



## Professional Responses to Potentially Traumatic Events

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### “Diagnosis” of Post-Traumatic Stress Disorder (PTSD)

- It is not like a disease, which you either have got or not, and medical tests can identify what disease it is
- It is just a collection of difficulties (called symptoms) that a committee have decided to call PTSD when they appear together
- PTSD is quite a fuzzy and broad collection of symptoms; but as a rough and ready description of post-traumatic distress, it is quite useful

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### Diagnostic criteria PTSD (DSM-5, 2013)

- A. Exposure to actual or threatened death, serious injury, or sexual violence
- B. Intrusions**
- C. Avoidance**
- D. Changes in cognitions and mood**
- E. Arousal & reactivity**
- F. Duration more than 1 month
- G. Clinically significant distress or impairment of function
- H. Due to event, not due to physiological effects of a substance or medical condition

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**Intrusion symptoms**  
(PTSD Criterion B; 1 of 5: DSM-5, 2013)

- Intrusive memories
  - Or repetitive play in which the event or aspects or themes of the event are expressed
- Nightmares
  - Content may not be recognisable
- Dissociative reactions (e.g. flashbacks, reenactment)
- Psychological distress or physiological reactivity in response to reminders

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**Avoidance of stimuli associated with the event**  
(PTSD Criterion C; 1 of 2: DSM-5, 2013)

- Of internal reminders (e.g. memories, thoughts, feelings)
- Of external reminders (e.g. people, places, conversations, activities, objects, situations)

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**Negative alterations in cognitions & mood**  
(PTSD Criterion D; 2 of 7: DSM-5, 2013)

- Amnesia
- Exaggerated negative beliefs about self, others or world
- Distorted thoughts about causes or consequences
- Persistent negative emotional state (e.g. fear, horror, anger, guilt or shame)
- Diminished interest or participation in significant activities
- Feelings of detachment or estrangement
- Inability to experience positive emotions (e.g. happiness, satisfaction, love)

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**Marked alterations in arousal & reactivity**  
(PTSD Criterion E; 2 of 6: DSM-5, 2013)

- 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 behaviour
- Hypervigilance
- Exaggerated startle response
- Problems with concentration
- Sleep disturbance (e.g. difficulty falling or staying asleep or restless sleep)




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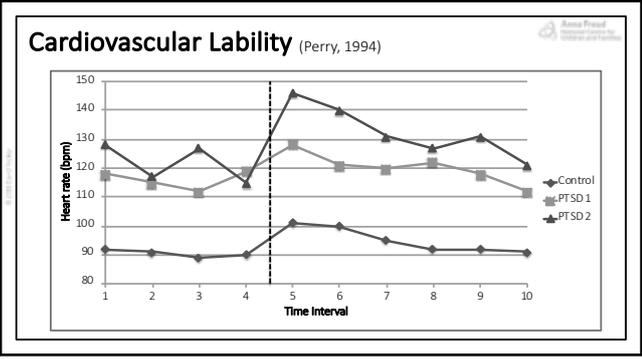
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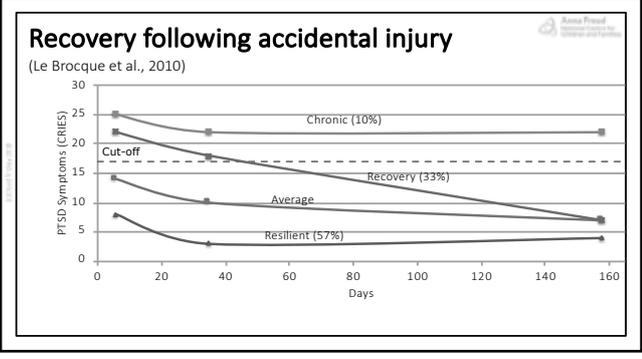
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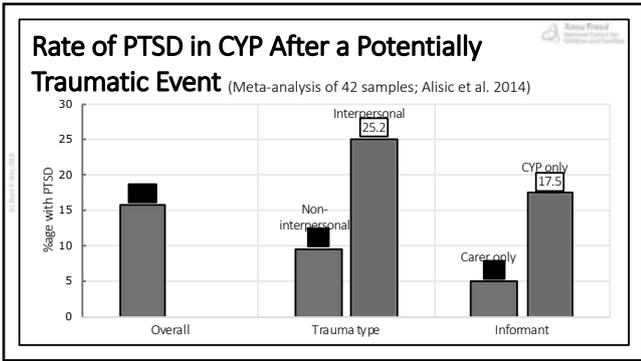
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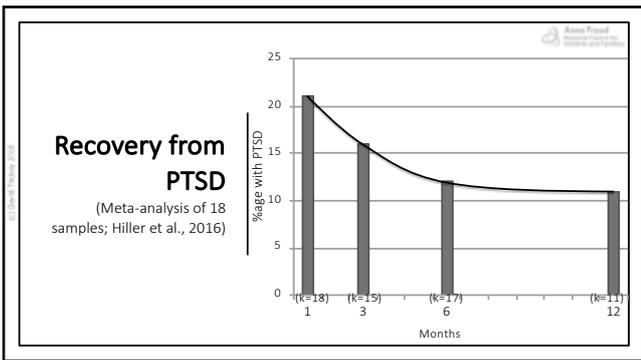
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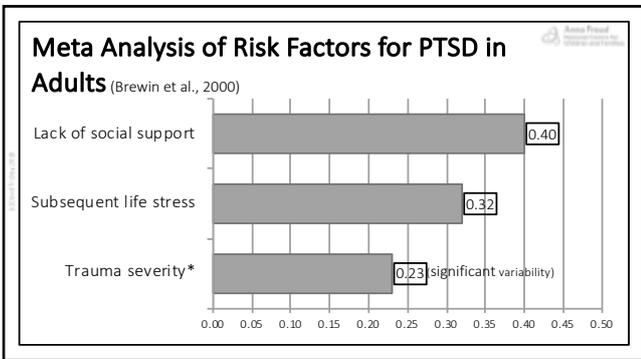
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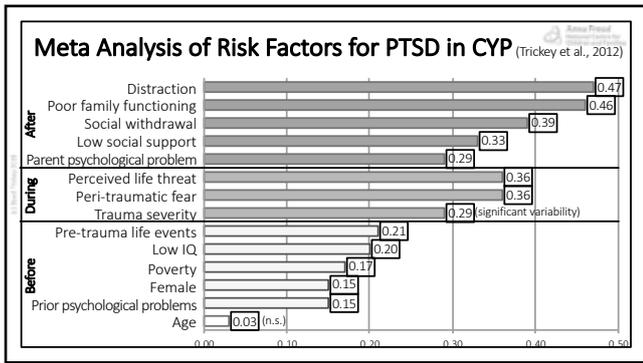
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### So what?

- Perception trumps reality
  - So it doesn't really matter what we think about whether an event was traumatic or not; it matters what they think
- How well the carers are doing is as important as the actual event
- Some things that happen afterwards are more important than how big or bad the event actually was, especially:
  - Lack of social support
  - Social withdrawal
  - Poor family functioning
  - Distraction

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### Watchful waiting

- Lots of children and young people recover spontaneously
- Some develop chronic problems
- (There is also a group from 2%-10% that develop delayed PTSD)
- Trauma-focused CBT seems to help those that get PTSD
- Watchful waiting is an approach of active monitoring suggested in the current NICE guidelines
- But rather than just waiting to see if they get PTSD, what can be done to enhance resilience and maximise the chance of spontaneous recovery?

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## Five Evidence-informed Principles

(Hobfoll et al., 2007)

- In the absence of any really good evidence, what can be done?
- Evidence-informed
- Guidelines, not a manual
- Resilience can be enhanced by promoting:
  - Sense of safety
  - Calming
  - Sense of self- and community-efficacy
  - Connectedness
  - Hopefulness



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