Department Name: Center for Health & Counseling (CHC)

Project (Assessment) Title: 2016-2017 Center for Health & Counseling - Counseling Services: Trauma Screening and Assessment

CHC Counseling Services will screen students who present for services for current symptoms of posttraumatic stress disorder with a brief screening instrument. The presence of trauma symptoms can interfere with students' optimal social and academic performance and may lead to dropout. Identification of symptoms can enhance treatment, which may result not only in improved mental health, but also improved retention, academic performance and social relationships.

Strategic Goals: Increase Student Completion
Achieve Equity in Student Participation / Completion

SLCC Strategic Priority:

Strategic Priority II – Improve Student Access and Success

Objective II D Improve student participation in advising, learning support and non-curricular activities that are related to student persistence.

Objective II E Improve student completion of desired educational goals: certificates, degrees, and successful transfer to four year colleges and universities.

Methodology (Plan/Timeline/Method):

<u>Importance of Screening and Assessment</u>

According to the 2014 publication *A Strategic Primer on College Student Mental Health*, "Mental health problems…can impair the quality and quantity of learning. They decrease students' intellectual and emotional flexibility, weaken their creativity, and undermine their interest in new knowledge, ideas, and experiences. Mental and behavioral health problems are also learning problems." This is particularly true of posttraumatic stress disorder, which can severely disrupt normal cognitive, emotional and interpersonal functioning.

While the most commonly used survey of college students' mental health, the annual *American College Health Association -National Collegiate Health Assessment* asks students about stress, anxiety and depression, there is no data gathered on the presence and impact of posttraumatic stress symptoms. However, these symptoms are common in the aftermath of a variety of traumas, including physical abuse/assault, sexual abuse/assault, emotional maltreatment, neglect, serious accident or illness, domestic violence, bullying, military experience, and natural disasters, among others. The few studies of college students that exist suggest around 67% to 84% have experienced a traumatic event, with 6% to 17% having a diagnosis of posttraumatic stress disorder (Read et al., 2015).

Although people can often identify if they are depressed or stressed, it is more difficult for people to identify if they are experiencing symptoms of trauma. They often do not make the connection between a past life event and their current life functioning. Thus, it is suggested in the Substance Abuse and

Mental Health Services Administration's 2014 publication *Trauma-Informed Care in Behavioral Health Settings*, that screenings for trauma-related symptoms should be universal. It is further noted that:

> "Exposure to trauma is common; in many surveys, more than half of respondents report a history of trauma. Furthermore, behavioral health problems…are more difficult to treat if trauma-related symptoms aren't detected and treated effectively.
>
> "Not addressing traumatic stress symptoms, trauma specific disorders, and other symptoms/disorders related to trauma can impede successful mental health treatment. Unrecognized, unaddressed trauma symptoms can lead to poor engagement in treatment, premature termination, greater risk for relapse of psychological symptoms or substance abuse, and worse outcomes.
>
> "Without screening, client's trauma histories and related symptoms often go undetected, leading providers to direct services toward symptoms and disorders that may only partially explain client presentations and distress. Universal screening for trauma history and trauma-related symptoms can help behavioral health practitioners identify individuals at risk of developing more pervasive and severe symptoms of traumatic stress." (p. 91)

Method

CHC Counseling services will implement a universal screening for PTSD during the Fall 2016 and Spring 2017 semesters. New students presenting for counseling will complete the Primary Care PTSD Screen (PC-PTSD) along with their other initial paperwork upon intake. The PC-PTSD is a brief, four yes/no question screening instrument tapping into some major symptoms of PTSD, which takes less than five minutes to complete (see Appendix A). Research has shown that the PC-PTSD has good diagnostic sensitivity, as it correlates highly with the much longer PTSD CheckList – Civilian Version (PCL-C) developed by the Veteran's Administration. A score of three or four "yes" responses on the PC-PTSD is considered positive for PTSD.

If a new client tests positive for PTSD on the PC-PTSD, they will be asked if they are interested in having a more definitive assessment for PTSD performed. If yes, they will then be administered the PTSD CheckList-5 (PCL-5) (this is an updated version of the PCL-C in accordance with the new DSM-5) along with a clinical interview to determine if they meet the full DSM-5 criteria for a PTSD diagnosis (see Appendix B). All clients who test positive on the PC-PTSD, regardless of whether they are interested in being further assessed for a PTSD diagnosis, will be asked whether they would like to address the traumatic experience they referred to in the screening as part of their counseling.

Thus, this needs assessment should generate several significant data points: 1) clients testing positive on the PTSD screening, 2) clients meeting full DSM-5 criteria for PTSD, and 3) clients wanting to address past trauma (with or without a diagnosis of PTSD) as part of their counseling process. Results of the PC-PTSD screening, assessment for PTSD with the PCL-5, and whether the client was interested in addressing trauma during counseling will be documented in each client's chart in the EHR.

Results / Findings:

A total of 340 clients presented for an intake during Fall 2016 and Spring 2017 semesters, with 90% of these clients completing the PC-PTSD screening. This resulted in 306 total screenings, including 104

males (34%) and 202 females (66%). About twice as many females as males presented for counseling, and this is consistent with the literature indicating females are more likely to seek counseling than males. These and other data from the needs assessment are summarized below in Table 1.

Table 1. PTSD Screening, Assessment and Diagnostic Data for Fall 2016 / Spring 2017

	Males	Females	Total
Screened:	104 (34%)	202 (66%)	306 (100%)
Positive Screen:	31 (30%)	89 (44%)	120 (39%) [1]
--Assessed for PTSD	21 (68%)	69 (78%)	90 (75%) [2]
--PTSD Criteria Met	15 (48%)	59 (66%)	74 (62%) [2]
PTSD Criteria Met:	15 (14%)	59 (29%)	74 (24%) [1]
Estimated Dx Range:	14%-19%	29%-36%	24%-30% [1]
Trauma Counseling:	23 (22%)	74 (37%)	97 (32%) [1]

[1]percentage of those Screened; [2]percentage of those with a Positive Screen

Out of the total number of clients screened, a significant number (39%) screened positive for possible PTSD. Positive screenings were higher for females (44%) than males (30%). Of clients with positive screens, the large majority (75%) were willing to be assessed for possible PTSD. There was some concern prior to the study that clients with a positive screen might be intimidated and reluctant to be further assessed. This proved not to be the case, with 78% of females and 68% of males with positive screens agreeing to further assessment.

Of those undergoing further assessment, significantly more than half, or 62%, were able to be definitively identified as meeting criteria for a diagnosis of PTSD. This high rate indicates that use of a screening instrument is a good return on investment. The rate of diagnosis was higher for females (66%) than males (48%). A small percentage of these clients came to counseling having previously been diagnosed with PTSD, that being the case with about 13% of males and 14% of females (data not included in Table 1.).

To get a broader picture of the number of clients coming to counseling with PTSD, we can look at the number of clients diagnosed with PTSD out of the total screened. This data indicates that 24%, or almost a quarter, of all clients were identified as meeting the diagnosis for PTSD. The percentage is about twice as high for women (29%) as for men (14%). These figures represent the lower end of the range of clients presenting with PTSD, as approximately 25% of clients with positive screens declined to be further assessed. If we include the number of clients who might have met criteria for PTSD but did not want to be further assessed (based on percentage of those who had a positive screen and were further assessed), then the possible range of clients presenting for counseling who may have PTSD is about 24% - 30%. And again, the rate is about twice as high for females (29% - 36%) as for males (14% - 19%).

Finally, regardless of whether they tested positive or negative on the PC-PTSD screening instrument, clients were asked, as a result of the screen, if they would be interested in exploring past trauma at some point as part of their counseling, whether that trauma met criteria for PTSD or not. About a third of clients screened (32%) indicated they would, with the results slightly higher for females (37%) than males (22%).

The significant findings from these results can be generalized and summarized as follows:

- Almost 40% of clients presenting for counseling screen positive for significant symptoms of PTSD
- Three quarters (75%) of clients with positive screens are willing to be further assessed
- Close to two thirds (62%) of clients with positive screens meet criteria for PTSD
- At least a quarter (24)% of all clients presenting for counseling meet criteria for PTSD
- Rates for diagnosed PTSD are about twice as high for women (29%) as for men (14%)
- A third of all clients (32%) are concerned about past trauma, whether they have PTSD or not

Actions Taken (Use of Results/Improvements):

The use of trauma screening during this needs assessment resulted in no identifiable negative consequences to clients. And, the addition of the PC-PTSD to the paperwork clients already complete upon intake contributed minimally to that burden, both in terms of time and effort. Conversely, given the clinical results of using the instrument noted above (e.g. significant percentage of positive screens, significant percentage of positive screens diagnosed with PTSD, and significant number of clients prompted to address trauma due to the screen), continued use of the instrument to screen new clients for potential trauma and PTSD is strongly indicated. As a result, the PC-PTSD will continue to be included in initial paperwork, with our clinicians choosing to utilize it in the manner best suited to their clients' assessment and treatment needs.

The substantial number of clients diagnosed with PTSD during this needs assessment (a quarter of clients presenting for services) highlights the need for ongoing staff training in the latest advances in conceptualization and treatment for PTSD. For example, Eye Movement Desensitization and Reprocessing (EMDR) is emerging as an effective treatment for clients who cannot take full advantage of the verbal processing required during counseling, as well as for those having suffered an acute traumatic event. Another new therapy showing promise in treating clients with PTSD, which is designed to be brief (so applicable to the college population) and which draws on principles of EMDR, is Accelerated Resolution Therapy (ART).

All the counselors have expressed an interest in receiving EMDR training. However, the cost is somewhat prohibitive (between $1000-$2000 for certification), so to date, none of the counselors have been trained. Exploration of funding sources to provide counselors with this training is something that would merit further exploration and consideration. Additionally, the acquisition of books and/or treatment manuals detailing effective intervention approaches to PTSD (e.g. Briere's *Principles of Trauma Therapy* (2014), etc.) to supplement our in-house resource library would also be in order.

The results of this study can also be used to supplement data we have from our recent American College Health Association-National College Health Assessment II survey of SLCC students to help educate the College about student mental health issues on our campus. It would be beneficial for students to know that a quarter of all students seeking counseling at the CHC have diagnosable PTSD, and that our counselors have experience and training in helping students with this issue.

Finally, the data generated from this assessment seem interesting and valuable enough to share with other professionals working with students in college counseling and health. With this purpose in mind, we will submit the results for a poster presentation at the upcoming Utah University and College

Counseling Centers (UUCCC) conference in November of this year. We will also consider presenting the results, either in a poster presentation or 60-miniute program, at the upcoming American College Health Association (ACHA) in May 2018, to be held in Washington, D.C.

Acknowledgments

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Appendix A

In order to assess and improve our services this 2016-2017 academic year, we are having all new counseling clients complete the following brief screening (the Primary Care PTSD Screen), which should take no more than a couple minutes. During your first counseling meeting, your counselor will review this form with you. Thank you!

Primary Care PTSD Screen

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, **in the past month**, you…

1. Have had nightmares about it or thought about it when you did not want to?

   YES NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

   YES NO

3. Were constantly on guard, watchful, or easily startled?

   YES NO

4. Felt numb or detached from others, activities, or your surroundings?

   YES NO

Appendix B

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	**Not at all**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4

19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4