieve withdrawal. ▪ Substance taken in larger amount and for longer period than intended. ▪ Persistent desire or repeated unsuccessful attempts to quit. ▪ Much time/activity to obtain, use, recover. ▪ Important social, occupational, or recreational activities given up or reduced. ▪ Use continues despite knowledge of adverse consequences (e.g., failure to fulfill role obligation, use when physically hazardous).

Many trauma survivors see substance abuse and dependence as means of self-medicating their psychological or physical pain. Unfortunately, substance abuse only worsens symptoms and can bring on additional problems such as:

- Anxiety and panic disorders
- Compulsive or uncontrollable behaviors
- Depression
- Chronic physical conditions such as diabetes and heart and liver disease
- Chronic pain
- Other addictions

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According to the National Comorbidity Study (1990-1992), 52 percent of people with PTSD also have been diagnosed with alcohol abuse or dependence (twice the rate in the normal adult population), and 35 percent with drug abuse or dependence (three times the rate in the normal adult population).