North Sound Mental Health Administration
Regional Training Committee
Training Module

Post-Traumatic Stress Disorder

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Training Objectives:

After completing this module, you will be able to:

1. Define Post-Traumatic Stress Disorder (PTSD)
2. List the effects of traumatic experiences
3. List the types of traumas that can lead to PTSD
4. List co-occurring disorders and health problems that often accompany PTSD
5. List indicators in a client's history that would lead to investigating the possibility of PTSD
6. List the diagnostic, clinical criteria for PTSD
7. Describe treatment options for people with PTSD
8. Describe the qualities for effective treatment of PTSD

1. *Effects of Traumatic Experiences*

As a society, we value and teach the importance of self-reliance, inner strength, and the ability to overcome adversity. In fact, it is common for people to feel that no matter what they've faced or lived with, no matter how extreme the ordeal, they should be able to carry on.

But regardless of how competent people may be, personally or professionally, sometimes they face trauma of such magnitude that they become unable to cope and function in their daily lives. Some people become so distressed by memories of trauma – memories of trauma that won't go away – that they begin to live their lives trying to avoid any reminders of what happened to them.

When people find themselves suddenly in danger, sometimes they are overcome with feelings of fear, helplessness, or horror. These events are called *traumatic experiences*. Some common traumatic experiences include being physically attacked, being in a serious accident, being in combat, being sexually assaulted, being in a fire or natural disaster like a hurricane or a tornado, and being abused as a child.

After traumatic experiences, people may have problems they did not have before the event. If these problems are severe and the trauma survivor does not get help for them, they can begin to cause problems in the survivor's daily functioning and in their relationships, particular within their family. The extreme effects of trauma cause a *psychiatric injury*, not a mental illness or personality disorder.

2. *What is Post-Traumatic Stress Disorder?*

Post-traumatic Stress Disorder, or PTSD, is marked by *emotional, biological,* and *psychological* symptoms. It is a complex psychiatric disorder that can occur after a person experiences extreme trauma. PTSD sufferers often feel alone and isolated by their experience and tend to disconnect from others, and in a sense, from their own lives. Clusters of symptoms may or may not appear for months—or even years—following the traumatic experience. Often symptoms can be dramatic, with the individual reliving the traumatic experience through nightmares and flashbacks. Symptoms can also appear more subtle—difficulty sleeping, excessive feelings of anger, irritability, lack of concentration, avoiding reminders of the trauma, harming themselves, loss of appetite, feeling depressed and lacking interest in their lives. However, any of these symptoms may cause a significant impairment to the person's daily life---inability to function in social or family life, job/work instability, marital problems and divorces, family discord and difficulties in parenting.

Physical complaints, any or all which may be accompanied by depression can include:

- chronic pain with no medical basis (frequently gynecological in women)
- stress-related conditions such as chronic fatigue syndrome or fibromyalgia
- stomach pain or other digestive problems
- eating disorders
- breathing problems or asthma

- headaches
- muscle cramps or aches such as low back pain
- cardiovascular problems
- sleep disorders.

PTSD is often complicated by the fact that it frequently occurs in conjunction with related disorders such as depression, substance abuse, problems of memory and cognition, and other problems of physical and mental health.

3. Background of PTSD

Though the American Psychiatric Association formally recognized PTSD in 1980, PTSD is not a new disorder. The concept of trauma-related emotional disturbance has existed for over a century, having names such as “shell shock,” “war neurosis,” and “rape trauma syndrome.” There are written accounts of similar symptoms that go back to ancient times, and there is clear documentation in the historical medical literature starting with the Civil War, when a PTSD-like disorder was known as “Da Costa’s Syndrome.” There are particularly good descriptions of post-traumatic stress symptoms in the medical literature on combat veterans of World War II, and on Holocaust survivors.

Careful research and documentation of PTSD began in earnest after the Vietnam War. The National Vietnam Veterans Readjustment Study estimated in 1988 that the prevalence of PTSD in that group was 15.2% at that time and that 30% had experienced the disorder at some point since returning from Vietnam.

PTSD has no boundaries. While responses may differ from culture to culture, it can affect anyone, regardless of age, gender, race, ethnicity and socio-economic background. It is important to consider any cultural influences that are part of a person’s background or life. “Cultural” factors may include ethnicity, religious/spiritual beliefs, or social identities, among others, and these factors can affect the way the individual perceives and deals with trauma. Inquiries about these influences can be made during initial treatment sessions as well as on an ongoing basis, so that the clinician’s cultural competence is increased and treatment is more effective. Showing a willingness to learn about the cultural factors present in a person’s life builds trust and enhances the therapeutic relationship.

4. How common is PTSD?

An estimated 7.8 percent of Americans will experience PTSD at some point in their lives, with women (10.4%) twice as likely as men (5%) to develop PTSD. About 3.6% of US adults, aged 18-54 (5.2 million people) have PTSD during the course of a given year. This represents a small portion of those who have experienced at least one traumatic event. It is estimated that 70% of adults in this country have experienced a traumatic event at least once in their lives and that up to 20% of these people go on to develop PTSD. Furthermore, the National Center for PTSD estimates that up to 43% of both boys and girls experience a traumatic event at least once in their lifetime. Of those children, up to 15% of girls and 6% of boys could meet clinical criteria for PTSD.

The traumatic events most often associated with PTSD for men are: rape, combat exposure, childhood neglect, childhood physical abuse. The most traumatic events for women are: rape, sexual molestation, physical attack, being threatened with a weapon, and childhood physical abuse. The traumatic events most often associated with PTSD in children/adolescents are: exposure to violent crimes including domestic violence to or murder of a parent, school shootings, motor vehicle accidents, exposure to community violence, peer suicide, physical and sexual abuse, natural or man made disasters (including terrorism and war).

It is important to know that not everyone who experiences a traumatic event is likely to develop PTSD. It is also important to understand that responses to trauma vary widely. Some people will have few problems, and the problems they do have will resolve themselves without treatment.

5. Who is most likely to develop PTSD?

- Victims of physical and sexual assault face the greatest risk of developing PTSD.
- Those who experience a greater degree and intensity of a stressor, unpredictability, uncontrollability, sexual (as opposed to nonsexual) victimization, real or perceived responsibility, and betrayal;
- Those with prior vulnerability factors such as: genetics, early age of onset and longer-lasting childhood trauma, lack of functional social support, and concurrent stressful life events;
- Those who report greater perceived threat of danger, suffering, upset, terror, and horror or fear;
- Those with a social environment that produces shame, guilt, stigmatization, or self-hatred.
- Women and girls are about twice as likely as men and boys to develop PTSD.

6. What are the diagnostic criteria for PTSD?

The Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV-TR, lists the criteria for PTSD. In addition to the criteria listed in the DSM-IV-TR, a person might experience symptoms of despair, hopelessness, anxiety or fear, or feeling in danger again. They might experience anger or aggressive feelings and feel the need to defend themselves.

In children, symptoms and behaviors associated with PTSD might *also* include distressing dreams or nightmares and somatic complaints such as stomachaches and headaches. Young children may also engage in repetitive play where they reenact and thus relive the trauma in their play. For example, a young child who has been exposed to violent crimes or domestic violence might reenact the violence by breaking toys, having dolls or action figures “fight” or “kill” each other or, reporting a fear that monsters are going to hurt them. Parents, caregivers, teachers and other adults are a valuable resource in evaluating changes in a child’s behavior, as the child may not be able to self-report or articulate their symptoms.

If an individual meets the diagnostic criteria for PTSD, it is likely that he or she will meet DSM-IV-TR criteria for one or more additional diagnoses. These disorders include: Generalized Anxiety Disorder, Major Depressive Disorder, alcohol or substance abuse disorders, or personality disorders. In addition to the DSM-IV-TR, the North Sound Mental Health Administration (NSMHA) has developed Clinical Guidelines for PTSD**,** which is used by all provider agencies in the region. Please see Appendix A for these guidelines.

It is important to note that people can also have physical reminders and/or reactions to the trauma. They might have experienced a head injury, burns or other physical injury as a result of the trauma. They may also feel shaky and sweaty, have a pounding heart, and have trouble breathing, loss of appetite, frequent headaches or other unexplained symptoms.

7. How is PTSD assessed?

Since 1980, there has been a great deal of attention devoted to the development of instruments for assessing PTSD. There are reliable and valid tools available for assessing both the psychometric and psychophysiological aspects of PTSD. It can be difficult to know whether distress is a normal reaction or a symptom of something more serious. PTSD is only one of many possible reactions to a traumatic experience. Responses to trauma can range from anxiety and depression, to experiencing profound effects of the trauma lasting for several months or even many years, indicating PTSD.

Accurate assessment is critical for effective treatment. NSMHA formed a Trauma Committee that was in effect from March – October 2004, with a mission to study trauma and examine best practice in an effort to enhance the trauma services provided in the North Sound region. A screening tool was developed by the task force and is included in Appendix B.

Diagnosing PTSD in an office visit can be challenging. The diagnosis is frequently missed because clients may present with symptoms that might not clearly relate to past trauma. In addition, the client might not typically volunteer information about the traumatic event. Although directing questions is necessary, making the diagnosis requires more than checking off a list of symptoms. It often requires a nonjudgmental approach and expressions of empathy and interest. Gently probing for symptoms facilitates the rapport clients need to be more forthcoming about their distress.

To ensure that the diagnosis is not missed, it is advisable to include a brief trauma history in evaluations for anxiety or depression. Traumatic events of adulthood can be asked about directly, for example, "Have you ever been physically attacked or assaulted? Have you ever been in a severe accident? Have you ever been in a war or disaster?" A positive response then alerts the examiner to inquire further about the relationship between the event and the current symptoms. Traumatic childhood experiences require reassuring statements of normality to put the client at ease, for example, "Many people continue to think about frightening aspects of their childhood. Do you?" There are resources available that provide numerous examples of sensitive, respectful questions that can be used in a dialogue with a client when investigating the possibility of PTSD.

The nature of an evaluation for PTSD can vary widely, depending on how the evaluation will be used and the training of the professional evaluator. Various survey-type tools have been developed that can either be administered by a clinician or can be completed by the client, according to their comfort level in disclosing and discussing any trauma they have experienced. An interviewer may take as little as 15 minutes to get a sense of a client's traumatic experience and the effect it has on their life to determine whether treatment for PTSD is called for. On the other hand, a specialized PTSD assessment can take eight or more 1-hour sessions when the information is needed for legal or disability claims. In all cases, diagnosis depends on the client's disclosure of their experience of trauma, the symptoms they are experiencing and how they are impacting their life.

Although there has been much research about PTSD, there has also been a lot of criticism from the perspective of cross-cultural psychology and medical anthropology, especially with respect to refugees, asylum seekers, and political torture victims from non-Western regions. Clinicians and researchers working with such survivors argue that since PTSD has usually been diagnosed by clinicians from Western industrialized nations working with patients from a similar background, the diagnosis does not accurately reflect the clinical picture of traumatized individuals from non-Western traditional societies and cultures. Researchers have only recently begun to delineate possible differences between Western and non-Western societies regarding the psychological impact of traumatic exposure and the clinical manifestations of such exposure.

When diagnosing PTSD, it is additionally important to consider differential diagnosis. According to the DSM-IV-TR, with Posttraumatic Stress Disorder, "the stressor must be of an extreme nature." Other possible diagnosis must also be considered such as Adjustment Disorder where the stressor and the response to the stressor can be of any severity. The DSM-IV-TR also recommends consideration of differential diagnosis of Acute Stress Disorder, Obsessive-Compulsive Disorder and Malingering. Along with differential diagnosis, assessment for PTSD should also include assessment for co-morbid substance abuse or dependence, which should be addressed if identified. A large body of information exists about Complex PTSD, another form of PTSD, although it is not currently a diagnosis listed in the DSM-IV-TR. More information about Complex PTSD can be found in Appendix C of this module.

8. How is PTSD treated?

Once a PTSD diagnosis has been established, there are three key aspects to treatment: patient education, pharmacology, and psychotherapy. Nearly every patient can benefit from education, which is started at the time of diagnosis. Families may also welcome education about PTSD, so that they are better able to cope with the situation and provide needed support to the individual.

There is no definitive treatment, and no cure for PTSD, but some treatments appear to be quite promising, especially cognitive-behavioral therapy (CBT), Dialectical Behavior Therapy (DBT), group therapy, exposure therapy and Eye Movement Desensitization and Reprocessing (EMDR). Effective therapy usually involves helping the survivor maintain safety, managing symptoms, working through the traumatic experience, and focusing on rebuilding the ability to trust others in order to view the world as a tolerable place to function.

In addition, the NSMHA Medical Director suggests that treatment should be trauma focused because supportive psychotherapy alone is not typically sufficient. The type of therapy used with children should be based upon their developmental age. Trauma-focused play therapy is one type of therapy that can be helpful with children. Exposure therapy involves having the client repeatedly relive the frightening experience under controlled conditions to help her or him work through the trauma.

EMDR is a relatively new treatment for traumatic memories that involves elements of exposure therapy and CBT combined with techniques (eye movements, hand taps, sounds) that create an alternation of attention back and forth across the person's midline. While the theory and research are still evolving for this form of treatment, evidence suggests that it is the exposure and cognitive components of EMDR that make it effective, rather than the attentional alternation.

Studies have also shown that medications help ease associated symptoms of depression and anxiety and help with sleep. The most widely used drug treatments for PTSD are the selective serotonin reuptake inhibitors, such as Prozac and Zoloft. At present, cognitive-behavioral therapy appears to be somewhat more effective than drug therapy, although drug trials for PTSD are at a very early stage. Drug therapy appears to be highly effective for some individuals and is helpful for many more. Medications and cognitive-behavioral therapy have been shown to alleviate the three clusters of PTSD symptoms: re-experiencing, avoidance and hypervigilance.

There is a wealth of information and research being conducted about PTSD, since it is such a prevalent, pervasive, and important disorder. Most communities offer support groups for survivors of trauma and their family members. The availability of information and support is promising for the recovery of individuals with PTSD.

9. Creating an effective treatment environment for people with PTSD.

The first steps in treating PTSD require skill and sensitivity—recognizing the problem and offering appropriate guidance and support. There are many reasons why this may be challenging:

- A person who has experienced an extremely traumatic event may hope or even expect to be able to “handle it” or “get over it” on their own.
- Sometimes victims feel guilty about what happened and may mistakenly believe that they were to blame or deserved the pain and hurt. Sometimes the experience may be too personal, painful, or embarrassing to discuss.

- One of the hallmark symptoms is the avoidance of thinking or talking about anything related to the trauma, especially as survivors try to restore activities in their daily lives.
- Some trauma survivors have learned from experience that the world is a dangerous place where trust has little meaning. PTSD tends to foster isolation, making it difficult for some to reach out for help.
- People with PTSD don't always make the connection between the traumatic event and the emotional emptiness, anger and anxiety and sometimes physical symptoms they unexpectedly find themselves feeling months, even years, after the trauma.
- In domestic violence situations, victims may not realize that their prolonged, constant exposure to abuse puts them at risk for PTSD.
- Often people don't know that treatment is available or where to turn for help.

It is vital to break through the isolation and silence. Professionals treating individuals with PTSD can increase their effectiveness by keeping the following factors in mind during the course of treatment:

- Learn to recognize and assess the signs of PTSD from what may seem to be unrelated symptoms.
- Develop a communications approach that enables you to assess a client for a history of trauma in a respectful, non-threatening way.
- Establish a level of trust that encourages a client to open up to you within what may be a limited amount of time for interaction.
- Know how to access available resources in your area so that you can effectively refer clients in need.
- Support the continuum of diagnosis and treatment beyond the parameters of your professional involvement and responsibility.

In working with individuals with PTSD, follow the **RICH** model:

- ✓ **RESPECT** the client as a person. Respect their experience, reserve judgment, provide assurance of confidentiality, and offer yourself as a professional worthy of their trust.
- ✓ **INFORMATION** – provide appropriate resources and referrals and encourage the individual and their family members to seek help.
- ✓ **CONNECTION** – be supportive and try to connect with the person even if the exchange is brief. Help them understand that you care and are concerned for their personal well-being.
- ✓ **HOPE** – offer hope for healing and recovery. Let them know that with appropriate diagnosis, treatment is available. Help them take the next step in seeking help.

Post-Traumatic Stress Disorder
POST-TEST

Please Print.
Name: ______________________________ ____________________________________
First Last

Program: Mailstop

1. A person who has been physically assaulted may experience which of the following?

   - ☐ horror
   - ☐ helplessness
   - ☐ detachment
   - ☐ insomnia
   - ☐ All of the Above

2. Sometimes, PTSD manifests years after the traumatic event.

   - ☐ True
   - ☐ False

3. Symptoms of what is now recognized as PTSD have been reported since the Civil War.

   - ☐ True
   - ☐ False

4. There is a higher incidence of PTSD among men.

   - ☐ True
   - ☐ False

5. Who is most likely to develop PTSD?

   - ☐ People who are poor
   - ☐ Those who report greater perceived threat of danger, suffering, upset, terror, horror, or fear.
   - ☐ People who are depressed
   - ☐ People have anxiety attacks and have trouble breathing

6. PTSD is commonly treated by:

   - ☐ Education
   - ☐ Exposure therapy
   - ☐ Cognitive-behavioral therapy and drug therapy
   - ☐ All of the above

7. People who survived a natural or man-made disaster are at increased risk for developing PTSD.

   - ☐ True
   - ☐ False

8. PTSD occurs across age groups, gender, cultural groups and socio-economic classes.

   - ☐ True
   - ☐ False

9. Why is it difficult to diagnose PTSD?

   - ☐ Clients might not voluntarily disclose information about trauma
   - ☐ Diagnosing PTSD involves more than just checking off a set of symptoms
   - ☐ A client might initially be seen due to a complaint of depression
   - ☐ All of the above
   - ☐ None of the above

10. PTSD is marked by emotional, biological and psychological symptoms.

   - ☐ True
   - ☐ False

1 point per question; 10 points available; 80% or 8 points = pass.

Name ________________________________ Mailstop ______________

PLEASE NOTE: This section will not be scored, but will be reviewed by your supervisor.

A. What are the implications of the information in this module to your clinical work?

B. What types of treatment for PTSD are available at your agency, and how do consumers access this treatment?

RESOURCES FOR INFORMATION ABOUT PTSD

General resources:

1. Sidran Traumatic Stress Foundation
   200 E. Joppa Road, Suite 207
   Baltimore, MD 21286
   Phone: (410) 825-8888
   www.sidran.org

   The Sidran Institute is considered to be a leader in traumatic stress education and advocacy. It is a nationally-focused nonprofit organization devoted to helping people who have experienced traumatic life events.

2. National Alliance for Mental Illness (NAMI)

   Colonial Place Three
   2107 Wilson Blvd., Suite 300
   Arlington, VA 22201-3042

   Main: (703) 524-7600
   Fax: (703) 524-9094
   TDD: (703) 516-7227
   Member Services: (800) 950-NAMI

   www.nami.org - NAMI website with information on advocacy for those with mental illness, including affiliates who provide family support groups in different states.

3. Anxiety Disorders Association of America
   11900 Parklawn Drive, Suite 100
   Rockville, MD 20852
   Phone: (301) 231-9350
   www.adaa.org

4. National Center for Victims of Crime's toll-free information and referral service. This is a comprehensive database of more than 6,700 community service agencies throughout the country that directly support victims of crime.
   1-800-FYI-CALL
   www.ncvc.org

5. PTSD Alliance Resource Center
   (877) 507-PTSD
   http://www.ptsdalliance.org

6. National Center for PTSD
   http://www.ncptsd.va.gov

7. The International Society for Traumatic Stress Studies
60 Revere Drive, Suite 500
Northbrook, IL 60062
Phone: (847) 480-9028
www.istss.org

8. MH Sanctuary
PO Box 10563
Yakima, WA 98909
http://www.mhsanctuary.com/ptsd/index.htm

9. http://www.ptsdinfo.org/ - this website is the gateway to four non-profit organizations that provided resources and support for PTSD.

10. National Institute of Mental Health

National Institute of Mental Health (NIMH)
Public Information and Communications Branch
6001 Executive Boulevard, Room 8184, MSC 9663
Bethesda, MD 20892-9663

301-443-4513 (local)
1-866-615-6464 (toll-free)
301-443-8431 (TTY)
1-866-415-8051 (TTY toll-free)

301-443-4279 (fax)

http://www.nimh.nih.gov

E-mail address:
nimhinfo@nih.gov

11. http://www.bullyonline.org – This website contains outstanding information about Complex PTSD and PTSD

Resources for Veterans:

1. VA Health Benefits Service Center toll free at 1-877-222-VETS!

2. Vietnam Veterans of America (VVA) - Comprehensive information for veterans, including how to file a disability claim (due to PTSD) with the VA.

   8605 Cameron Street, Suite 400
   Silver Spring, MD. 20910.
   (301) 585-4000 (telephone); (301) 585-0519 (fax); veteransbenefits@vva.org (e-mail).
   http://www.vva.org/benefits/ptsd.htm

3. http://www.lexisnexis.com/veterans/offer/ - comprehensive information for veterans

4. http://www.ptsdsupport.net/ -resources primarily for military personnel and veterans

Resources Children and Adolescents:

1. National Center for Child Traumatic Stress (NCCTS)
   NCCTS - University of California, Los Angeles
   11150 W. Olympic Blvd., Suite 650
   Los Angeles, CA 90064
   Phone: (310) 235-2633
   Fax: (310) 235-2612
   http://www.nctsnet.org

   NCCTS - Duke University
   905 W. Main St; Suite 24-E, Box 50
   Durham, NC 27701
   Phone: (919) 682-1552
   Fax: (919) 667-2350

   National Resource Center for Child Traumatic Stress - Duke University
   905 W. Main St.
   Suite 23-D
   Durham, NC 27701
   Phone: (919) 682-1552
   Fax: (919) 667-9578

2. Program Office of the National Child Traumatic Stress Initiative
   Center for Mental Health Services
   Substance Abuse and Mental Health Services Administration
   Department of Health and Human Services
   1 Choke Cherry Road
   Room 6-1105
   Rockville, MD 20857
   Phone: (240) 276-1856

Books:
The PTSD Workbook: simple, Effective Techniques for Overcoming Traumatic Stress Symptoms, by Mary Beth Williams

Trauma and Recovery: The Aftermath of Violence—from Domestic Abuse to Political Terror, by Judith Herman

Seeking Safety: A Treatment Manual for PTSD and Substance Abuse, by Lisa M. Najavits

Too Scared to Cry: Psychic Trauma in Childhood, by Lenore Terr

Optional Appendices

Appendix A

North Sound Mental Health Administration

Clinical Guidelines – Post-Traumatic Stress Disorder

Posttraumatic Stress Disorder DSM-IV-TR codes 309.1, 308.3)	
Diagnostic Features	**Consistent with DSM IV –TR criteria. In cases where the client is not benefiting from treatment the diagnosis will be reassessed.**
Assessment Components and Considerations	**1. Post Traumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate.** **Criterion A) The person's response to the event must involve intense fear, helplessness, or horror.** **Criterion A-2) The characteristic symptoms resulting from the exposure to the extreme trauma include persistent re-experiencing of the traumatic event.** **Criterion B) Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness.** **Criterion C) Persistent symptoms of increased arousal** **Criterion D) The full picture must be present for more than 1 month** **Criterion E) Disturbance must cause clinically significant distress or impairment in social, occupation, or other important areas of functioning** **Criterion F) Traumatic events that are experienced directly include, but are not limited to, military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in concentration camp, natural or manmade disasters, severe auto accidents, or being diagnosed with a life-threatening illness. Multi-generational trauma among both mainstream and minority cultures also needs to be assessed and considered.**
Treatment Guidelines	**1. Initial and periodic psychiatric screening to determine need for consultation, evaluation and/or medications.** **2. Treatment plan includes interventions consistent with the level of risk for self-harm.** **3. Acute PTSD will require active treatment during this acute phase of PTSD may help to reduce the otherwise high risk of developing chronic PTSD.** **4. Chronic PTSD Long-term symptoms may need longer and more aggressive treatment and are likely to be associated with a higher incidence of comorbid disorders.** **a. The most Common Co-morbid Disorders in a Patient with PTSD:** **i. Substance abuse or dependence** **ii. Major depressive disorder** **iii. Panic disorder/agoraphobia** **iv. Generalized anxiety disorder** **v. Obsessive-Compulsive Disorder** **vi. Social Phobia** **vii. Bipolar Disorder** **viii. Personality Disorders, especially Borderline** **5. Patients presenting with the co-morbid disorders of major depression, bipolar disorder, panic disorder, social phobia, obsessive-compulsive disorder, psychotherapy should be combined with medication from the start of therapy.** **6. Patients presenting with co-morbid substance abuse, treatment or both substance abuse and PTSD should be provided simultaneously. Serous**

	consideration should also be given to postponing treatment for PTSD until substance abuse problems have been treated first. 7. Medication visits should occur as often as clinically indicated and medically necessary for the duration of treatment. 8. Case management services may be helpful for coordination and family support and advocacy. 9. Brief Descriptions of the Most Recommended Psychotherapy techniques i. Relaxation training ii. Breathing retraining iii. Positive thinking and self-talk iv. Assertiveness training v. Anxiety management vi. Thought stopping vii. Cognitive therapy viii. Exposure therapy ix. Imaginal exposure x. In vivo exposure xi. Psychoeducation 10. Individual and/or group psychotherapy can be provided to promote mood stabilization and provide skill building and support. 11. Education about the illness, incidence and treatment options are important. Family members and significant others may be included in this process whenever appropriate and possible. 12. Varied employment strategies including prevocational and supported employment to assist clients ready to pursue employment. 13. Co-occurring disorder treatment as indicated. 14. Crisis planning focusing on early signs of decompensation, safety and management strategies. 15. Because of the chronic nature of the disorder, treatment may be long term. Relapse prevention should be included in treatment planning. 16. Residential Treatment/Housing/Crisis beds for those requiring 24 hour care or access to appropriate community-based housing. 17. Inpatient services for acute stabilization as necessary.
Optimal Outcome of Treatment	**The client will attain symptom relief, learn skills to prevent or manage future episodes and improve functioning in daily life.**
References	**DSM IV-TR** **The Expert Consensus Guideline Series Treatment of Post-Traumatic Stress Disorder, Consultation with Edna Foa, Ph.D., Jonathan R.T. Davidson, MD, Allen Frances, M.D., Ruth Ross, M. A. Journal of Clinical Psychiatry** **VA/DoD Practice Guideline for Management of PTSD and Acute Stress Reaction Module**

Appendix B

Post-Traumatic Stress Disorder Screening Tool

Trauma Screening Tool

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

		Not at all	A little bit	Moderately	Quite a bit	Extremely
1.	Repeated disturbing memories, thoughts or images of a stressful experience from the past?	1	2	3	4	5
2.	Repeated, disturbing dreams of a stressful experience from the past?	1	2	3	4	5
3.	Suddenly acting or feeling as if a stressful experience from the past were happening again (as if you were reliving it)?	1	2	3	4	5
4.	Feeling very upset when something reminded you of a stressful experience from the past?	1	2	3	4	5
5.	Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past?	1	2	3	4	5
6.	Avoiding thinking about or talking about a stressful experience from the past or avoiding feelings related to it?	1	2	3	4	5
7.	Avoiding activities or situations because they reminded you of a stressful experience from the past?	1	2	3	4	5
8.	Trouble remembering important parts of a stressful experience the past?	1	2	3	4	5
9.	Loss of interest in activities that you used to enjoy?	1	2	3	4	5
10.	Feeling distant or cut off from other people?	1	2	3	4	5
11.	Feeling emotionally numb or being unable to have loving feeling for those close to you?	1	2	3	4	5
12.	Feeling as if your future somehow will be cut short?	1	2	3	4	5
13.	Trouble falling or staying asleep?	1	2	3	4	5
14.	Feeling irritable or having angry outbursts?	1	2	3	4	5
15.	Having difficulty concentrating?	1	2	3	4	5
16.	Being “super-alert” or watchful or on guard?	1	2	3	4	5
17.	Feeling jumpy or easily startled?	1	2	3	4	5

PLC-C for DSM-IV (11/1/94) National Center for PTSD Behavioral Sciences Division

Appendix C

North Sound Mental Health Administration

Complex PTSD

***Another form of PTSD is the subject of much discussion in the United States and other countries – Complex PTSD, although it is not currently a diagnosis listed in the DSM-IV-TR. Information about this form of PTSD is presented below, and there is a wealth of literature available for further study.**

1. Complex PTSD – a newly-recognized form of PTSD

The diagnosis of PTSD accurately describes the symptoms that result when a person experiences a short-lived trauma. For example, car accidents, natural disasters, and rape are considered traumatic events of time-limited duration. However, **chronic** traumas continue for months or years at a time. Clinicians and researchers have found that the current PTSD diagnosis often does not capture the severe psychological harm that occurs with such prolonged period of negative stress, or repeated trauma. For example, ordinary, healthy people who experience chronic trauma can experience changes in their self-concept and the way they adapt to stressful events. Dr. Judith Herman of Harvard University suggests that a new diagnosis, called **Complex PTSD**, is needed to describe the symptoms of long-term trauma.

Situations which might give rise to Complex PTSD include bullying, harassment, abuse, domestic violence, stalking, long-term caring for a disabled relative, unresolved grief, exam stress over a period of years, mounting debt, contact experience, etc. Those working in regular traumatic situations, e.g., the emergency services, are also prone to developing Complex PTSD.

The nature of the traumatic experience includes other factors such as: which may include any of captivity, lack of means of escape, entrapment, repeated violation of boundaries, betrayal, rejection, bewilderment, confusion, and - crucially - lack of control, loss of control and disempowerment. It is the overwhelming nature of the events and the inability (helplessness, lack of knowledge, lack of support etc) of the person trying to deal with those events that leads to the development of Complex PTSD.

A key feature of Complex PTSD is the aspect of captivity. The individual experiencing trauma by degree is unable to escape the situation. Despite some people's assertions to the contrary, situations of domestic abuse and workplace abuse can be extremely difficult to get out of. In the latter case there are several reasons, including financial vulnerability (especially if you're a single parent or main breadwinner), unavailability of jobs, ageism (many people who are bullied are over 40), partner unable to move, and kids settled in school and you are unable or unwilling to move them. The real killer, though, is being

unable to get a job reference - the bully will go to great lengths to blacken the person's name, often for years, and it is this lack of reference more than anything else which prevents people escaping.

Examples of captivity include:

- Concentration camps
- Prisoner of War camps
- Prostitution brothels
- Long-term domestic violence
- Long-term, severe physical abuse
- Child sexual abuse
- Organized child exploitation rings

Until recently, little (or no) attention was paid to the psychological harm caused by bullying and harassment. Misperceptions (usually as a result of the observer's lack of knowledge or lack of empathy) still abound: *"It's something you have to put up with"* (like rape or repeated sexual abuse?) and *"Bullying toughens you up*" (ditto). Armed forces personnel faced threats of being labeled with "cowardice" and "lack of moral fiber" if they gave in to the symptoms of PTSD. In World War I, 306 British and Commonwealth soldiers were shot as "cowards" and "deserters" on the orders of General Haig in an act which today would be treated as a war crime.

In the United Kingdom (UK), at least 16 children kill themselves each year because they are being bullied at school. This figure is established in the book, Bullycide: death at playtime. Each of these deaths is **unnecessary**, **foreseeable**, and **preventable**. Since Andrea Adams first identified workplace bullying and gave it its name in 1988, recognition of adult bullying has grown steadily.

2. Common features of Complex PTSD from bullying

People suffering Complex PTSD as a result of bullying report consistent symptoms which further help to characterize psychiatric injury and differentiate it from mental illness. These include:

- Fatigue with symptoms of or similar to Chronic Fatigue Syndrome
- An anger of injustice stimulated to an excessive degree (sometimes but improperly attracting the words "manic" instead of motivated, "obsessive" instead of focused, and "angry" instead of "passionate", especially from those with something to fear)
- An overwhelming desire for acknowledgement, understanding, recognition and validation of their experience
- A simultaneous and paradoxical unwillingness to talk about the bullying
- A lack of desire for revenge, but a strong motivation for justice
- A tendency to oscillate between conciliation (forgiveness) and anger (revenge) with objectivity being the main casualty
- Extreme fragility, where formerly the person was of a strong, stable character

- Numbness, both physical (toes, fingertips, and lips) and emotional (inability to feel love and joy)
- Clumsiness
- Forgetfulness
- Hyperawareness and an acute sense of time passing, seasons changing, and distances traveled
- An enhanced environmental awareness, often on a planetary scale
- An appreciation of the need to adopt a healthier diet, possibly reducing or eliminating meat - especially red meat
- Willingness to try complementary medicine and alternative, holistic therapies, etc
- A constant feeling that one has to justify everything one says and does
- A constant need to prove oneself, even when surrounded by good, positive people
- An unusually strong sense of vulnerability, victimization or possible victimization, often wrongly diagnosed as "persecution"
- Occasional violent intrusive visualizations
- Feelings of worthlessness, rejection, a sense of being unwanted, unlikable and unlovable
- A feeling of being small, insignificant, and invisible
- An overwhelming sense of betrayal, and a consequent inability and unwillingness to trust anyone, even those close to you
- In contrast to the chronic fatigue, depression etc, occasional false dawns with sudden bursts of energy accompanied by a feeling of "I'm better!", only to be followed by a full resurgence of symptoms a day or two later
- Excessive guilt - when the cause of PTSD is bullying, the guilt expresses itself in forms distinct from "survivor guilt"; it comes out as:
    - ✓ an initial reluctance to take action against the bully and report him/her knowing that he/she could lose his/her job
    - ✓ later, this reluctance gives way to a strong urge to take action against the bully so that others, especially successors, don't have to suffer a similar fate
    - ✓ reluctance to feel happiness and joy because one's sense of other people's suffering throughout the world is heightened
    - ✓ a proneness to identifying with other people's suffering
    - ✓ a heightened sense of unworthiness, undeservingness and non-entitlement (some might call this shame)
    - ✓ a heightened sense of indebtedness and undue obligation
    - ✓ a reluctance to earn or accept money because one's sense of poverty and injustice throughout the world is heightened
    - ✓ an unwillingness to take ill-health retirement because the person doesn't want to believe they are sufficiently unwell to merit it
    - ✓ an unwillingness to draw sickness, incapacity or unemployment benefit to which the person is entitled
    - ✓ an unusually strong desire to educate the employer and help the employer introduce an anti-bullying ethos, usually proportional to the employer's lack of interest in anti-bullying measures
    - ✓ a desire to help others, often overwhelming and bordering on obsession, and to be available for others at any time regardless of the cost to oneself

- ✓ an unusually high inclination to feel sorry for other people who are under stress, including those in a position of authority, even those who are not fulfilling the duties and obligations of their position (which may include the bully) but who are continuing to enjoy a salary for remaining in the job.

3. Complex PTSD and Fatigue

The fatigue is understandable when you realize that in bullying, the target's fight or flight mechanism eventually becomes activated from Sunday evening (at the thought of facing the bully at work on Monday morning) through to the following Saturday morning (phew - weekend at last!). The fight or flight mechanism is designed to be operational only briefly and intermittently; in the heightened state of alert, the body consumes abnormally high levels of energy. If this state becomes semi-permanent, the body's physical, mental and emotional batteries are drained dry. Whilst the weekend theoretically is a time for the batteries to recharge, this doesn't happen, because:

- the person is by now obsessed with the situation (or rather, resolving the situation), cannot switch off, may be unable to sleep, and probably has nightmares, flashbacks and replays;
- sleep is non-restorative and unrefreshing - one goes to sleep tired and wakes up tired
- this type of experience plays havoc with the immune system; when the fight or flight system is eventually switched off, the immune system is impaired such that the person is open to viruses which they would under normal circumstances fight off; the person then spends each weekend with a cold, cough, flu, glandular fever, laryngitis, ear infection etc so the body's batteries never have an opportunity to recharge.

When activated, the body's fight or flight response results in the digestive, immune and reproductive systems being placed on standby. It is no coincidence that people experiencing constant abuse, harassment and bullying report malfunctions related to these systems (loss of appetite, constant infections, flatulence, irritable bowel syndrome, loss of libido, impotence, etc). The body becomes awash with cortisol, which in high prolonged doses is toxic to brain cells. Cortisol kills off neuroreceptors in the hippocampus, an area of the brain linked with learning and memory. The hippocampus is also the control centre for the fight or flight response, thus the ability to control the fight or flight mechanism itself becomes impaired.

4. Implications of Complex PTSD

The word "breakdown" is often used to describe the mental collapse of someone who has been under intolerable strain. There is usually an (inappropriate) inference of "mental illness". All these are lay terms and mean different things to different people. There is a distinction between the different types of breakdown:

- **Nervous breakdown** or **mental breakdown** is a consequence of mental illness
- **Stress breakdown** is a psychiatric injury, which is a *normal* reaction to an *abnormal* situation

The two types of breakdown are distinct and <u>not to be confused</u>. A stress breakdown is a natural and normal conclusion to a period of prolonged negative stress; the body is saying "I'm not designed to operate under these conditions of prolonged negative stress so I am going to do something dramatic to *ensure* that you reduce or eliminate the stress otherwise your body may suffer irreparable damage; you must take action now". A stress breakdown is often predictable days - sometimes weeks - in advance as the person's fear, fragility, obsessiveness, hypervigilance and hypersensitivity combine to evolve into paranoia (as evidenced by increasingly bizarre talk of conspiracy). If this happens, a stress breakdown is only days or even hours away, and the person needs urgent medical help. The risk of suicide at this point is heightened.