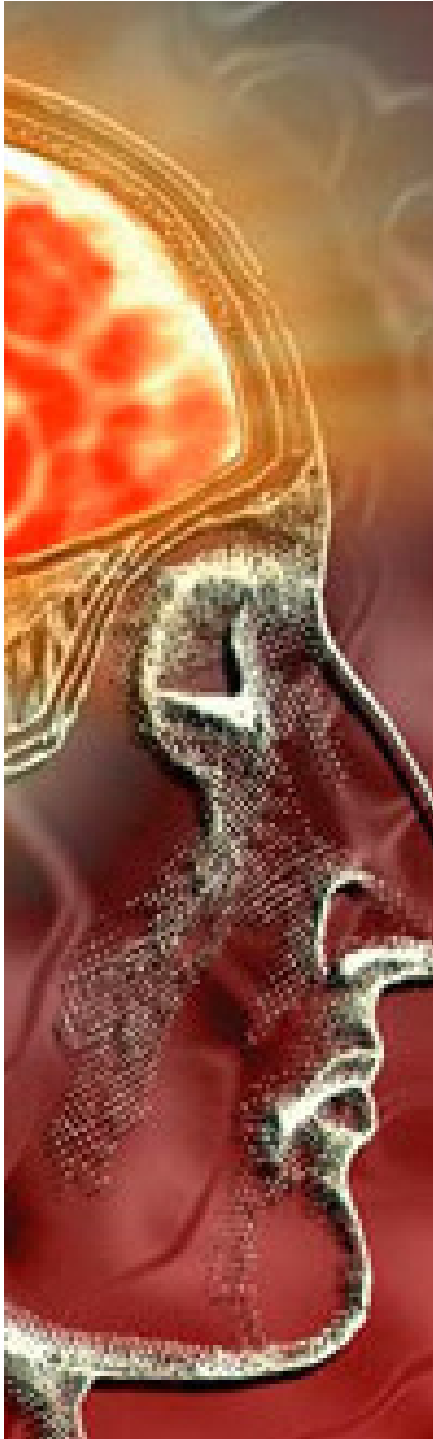


Post Traumatic Stress Disorder

Jane Litchfield

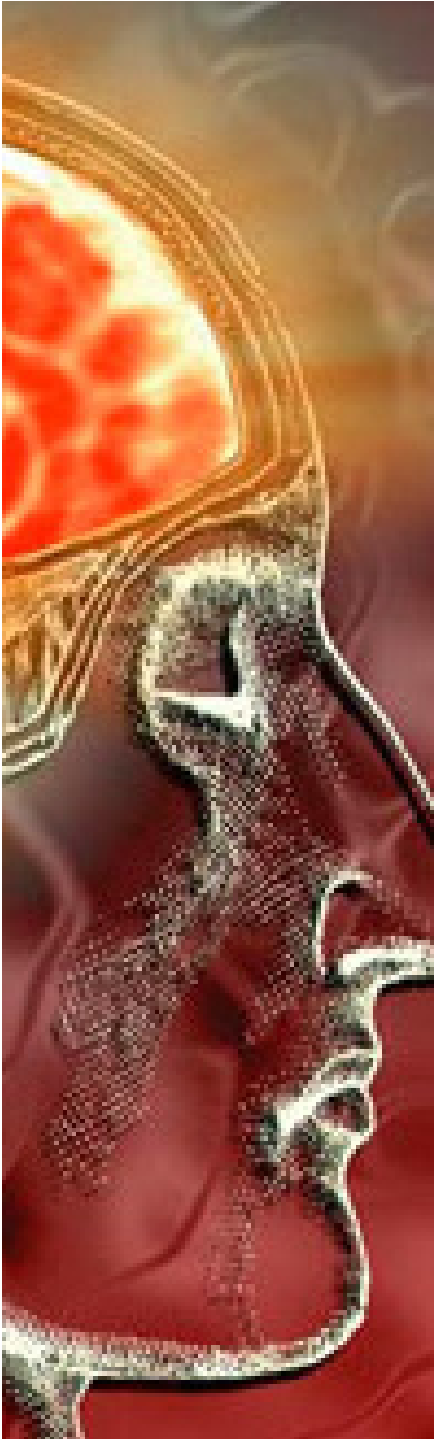
Acting Clinical Supervisor





Presentation Goals

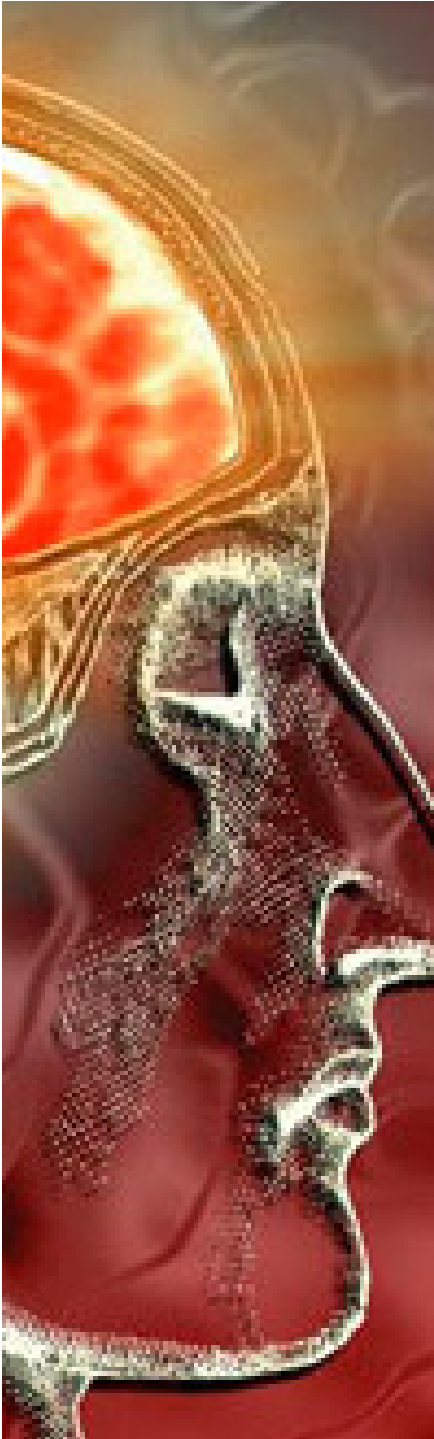
- provide a brief look at PTSD
- raise curiosity about TRAUMA that will lead to further exploration and knowledge
- dispel myths of PTSD which fuel survivor's isolation and silence
- **ENABLE US TO RESPOND WITH SUPPORT TO ADOLESCENT PARENTS IN NEED.**



What is trauma?

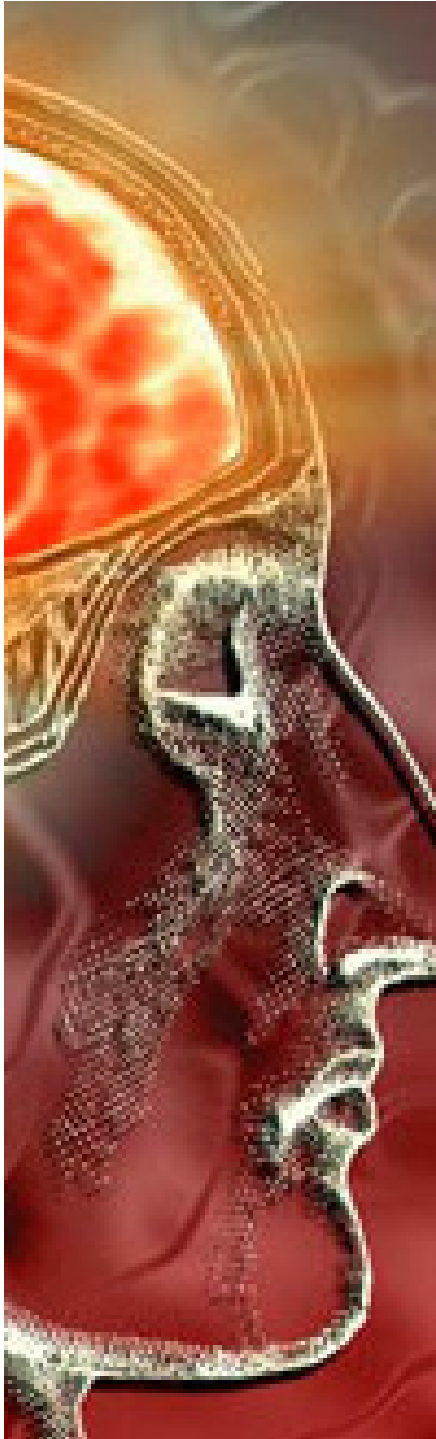
Used to describe terrorist attacks, natural disasters, sexual, physical and emotional abuse.

- psychological trauma is the psycho-biological response to a threatening event.
- trauma responses cross gender, age and race.
- inherent to all human beings.
- originates with flight/fight response.



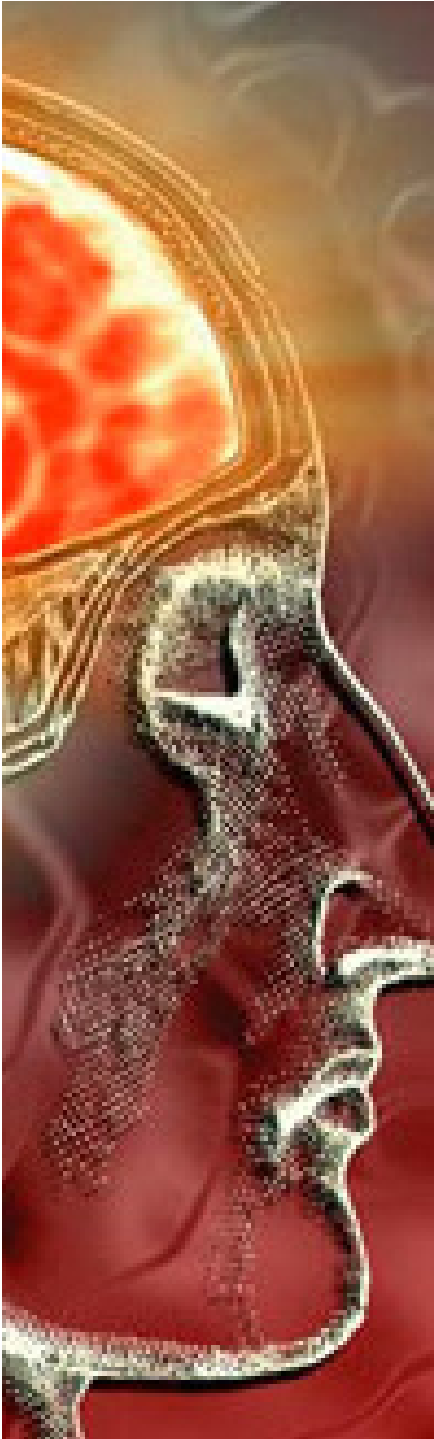
What is Post Traumatic Stress Disorder?

- a psychiatric disorder from DSM
- a cluster of symptoms and behaviors identified as PTSD
- Describes a specific configuration for the diagnosis but does not **explain** the past trauma of the client



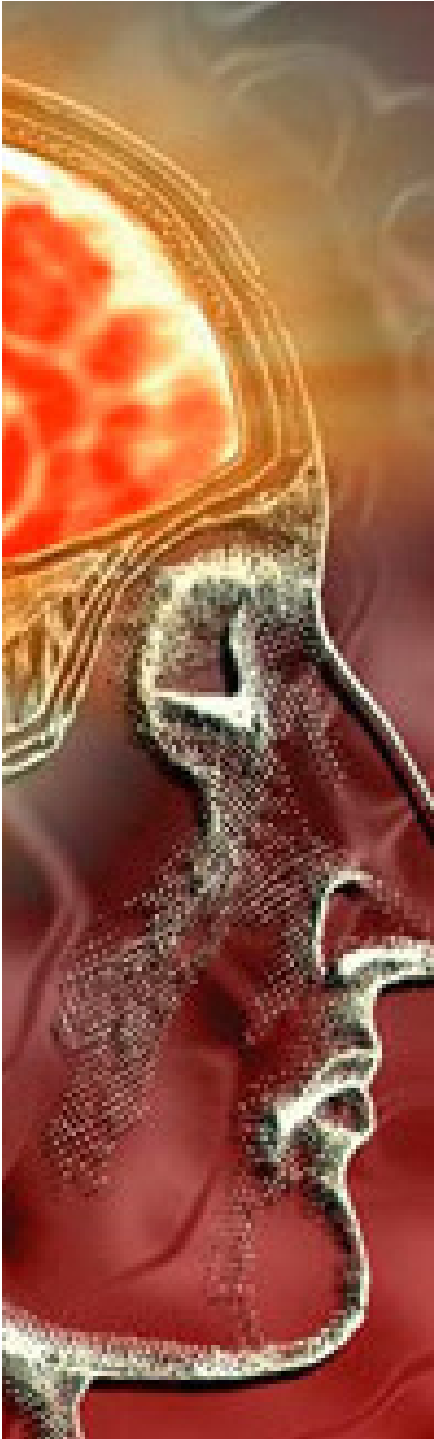
Post Traumatic Stress Disorder Diagnosis

- A. Exposure to a threatening event
- B. Re experiencing the traumatic event
- C. Avoidance of reminders associated with the traumatic event.
- D. Increased arousal that were not present before the threatening event.



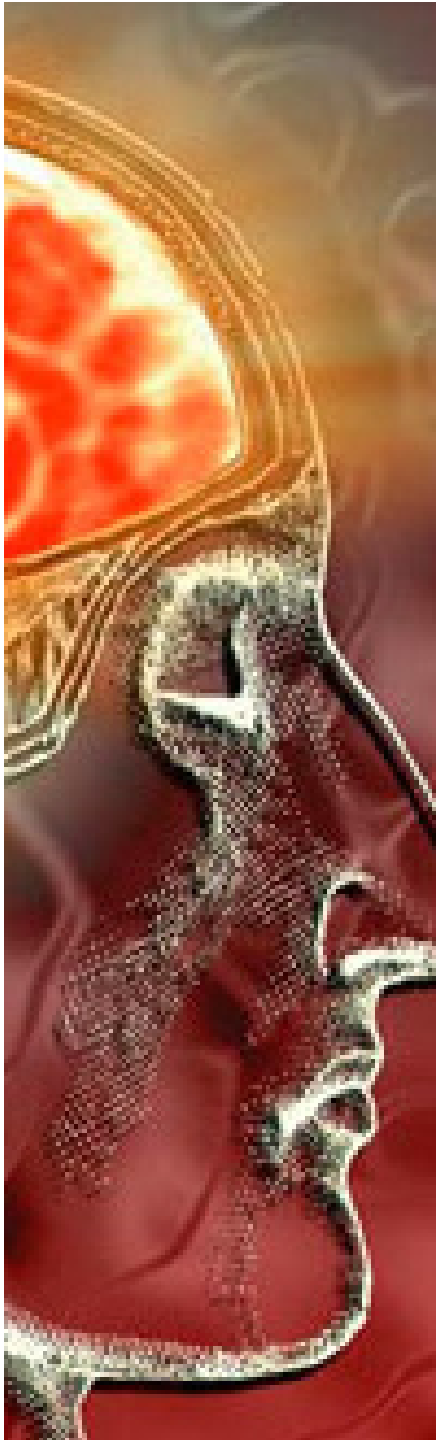
A. Exposure to a threatening event.

- experienced, witnessed or were confronted with an event/events that involved actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.
- response involved intense fear, helplessness, or horror.



Threatening Events

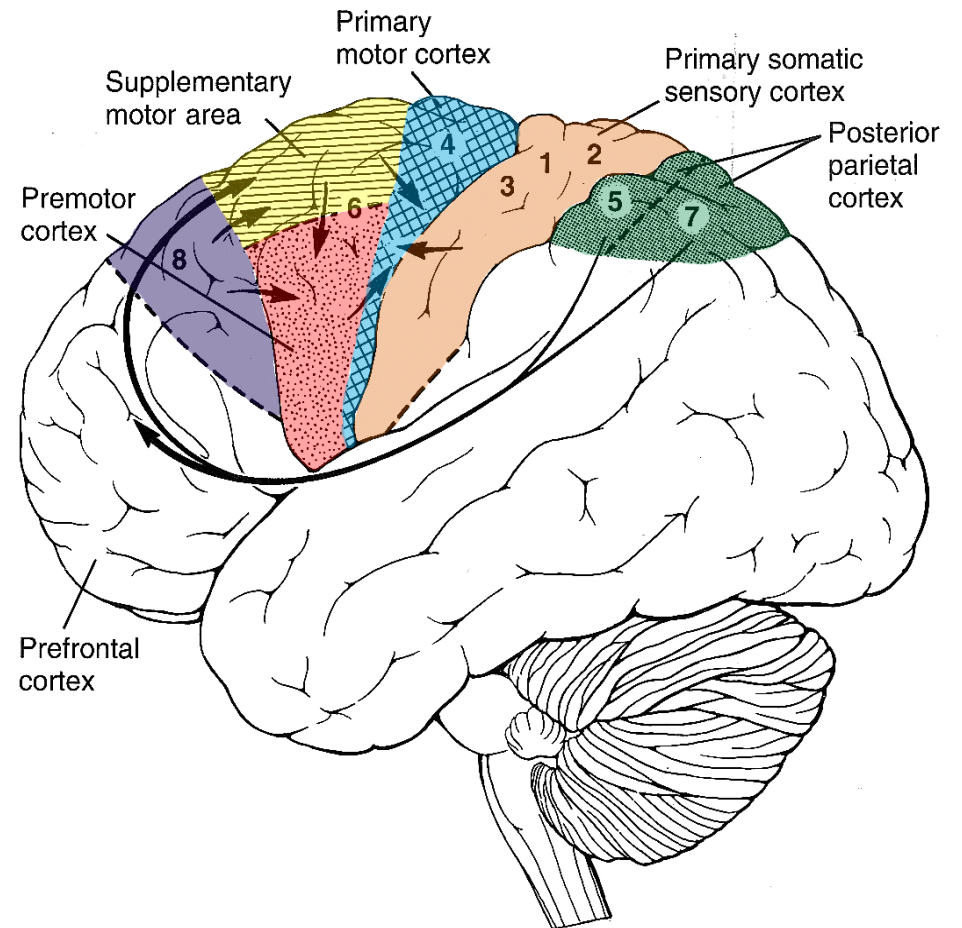
1. Natural Disasters – fires, hurricanes
2. Unexpected events, car accidents, shootings
3. Wars, terrorist actions
4. Assault, interpersonal violence or threat of violence, rape
5. Severe dysfunctional parenting
6. Psychological abuse
7. Invasive medical procedures
8. Responding to emergencies

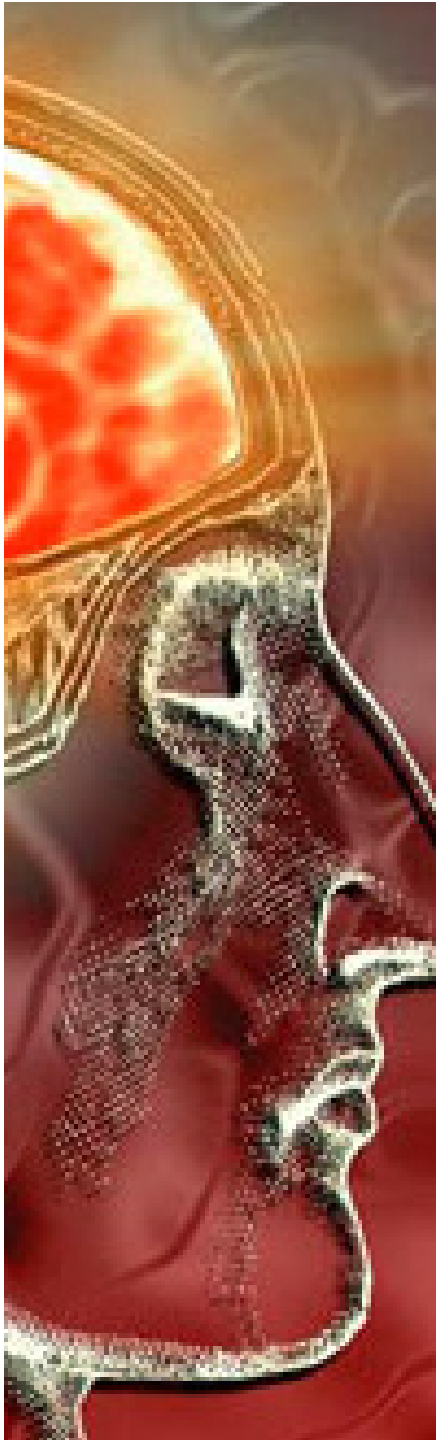


Fight – Flight/Freeze Response

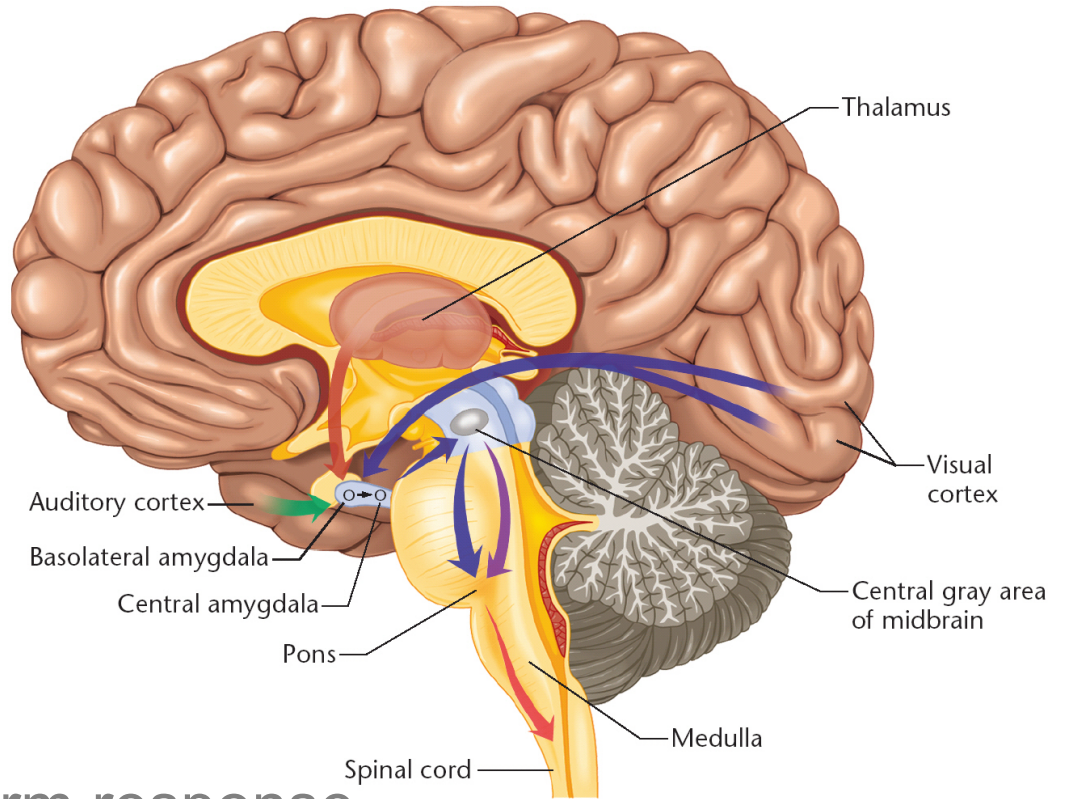
- Evolutionary function of the brain
- Brain structure

Cortex:
Thinking
Reasoning
Planning





Fight – Flight/Freeze Response



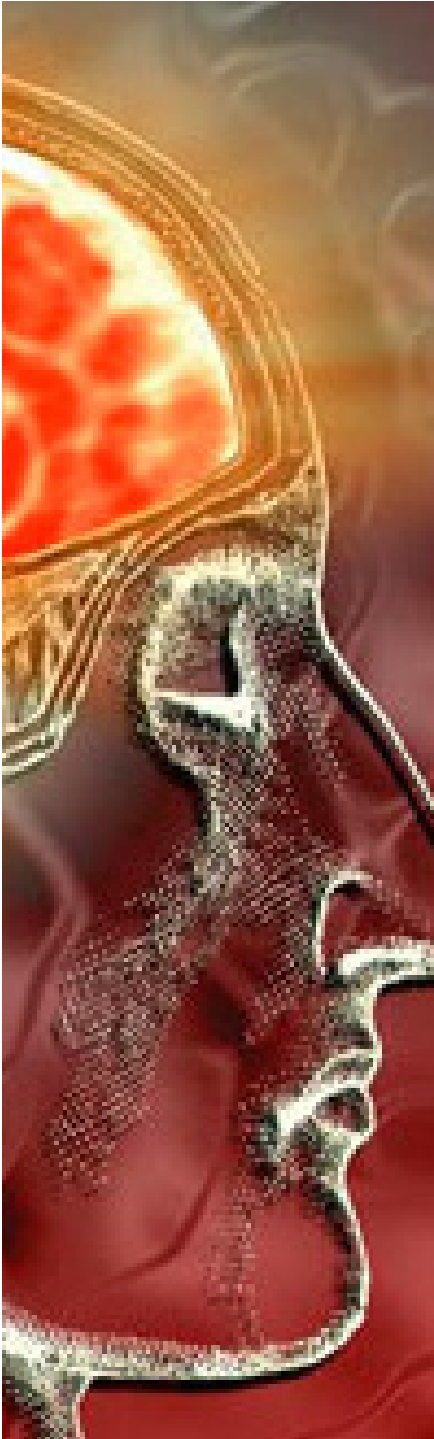
Amygdala

Primitive Alarm response

Signals danger to the body

FEAR RESPONSE

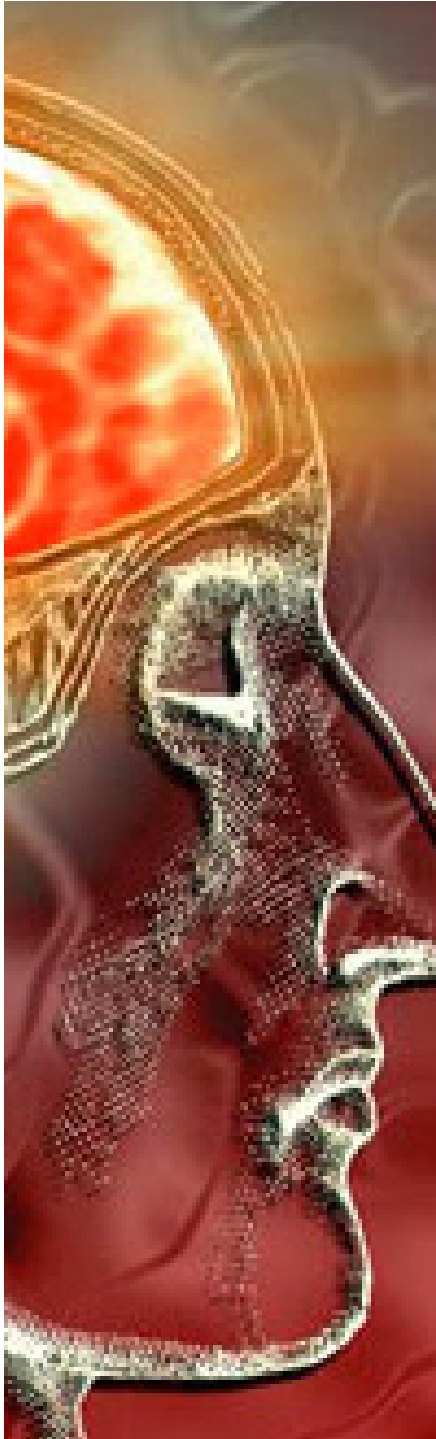
Readies the body for flight/fight



Physiology of Fear fight/flight

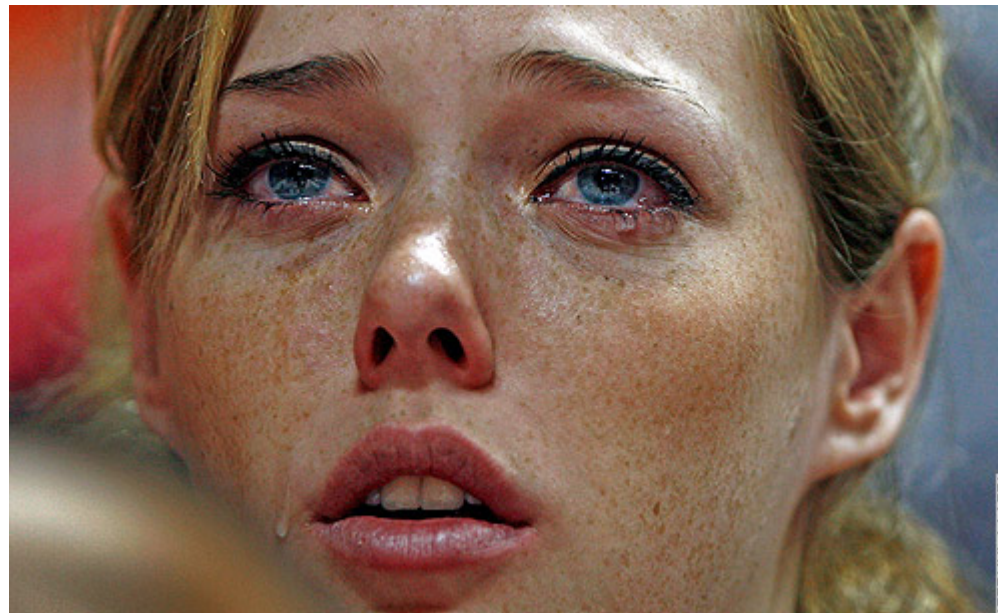
Body changes after amygdala sounds the alarm:

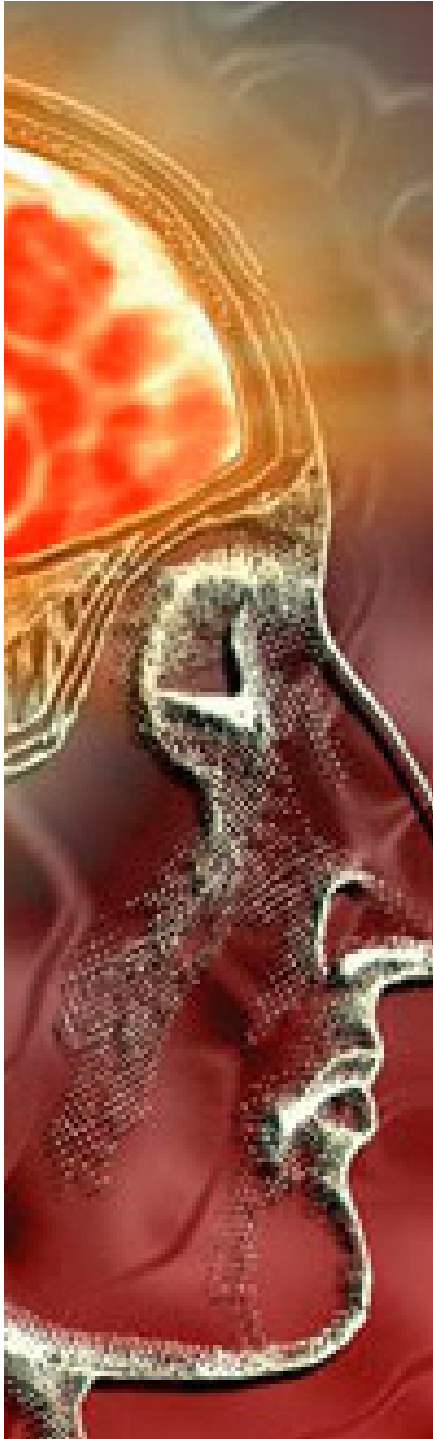
- Pituitary gland produces adrenaline, stress hormones
- Heart rate and blood pressure rise
- Spleen contracts pumping out white blood cells
- Liver breaks down glycogen for energy
- Hair stands on end
- Lung bronchides dilate
- Digestive system slows
- Pupils dilate
- Skin vessels constrict, causing chills and sweat
- Body readies for flight/fright



Futility of Fight/Flight - Freeze

- Physiological arousal proves ineffective, freeze response becomes dominant
- Body numbs and becomes immobile (in nature, this is seen as playing dead)
- Brain hardwired for fear response to dominate
- Over rides the conscious (cortex)

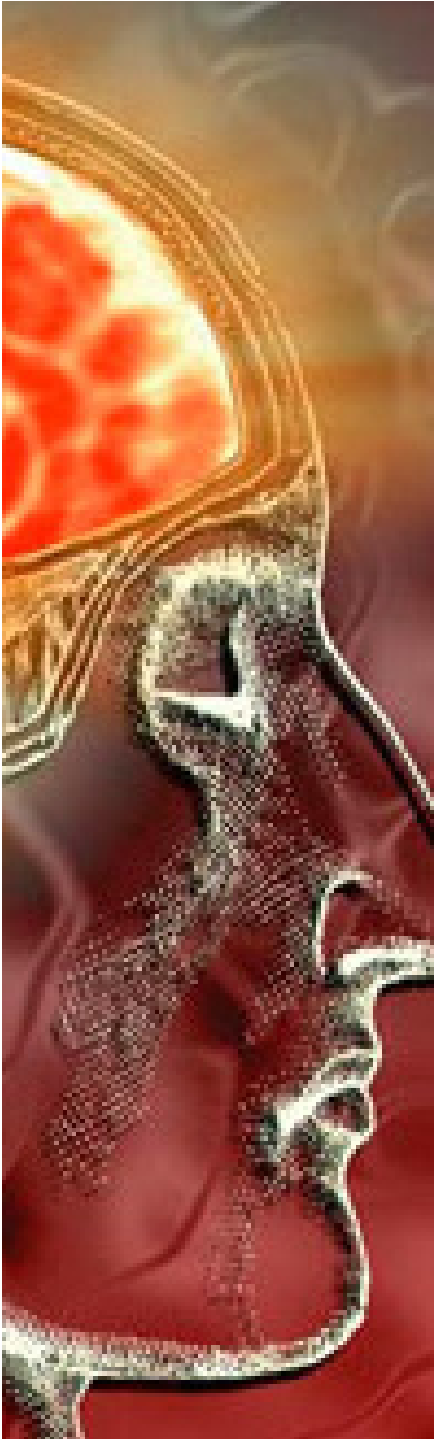




B. Re-experiencing the traumatic event

Intrusion

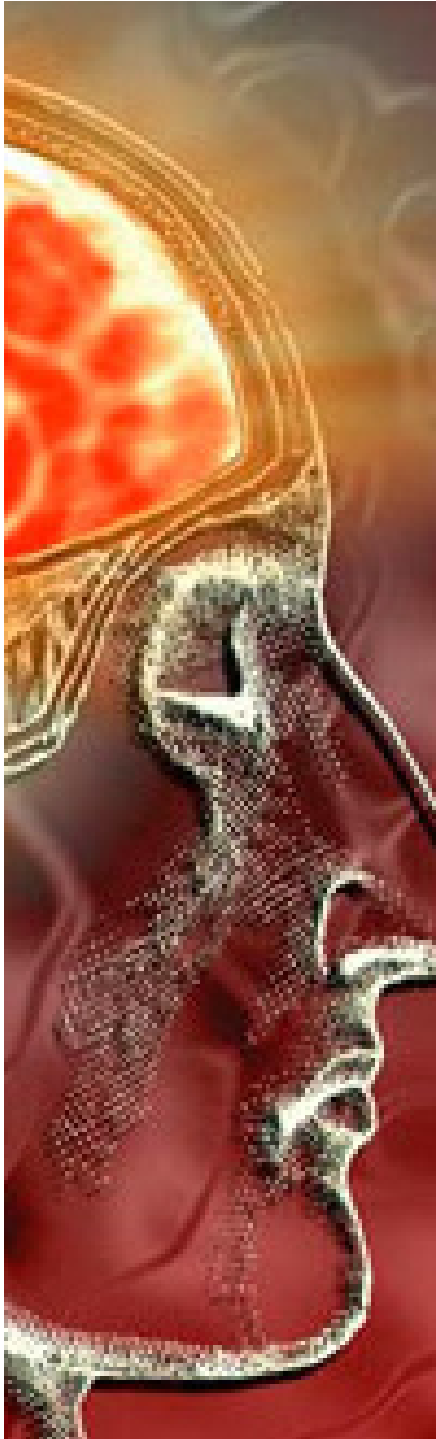
- recurring distressing recollections of the event including images, thoughts and perceptions
- recurring distressing dreams
- feeling as if the event is recurring through illusions, hallucinations and flashbacks
- psychological or body distress when exposed to internal cues or external cues (triggers) that resemble or symbolize an aspect of the event. (sights, smells, sounds, dates)



C. Avoidance of Reminders

Persistently avoid triggers associated with the threatening event using 2 or more of the following:

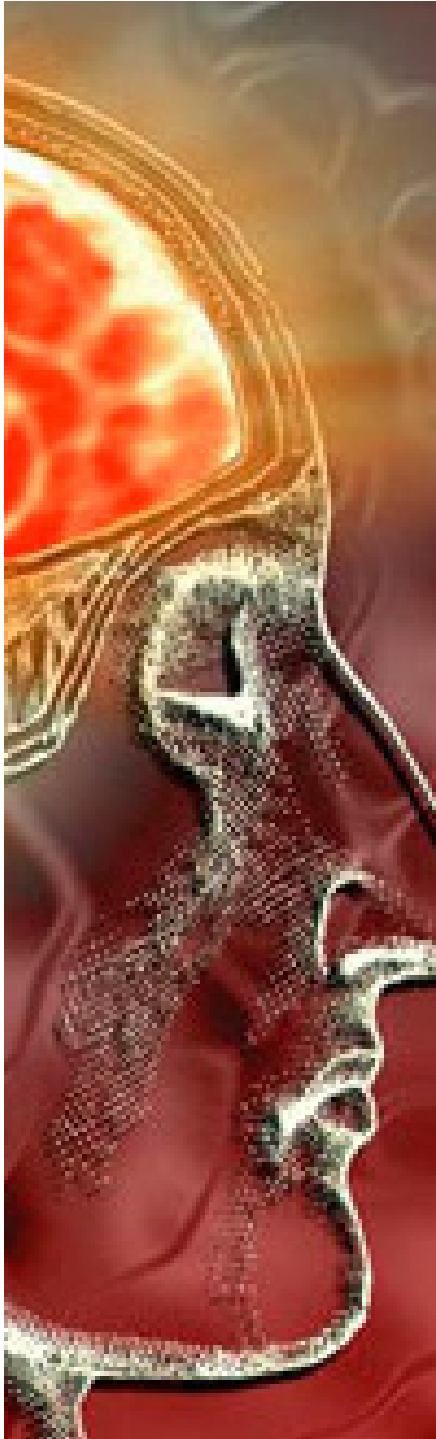
- Avoidance of thoughts, feelings, conversations associated with the trauma.
- Avoidance of activities, places or people that arouse recollections of the trauma.
- Inability to recall an important aspect of the trauma.
- Diminished interest/participation in pre-trauma activities.
- Feel detached or estranged from others.
- Restricted range of affect, (unable to have loving feelings)
- Sense of foreshortened future, (not expecting a normal lifespan)



D. Increased Arousal

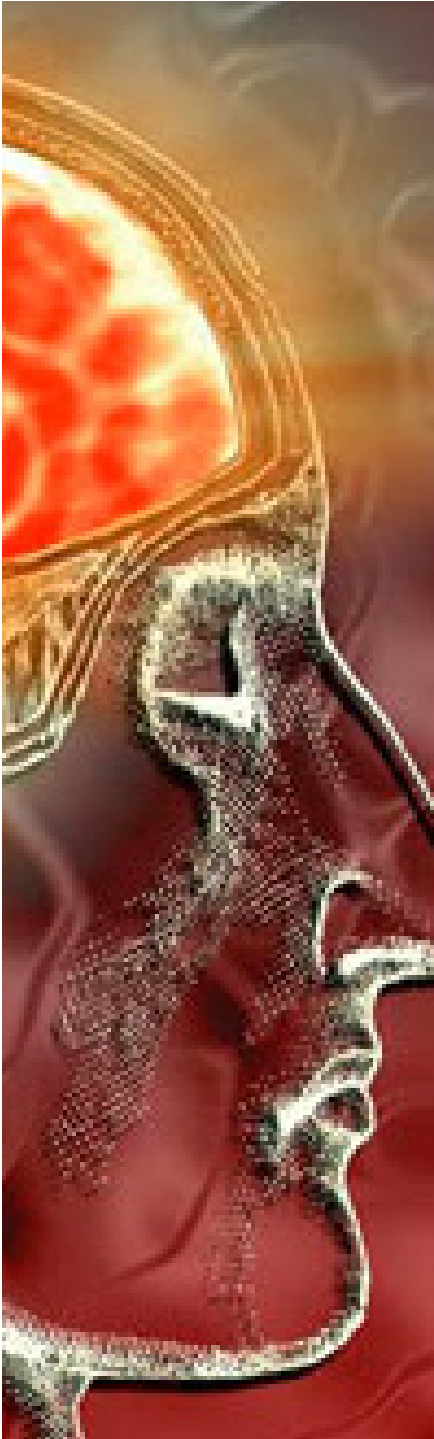
Persistent symptoms of increased physical arousal not present before the trauma indicated by 2 or more of the following:

- difficulty falling or staying asleep
- irritability or outbursts of anger
- difficulty concentrating
- hyper vigilance
- exaggerated startle response.



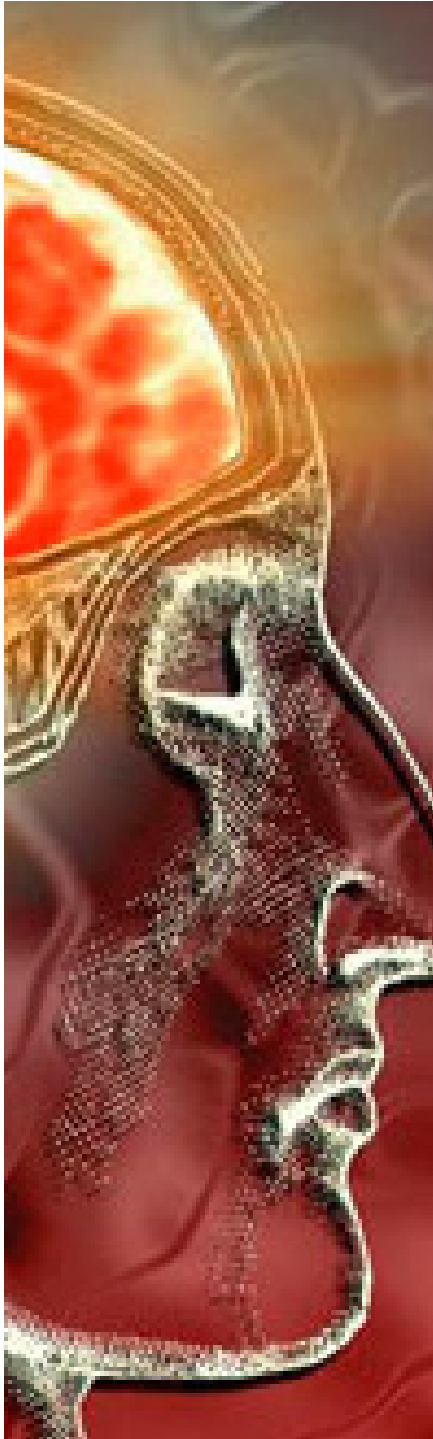
Dissociation

- Seen in populations with PTSD, OCD reactive attachment and traumatized adolescents
- Shameful, confusing “secret”
- Secrecy precludes getting mental health services



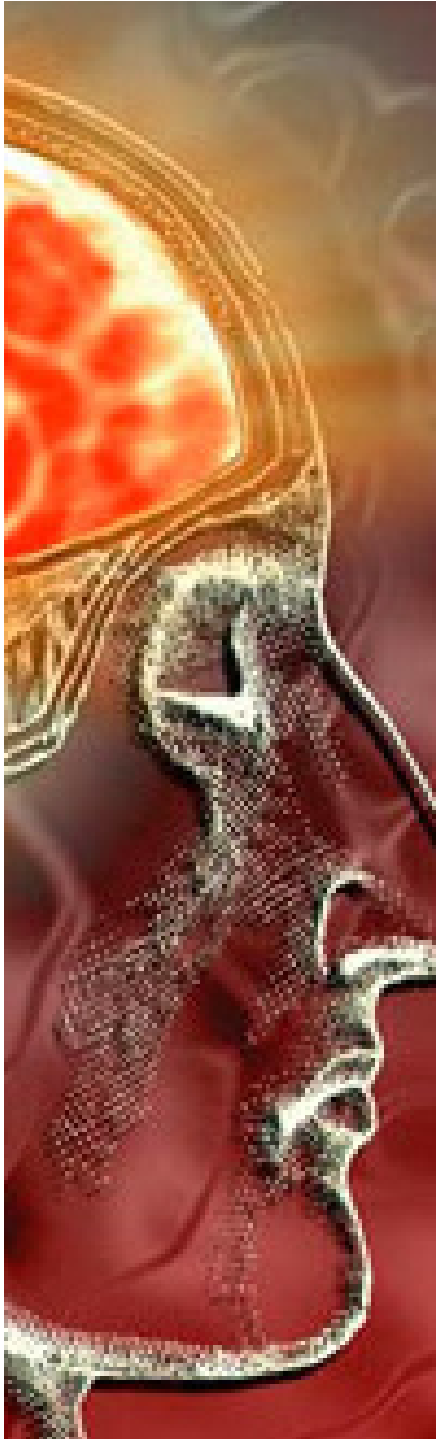
Dissociative Symptoms

- Trance states
- Amnesia for behaviour, life story, trauma
- Depersonalization – outside observer to one's body and mind
- De realization – external world is vague, unknowable



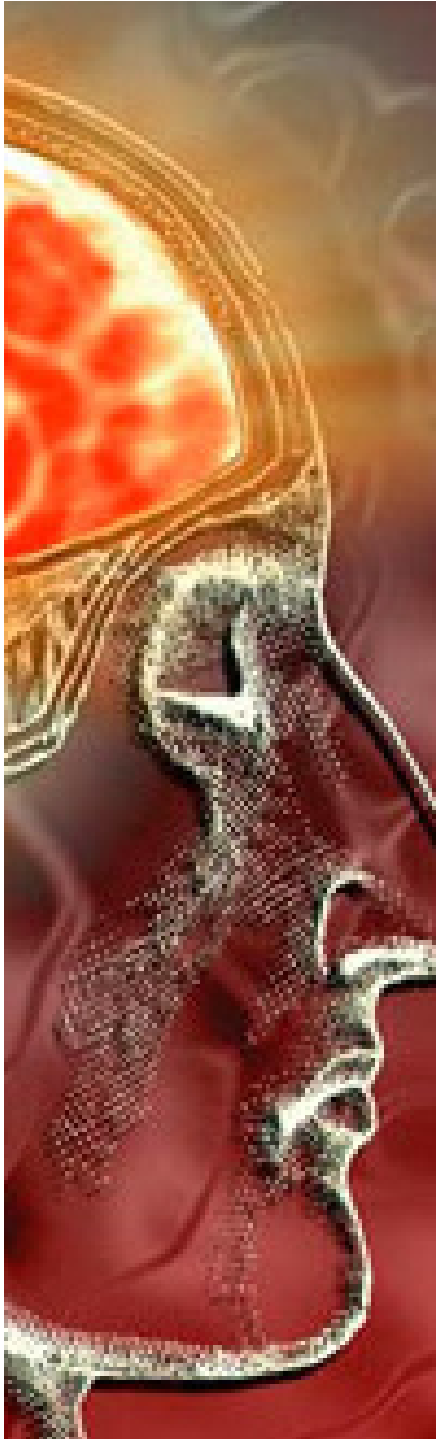
Creativity of Dissociation

- Survival skill for overwhelming danger
- Shuts out awareness of physical and emotional pain
- Allows a survivor to cope in a dangerous environment
- Allows disengagement with an abuser
- Maladaptive when survivor can not control the response



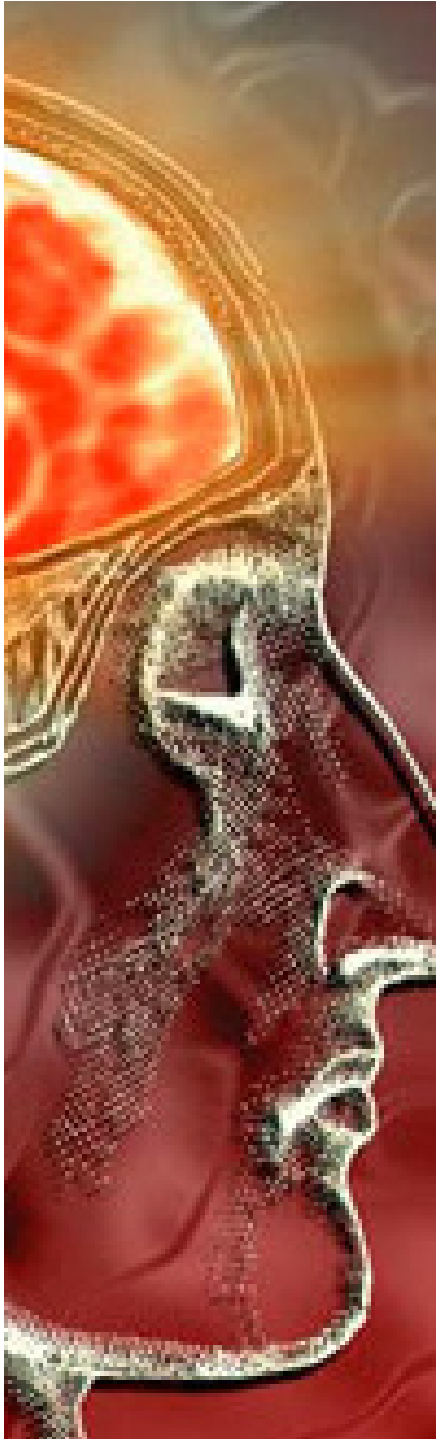
Risk Factors for Developing PTSD

1. Traumatic experiences in early childhood
2. Family members with PTSD
3. Pre-existing mental health condition
4. Traumatic event was long-lasting
5. Traumatic event was severe and dangerous
6. The proximity to the traumatic event
7. Previous trauma
8. Traumatic event inflicted by a person-intentional victimization compared with a natural disaster
9. Negative reactions from family and friends
10. high degree of psycho - physiological arousal in acute aftermath (heart rates)
11. Use of dissociation and freezing during the event



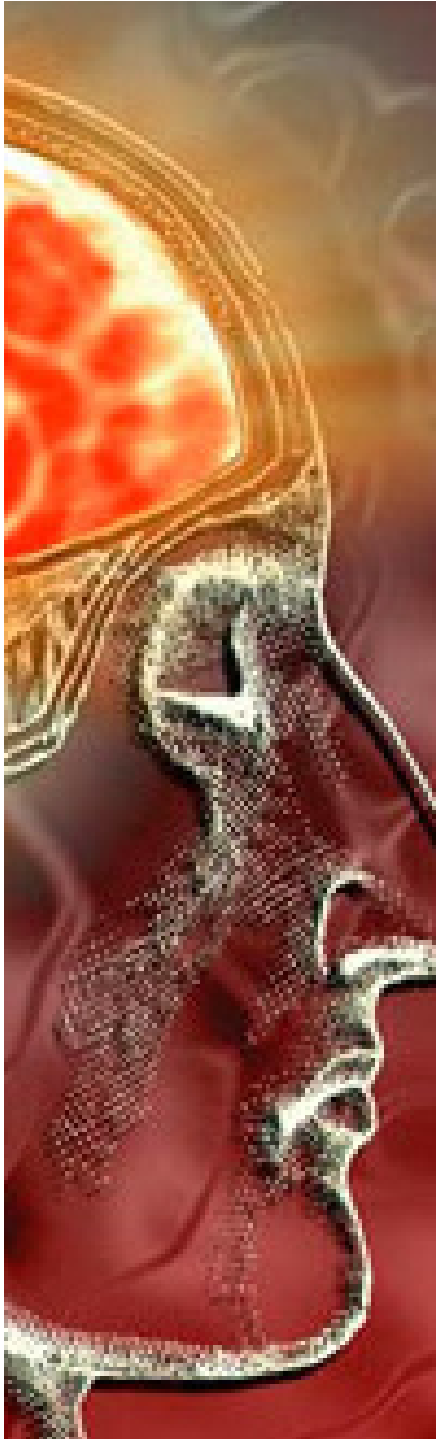
Dimensions of Complex Posttraumatic Stress Disorder

1. Alterations in regulation of affect and impulses
2. Alterations in attention or consciousness
3. Alterations in self-perception
4. Alterations in relations with others
5. Somatization
6. Alterations in systems of meaning



Characteristic Backgrounds for diagnosis of complex PTSD

- Interpersonal victimization
- Multiple traumatic events and/or
- Extended duration of traumatic experience
- Chronic exposure to untenable environments.

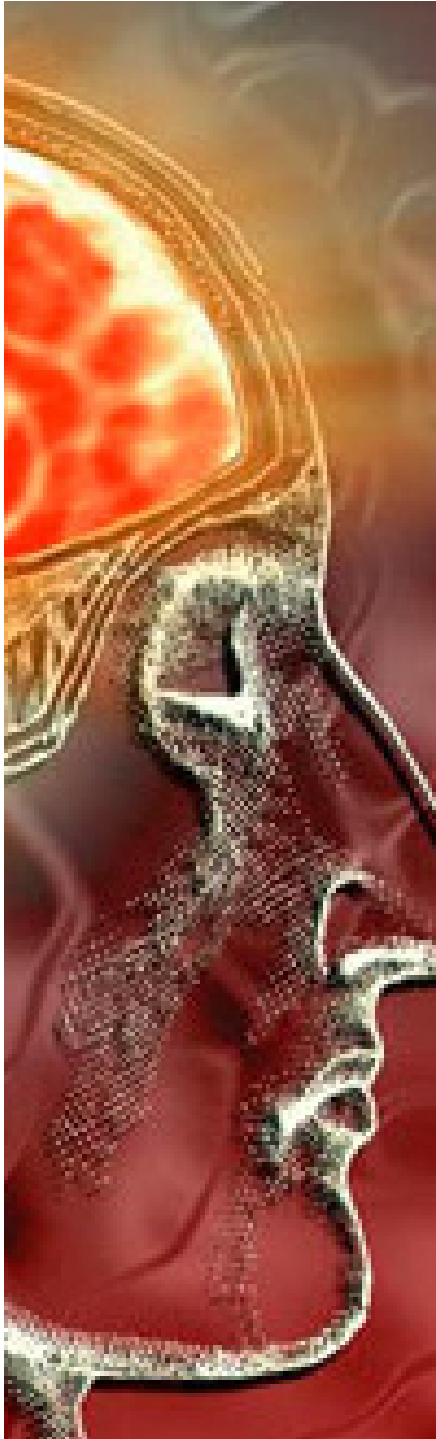


Treatment of PTSD

Trauma therapy requires stages:

First stage

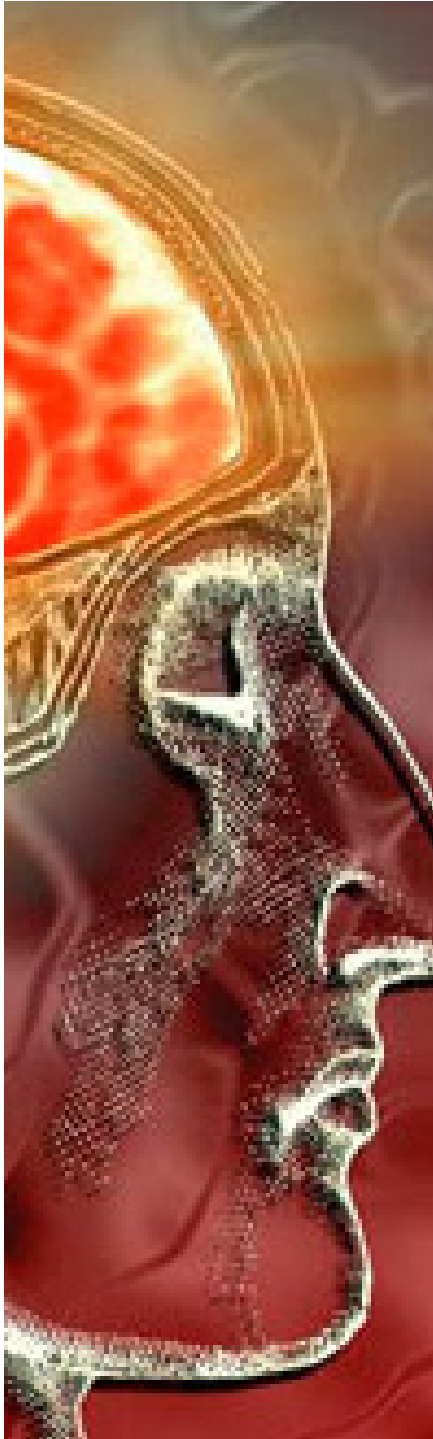
- Psycho-educational
- Safety
- Developing self-capacities



Purpose of Psycho-Education

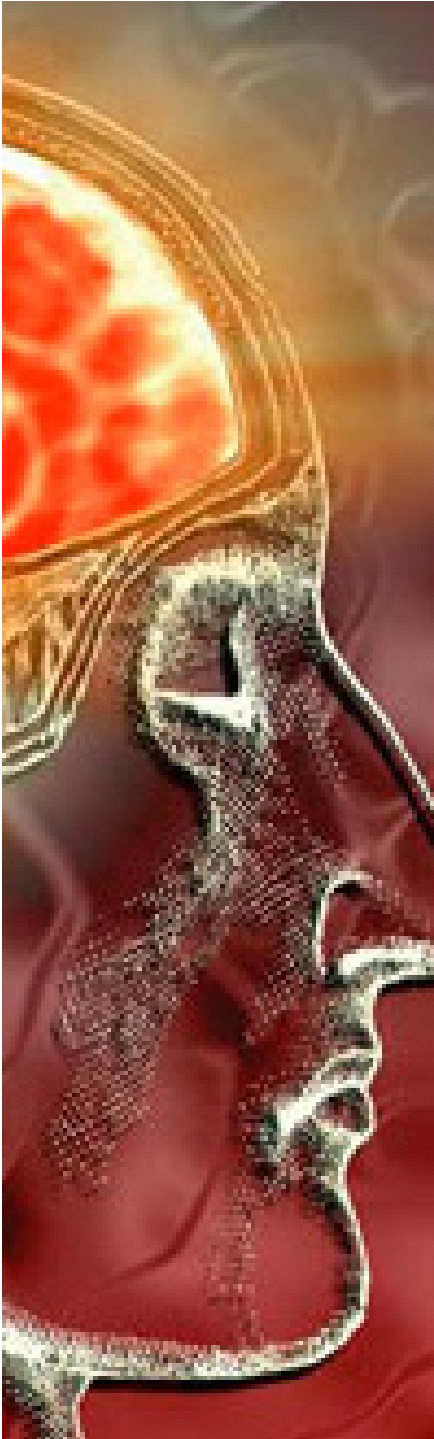
- Convey information
- Instill hope
- Expand context of meaning
- Dispel stigma
- Control post traumatic stress responses

Trauma responses are normal and adaptive responses to overwhelming life threats.



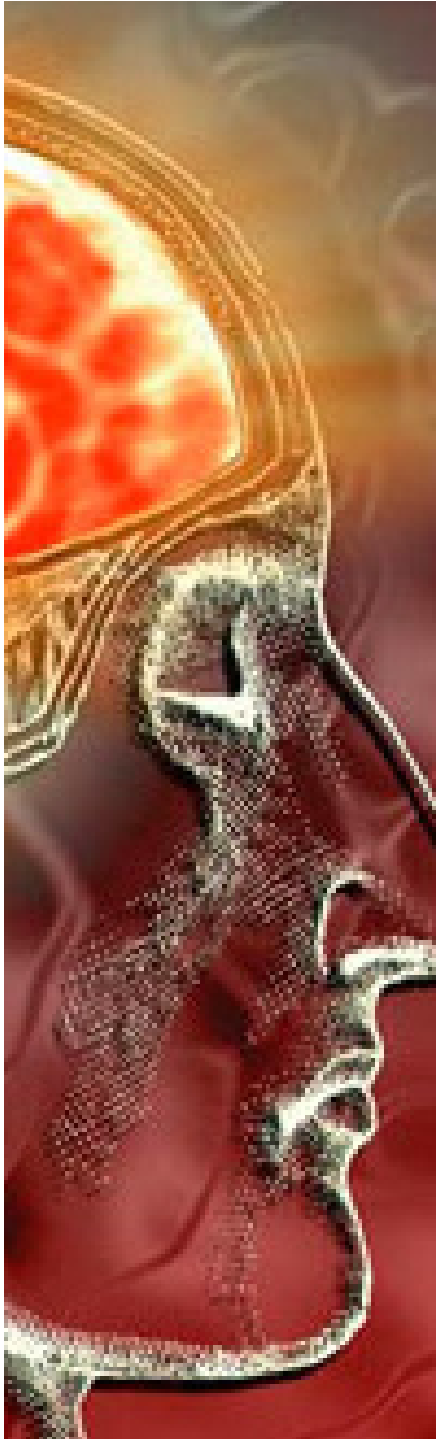
Indicators for Mental Health Involvement

1. Client experiences symptoms of PTSD
2. Client is flooded with feelings/sensations which are confusing to her
3. Client is frequently overwhelmed by normative life experiences
4. Client appears depressed, which may be a chronic state of being
5. Client is unable to care for herself displaying poor hygiene, eating and sleeping patterns.
6. Client lacks an internal locus of control re victimization and sexual exploitation
7. Client uses drugs/alcohol/self harm to regulate emotional states
8. Client is emotionally unresponsive to child, lack of attunement to child
9. Socially is isolated
10. High Risk Behavior – street life



How to facilitate a referral.

1. Share your concern with your client in a compassionate non judgmental style.
2. Explore your client's view of the concern. (Assess for "myths" of mental illness or fear of craziness)
3. Present the mental health services as an opportunity to explore resources to ease stress or suffering. Use stories of "others" to help dispel stigma.
4. Support the scheduling of the appointment
5. Facilitate attendance and be with your client
6. Remain in connection

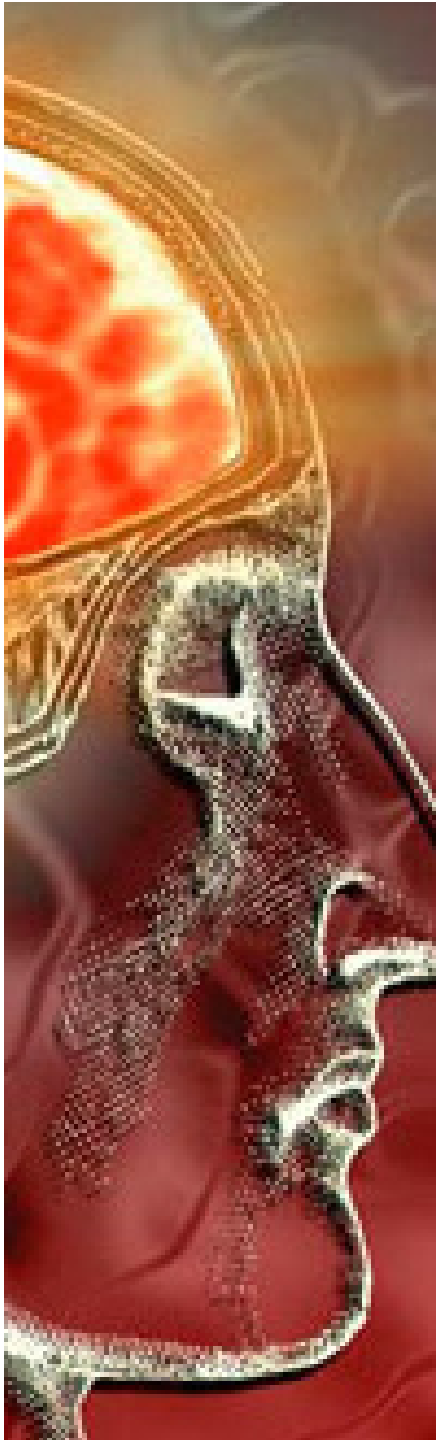


Our Response to Adolescent Parent's

Acknowledge the prevalence of trauma
systems

Acknowledge the creativity of trauma
symptoms as adaptations

**ENCOURAGE CONNECTION AND
HOPE**



FINDING THE
GOOD

 **MARYMOUND**

