YesCare
Say Yes To Exceptional Care

Understanding PTSD: Variances in Response to Trauma

Allison Genberg, LCSW, CCHP
Director of Behavioral Health Services

Dr. Joel S. Federbush, MD, MS
Psychiatrist

YesCare in partnership with the
Passaic County Sheriff's Department

Disclosure and Disclaimer

- We do not have any relevant financial relationships with any commercial interests.

Learning Objectives

- Define concepts related to PTSD
- Evaluate effects of trauma on various individuals and variability in resilience
- Debate whether PTSD can be diagnosed in the perpetrator of a violent or traumatic event

- The **DSM-5 definition** of **trauma** requires “actual or threatened death, serious injury, or sexual violence” [10] (p. 271). Stressful events not involving an immediate threat to life or physical injury such as psychosocial stressors [4] (e.g., divorce or job loss) are not considered **trauma** in this **definition**.

Common Experiences of Trauma in Incarcerated Individuals

- History of Childhood Physical Abuse
- History of Sexual Abuse or victimization
- History of or witness to Domestic Violence
- Witness to or participant in community violence
- Witness to or participant in gang related activity/violence
- Engagement in dangerous Criminal Behavior
- Witness to or history of substance related overdose or death

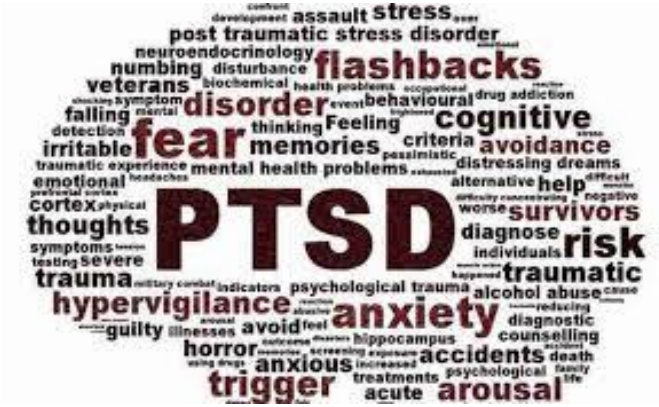
Being Incarcerated Contributes to re-experience of trauma

- Painful and devastating childhood memories may often be awakened when offenders experience prison life, with its dehumanizing, harsh and unloving environment and lifestyle.
- Violence between offenders, between offenders and staff members
- Demands of obedience to a rigid and impersonal discipline and schedule
- Cruel or domineering cell mates/peers
- Active avoidance of being the victim of rape or violence oneself

Posttraumatic Stress Disorder

- Criterion A: Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.



4 Clusters of PTSD Symptoms in DSM 5

The current DSM focuses on the behavioral symptoms of PTSD:

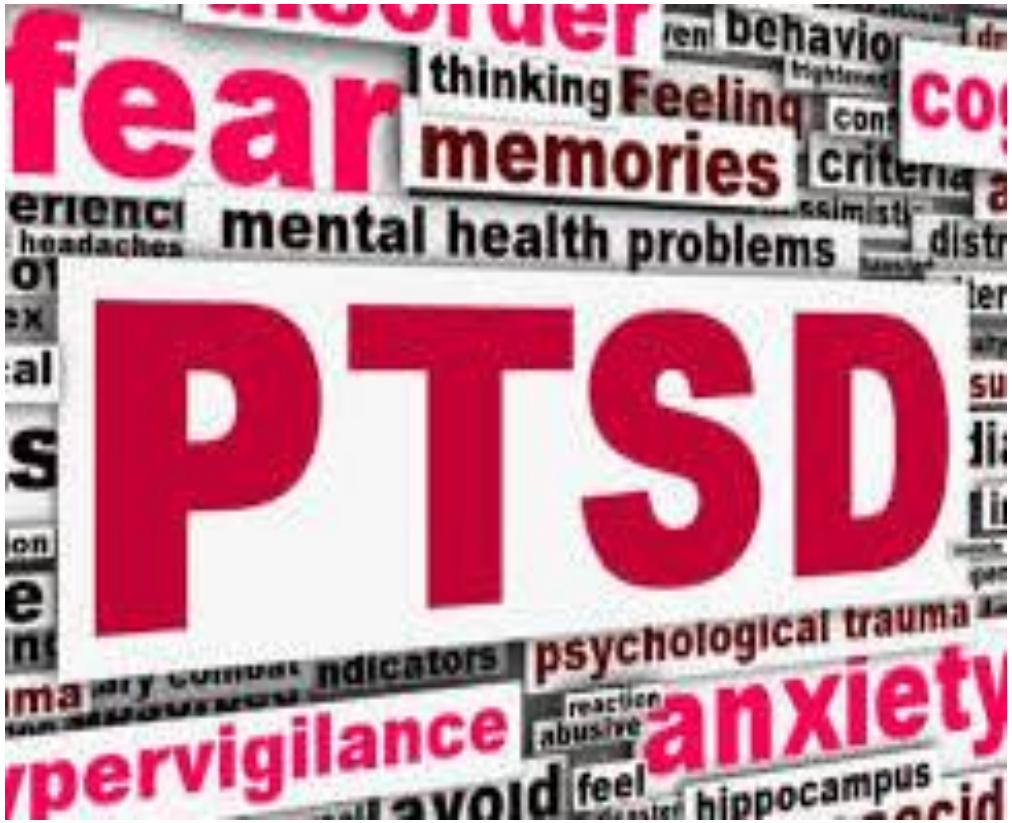
- **Re-experiencing** covers spontaneous memories of the traumatic event, recurrent dreams related to it, flashbacks or other intense or prolonged psychological distress.
- **Avoidance** refers to distressing memories, thoughts, feelings or external reminders of the event.
- **Negative cognitions and mood** represents myriad feelings, from a persistent and distorted sense of blame of self or others, to estrangement from others or markedly diminished interest in activities, to an inability to remember key aspects of the event.
- **Arousal** is marked by aggressive, reckless or self-destructive behavior, sleep disturbances, hypervigilance or related problems. The current manual emphasizes the “flight” aspect associated with PTSD.

Posttraumatic Stress Disorder

- Criterion B: Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). **Note:** In children, there may be frightening dreams without recognizable content.
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) **Note:** In children, trauma-specific reenactment may occur in play.
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Posttraumatic Stress Disorder



- Criterion C: Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Posttraumatic Stress Disorder

- Criterion D: Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia, and not to other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently ruined”).
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings)

Posttraumatic Stress Disorder

Criterion E: Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

- Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
- Reckless or self-destructive behavior.
- Hypervigilance.
- Exaggerated startle response.
- Problems with concentration.
- Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

Posttraumatic Stress Disorder

- Criterion F: Duration of the disturbance (Criteria B, C, D and E) is more than 1 month.
- Criterion G: The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Criterion H: The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Differential Diagnosis and Overlap Symptoms

- Adjustment Disorders
- Acute Stress Disorder
- Disruptive Mood Dysregulation Disorder
- Depression
- Anxiety/Panic Disorders
- Conduct Disorder/Personality Disorders
- Dissociative Disorders

- Insomnia
- Difficulty Concentrating
- Anhedonia
- Social isolation
- Excessive self blame or guilt
- Mood disturbances

Prevalence of Trauma and PTSD amongst male and female offenders

- Trauma among male prison population: varies between 62% to 100% - roughly double that in a community-based male population.
- Experiencing sexual abuse: 15-16% of male prisoners in sharp contrast to the 1-3% in the general population.
- 5% of men experience PTSD symptoms, however, an estimated 60% of men in prison have symptoms and signs of severe to moderate PTSD
- The lifetime prevalence of PTSD among a sample of incarcerated women was 53 %, compared with a prevalence of 10 % in the general population

Resilience: Why are some effected by trauma more than others?

- Early childhood attachment and support systems are the biggest predictor of future resilience.
  - Adverse experiences and other trauma in childhood, however, do not dictate the future of the child. Children survive and even thrive despite the trauma in their lives. For these children, adverse experiences are counterbalanced with protective factors.
- Tools common to resilient people are optimism/realistic outlook, a moral compass, religious or spiritual beliefs, cognitive capacity and emotional flexibility.
- Other factors for resilience include: the motivation and ability to learn and engage with the environment, the ability to regulate emotions and behavior, and supportive environmental systems, including education, cultural beliefs, and faith-based communities (social connectedness)

Treatment for PTSD

- Psychotropic Medication
  - FDA Approved Antidepressants: selective serotonin reuptake inhibitors (SSRIs) sertraline and paroxetine HCl.
  - Mood Stabilizers/Antipsychotics for management of acute symptoms
  - AVOID Benzodiazepines
- Psychotherapy Techniques
  - Cognitive Behavior Therapy
  - Relaxation, breathing, and grounding techniques
  - Prolonged Exposure Therapy
    - Teaches individuals to gradually approach their trauma-related memories, feelings and situations. They presumably learn that trauma-related memories and cues are not dangerous and do not need to be avoided.
  - Eye Movement Desensitization and Reprocessing (EMDR)
    - The person being treated is asked to recall distressing images; the therapist then directs the patient to start side-to-side eye movements or hand tapping. EMDR is based on the idea that negative thoughts, feelings and behaviors are the result of unprocessed memories.

Three Phases of Trauma Therapy

- There is a three phase treatment protocol that is recommended by expert bodies on trauma:

- Phase 1: **Achieving patient safety, reducing symptoms and increasing competencies.** This is the skills building phase and clinicians can use any evidence based therapy that has outcomes of improving emotion regulation, increasing distress tolerance, mindfulness, interpersonal effectiveness, cognitive restructuring, behavioral changes, and relaxation. This phase can also help move someone out of crisis to prepare for the next phase.
- Phase 2: **Review and reappraisal of trauma memories.** There are different techniques for doing this, but the success of this phase hinges on someone's ability to tolerate the discomfort of reviewing the memories. People with single incident trauma may be ready to withstand exposure with minimal distress tolerance training, while people with complex trauma may need months of skills building support in order to be ready to process their trauma.
- Phase 3: **Consolidating the gains.** The therapist is helping the client apply new skills and adaptive understanding of themselves and their trauma experience. This phase can also include "booster" sessions to reinforce skills, increase professional and informal support systems, and create an ongoing care plan.

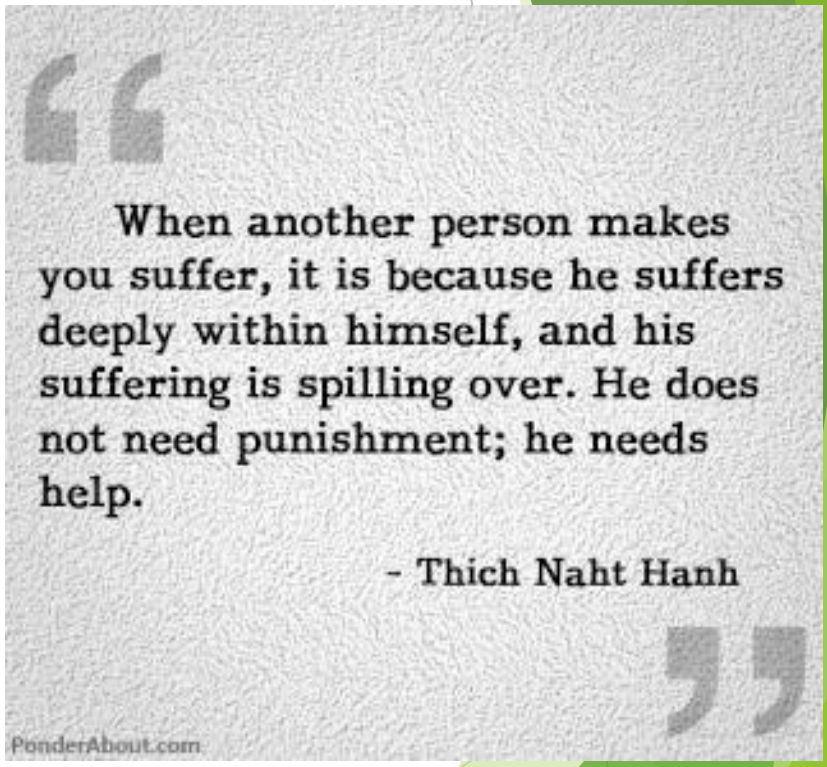
Perpetrator Trauma

- **Perpetrator trauma**, also known as **perpetration-** or **participation-induced traumatic stress** (both abbreviated PITS), occurs when the symptoms of posttraumatic stress disorder (PTSD) are caused by an act or acts of killing or similar horrific violence.

- Perpetrator trauma is similar but distinct from moral injury, which focuses on the psychological, cultural, and spiritual aspects of a perceived moral transgression which produces profound shame.

Perpetrator Trauma

- “Hurt people hurt people”
- Reactions to harming others
  - Remorse- our ability not only to know right from wrong, but also to feel regret for having made the wrong choice between the two
  - Pride- almost boastful of their legacy of violence
  - Rationalization- The vast majority of individuals who speak about their crimes rationalize their acts—to justify them as the right thing to do or to excuse them as forgivable or understandable in light of the circumstances.
  - Trauma-deeply scarred by being a participant in violent acts, so much that the person experiences the events repeatedly in a similar fashion to the victims.



Case Study #1

- 23-year-old male referred to behavioral health 3 weeks after admission for screening of insomnia and anxiety symptoms.
- Individual had no history of MH treatment. He was shot 4 years ago for the first time, and then shot again multiple times at the time of his arrest, resulting in injuries to his pelvis and both arms.
- Individual reported a recurring nightmare daily in which he is shot and dies. He wakes up in a panic and can not fall back asleep. He also reported feeling increasingly stressed. At this time, he denied any increased startle reflex, mood disturbance, or paranoia.
- On re-evaluation, the patient reported that he was becoming increasingly concerned that he was not safe and that he would be shot again. He stated he was starting to react to loud noises. He continues to have nightmares and insomnia despite vigorous workouts to tire himself out.
- He continued to struggle with medical issues related to his trauma event.

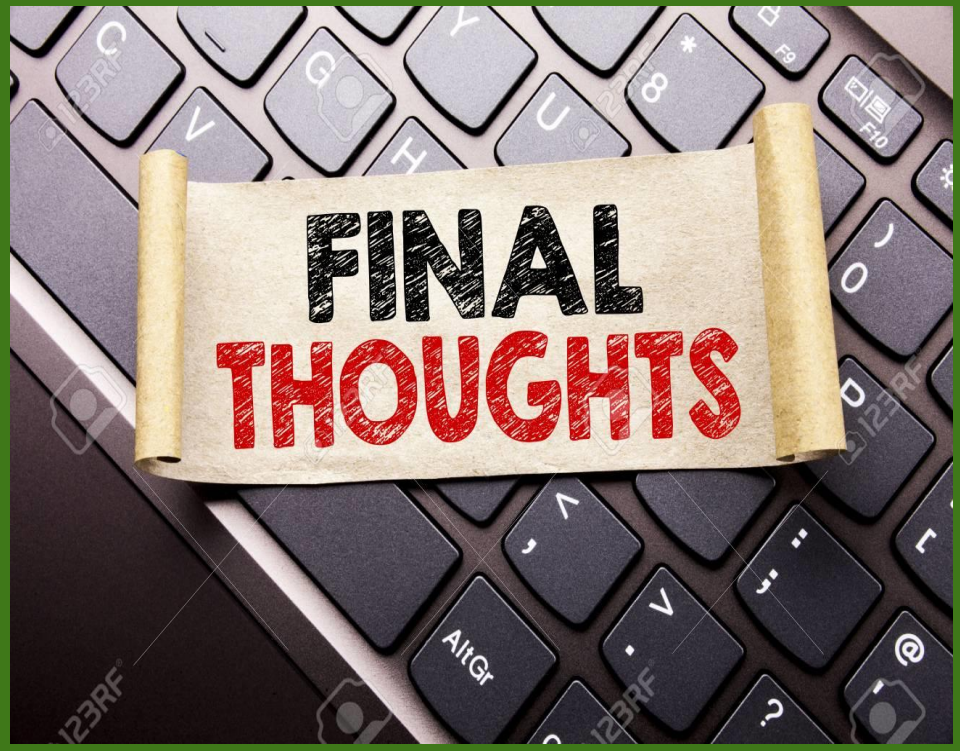
Case Study #2

- Admitted to the facility and screened by behavioral health. Reported history of abuse by aunt and uncle. No recent treatment. He was using cannabis prior to admission.
- Individual became increasingly anxious about housing placements, not feeling safe. Was placed on suicide watch about 3 weeks into incarceration and cleared to a new housing unit.
- A week later he was jumped by 5 individuals in his dormitory who caused significant injury to him. The aggressors were all placed in administrative segregation and the individual was admitted to the mental health unit for observation. It was reported that he was constantly on the phone, sometimes talking to no one. He denied this, stating he was using the phone to contact his family.
- Once in mental health housing he continues to present as anxious, not wanting to be outside of the watch of the post officer. He continued to report difficulty sleeping and excessive worry about his family, about his legal status, and his safety in the facility.
- A month after the assault he was transitioned to the mental health step down unit where he stated he felt safe amongst his peer group. He had some remaining symptoms of anxiety including excessive worry.

Case Study #3

- 6 individuals were involved in a riot in the correctional facility
  - Barricaded in maximum security unit, 6-hour standoff, set a fire and had to be extracted emergently from the unit by SORT.
- Immediately following the event, individuals were reporting symptoms such as nightmares, increased anxiety, agitation, increased paranoia, startle reflex, and insomnia.
- Individuals were followed weekly by mental health due to their placement in administrative segregation. Some had previously been engaged with mental health services prior to this incident and experienced a worsening of symptoms.
- Due to the traumatic way this event ended; these individuals had a great deal of difficulty taking responsibility for their role in the incident.

- There is a higher prevalence of trauma and associated symptoms in correctional populations
- This increased prevalence at times leads to the overdiagnosis of PTSD.
- Many individuals experience some symptoms and would benefit from treatment, yet do not meet the full criteria for a diagnosis of PTSD.
- The presented case examples demonstrate that even severe trauma experiences does not always equal a PTSD diagnosis.



Resources

- Posttraumatic Stress Disorder in the *DSM-5*: Controversy, Change, and Conceptual Considerations https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5371751/#:~:text=The%20DSM%2D5%20definition%20of,considered%20trauma%20in%20this%20definition
- Exhibit 1.3-4DSM-5 Diagnostic Criteria for PTSD https://www.ncbi.nlm.nih.gov/books/NBK207191/box/part1_ch3.box16/
- American Psychiatric Association Posttraumatic Stress Disorder file:///C:/Users/Owner/Downloads/APA_DSM-5-PTSD.pdf
- Psychotherapy Treatment for PTSD https://psychcentral.com/ptsd/psychotherapy-treatment-for-ptsd
- What Makes Some People More Resilient Than Others https://www.nytimes.com/2020/06/18/health/resilience-relationships-trauma.html
- Adverse Childhood Experiences and the Lifelong Consequences of Trauma https://www.aap.org/en-us/documents/ttb_aces_consequences.pdf
- Perpetrator Trauma https://en.wikipedia.org/wiki/Perpetrator_trauma#:~:text=Perpetrator%20trauma%2C%20also%20known%20as,killing%20or%20similar%20horrific%20violence.
- OF MONSTERS AND MEN: PERPETRATOR TRAUMA AND MASS ATROCITY https://columbialawreview.org/wp-content/uploads/2016/04/Mohamed.pdf
- Prison Traumatic Stress: https://www.news-medical.net/health/Prisoner-Post-Traumatic-Stress.aspx