TTTCP Physiologic Response Protocol

Examples of Physiological Responses:

- PTSD symptoms (triggered flashbacks; feeling "crazy" or "unreal"; exaggerated startle response)
- Non-suicidal self-injury (NSSI) (e.g. picking at skin [with or without bleeding]; pulling hair; cutting/carving, burning, biting, scraping/scratching skin, hitting, interfering with wound healing)
- Panic/anxiety attacks (e.g. feeling "crazy"; feelings sweaty or chills; sense of impending doom or death; breathing difficulties; increased heart rate, blood pressure; other).
- Other physical symptoms (that may or may not be associated with panic/anxiety attacks): pain, headaches, stomach aches, diarrhea, tightness/burning in chest, muscle cramps, low back pain.

PROTOCOL

1. Validate. Validate. Validate. Anything a patient feels or thinks *IS OKAY.* Always. *This is imperative.* In order to create a safe place, it NEEDS to be okay to feel and think in whatever way(s) arise(s). (Notice the distinction from thoughts/feelings vs. action/'materialized' behavior).

***If there is physical or verbal evidence for non-suicidal self-injury (NSSI), follow entire protocol:**
***For all other physiological responses, follow protocol, but SKIP OPTION d.iv!**

a. *If* thoughts/feelings are about self-injury (or if they aren't), *validate* those thoughts/feelings are *normal* and *give choice*.

E.g. "I THINK you're telling me that you're thinking of, or feel like, hurting yourself. It's perfectly OKAY to have those thoughts and feelings. It's NORMAL to have those thoughts and feelings, but sometimes thoughts MAY BE just thoughts, and it doesn't NECESSARILY mean we have to listen to them or put them into actions."

Also, "Do you have any prescribed medications that may support or help you right now, that you may be able to take" (see #2).

b. Assess for active suicide, if necessary/indicated

The only way to assess for an actively suicidal patient is to ASK. Follow the Suicide Protocol if a patient has suicidal thoughts, ideation, or a plan.

c. VALIDATE those thoughts/feelings are NORMAL and GIVE CHOICE. Ask about any prescribed medications that are meant to support patient with these symptoms (e.g. alprazolam for panic attacks; propranolol); give the patient choice to take any medications (if on their person or if the clinic is able to prescribe on-site and a provider believes acute medication is indicated to be prescribed).
Also ask about any other coping skills the patient has (e.g. "worry rocks", essential oils, other items that the patient perceives as supportive*; keep in mind cultural and religious differences*).

d. Offer coping skills and resources:

d.i. **A safe, quiet (i.e. low-stimuli) room**

(Trauma Team staff can stay or not, based on patient's choice).

d.ii. **Breathing technique:**

Inhale for 4 seconds, exhale for 6 seconds (or a variation the patient is comfortable with e.g. 2/4, 6/8, etc.; goal of this technique is to exhale longer than the inhale).

1. IF longer breaths cause anxiety, STOP or CHANGE technique.
2. Holding breath = trauma. So:

   Do not e.g. inhale 4, *hold 2*, exhale 6.

3. Focus is on the exhale (because physiology).
4. Can focus on e.g. how breath feels in/out of nose (e.g. warm/cool); focus on how stomach feels when breathing (e.g. in/out); or other interoceptive or exteroceptive foci.

d.iii. **Exteroceptive grounding technique:**

What are 5 things you can see
What are 4 things you can touch
3 " " hear
2 " " smell
1 " " taste

d.iv. **Holding ice (for NSSI ONLY, as an alternative):**

Sometimes patients with trauma may still feel the need to physically injure themselves. This is largely reported as a coping skill to decrease negative emotions that may or may not be associated with trauma. To mediate otherwise very injurious behaviors (e.g. interfering with wound healing; cutting wrists) holding ice can cause the same type of physical discomfort or pain that is sought, without actually causing any acute or long-term medical problem or actual injury.

d.v. **A behavioral health provider can assist** with immediate coping strategies and skills, as well as set up a follow up appointment.

Transportation (if needed):

Always consult the clinic supervisor or attending physician first!

- If transport recommended by attending, then work to facilitate with appropriate teams.

Options:

Consult director first!

- Local transport to hospital
  - If patient requests, Trauma Team volunteer can ride with patient (second Trauma Team volunteer can leave to pick up first volunteer from the hospital later)
- Ambulance
  - If patient requests, Trauma Team volunteer can ride with patient (second Trauma Team volunteer can leave to pick up first volunteer from the hospital later)
- Police as last resort - call for no sirens; ONLY use this option if patient explicitly chooses this option.

Please keep in mind that Trauma Team advocates are different from counselors and have a focus on education and safety rather than on treating any emotional, mental, or behavioral issues. We also can't give advice or tell people what to do because we respect the patient's right to make choices that work best for them. However, we do have many resources available, if they choose! Allow patients to pick the ones that feel right to them (patient-directed care!