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Intermittently through 2014

POST-TRAUMATIC STRESS DISORDER

Media background Q&A outline

1
Clinically, Post-Traumatic Stress Disorder (PTSD) is a very specific syndrome of emotional responses and symptomatology following exposure to trauma.

Unfortunately, the term "PTSD" has come into common usage in a general manner referring to any response to trauma, but that is not clinically useful (and has led to the over-diagnosis of "PTSD" in a manner that causes confusion regarding both the nature of the problems present and the best indicated mental health treatment).

2
A person may have uncomfortable memories and feelings about a disturbing/traumatic event – in fact, a person *should, quite normally,* have uncomfortable memories and after such an experience – but that, of itself, does not constitute symptoms of PTSD.

3
The specific clinical syndrome of Post-Traumatic Stress Disorder, it is best understood as an unresolved reaction of the mind and body to an experience that is of sufficient disturbance (trauma) to cause a "fight or flight" response.

4
That response involves the body automatically marshaling all resources (physical/physiological and mental) toward being ready to flee a danger or fight an enemy.

Processes related sleep, digestion, memory and even immune response are suppressed.

5
The focus of attention becomes narrowed and directed towards the perceived threat.

This causes a perception that time is "slowing down."

As the brain is intensely processing the threat, normal storage of memory does not occur.

6
If "all goes well", after the threat or danger has passed, the mind and body return to normal functioning - and the experience is "reprocessed" into memory, as would any event.

Depending upon many different variables, sometimes (but not always) this occurs spontaneously.

7
Post-Traumatic Stress Disorder occurs when memories of a traumatic/disturbing event have *not* been able to be re-processed into a "normal" memory.

Instead, all of the data – the cognitive memory and the sensory information – are retained "floating" in the unprocessed state available for immediate recall when triggered by even minor, irrelevant events or at times, spontaneously.

8
In this state, the experience can easily be triggered to flood back into consciousness – not as if recalling a memory, but *as if it is being re-experienced*. Hence, a "flashback."

The "re-experience" of the situation is then actually re-traumatizing, and *again* elicits a "fight or flight" response – even though the actual danger has passed.

9
This in turn deepens the unconscious commitment to staying at a level of "red alert" – which becomes increasingly disruptive of normal functioning.

The resulting constant state of hypervigilance and hyper-reactivity foments depression, psychophysiological symptomatology, impulsivity and counter-productive attempts to reduce distress (dysfunctional behaviors, substance abuse, etc.)

10

<u>PTSD can be treated through with modalities</u>. Most of the time, post-traumatic symptomatology can at least be lessened with comprehensive treatment.

- **Psychotropic medications – pharmaceutical suppression of some of the effects and symptoms**
- **Relaxation techniques**
- **Supportive ventilation that encourage a normal "reprocessing" of the information**
- **Deeper exploration into other issues of fear and trauma which may be complicating resolving the acute situation**

11

In the most severe situations, effective treatment can be very difficult.

Treatment is especially difficult when the trauma has been extreme or repetitive; when the person has other co-existing emotional problems; and/or when the person has a history of having previously been traumatized.

12

Effective treatment occurs when interventions are based upon a full and comprehensive evaluation of the individual regarding all contributing medical, emotional, family, relationship, psychosocial and socioeconomic factors.

EVERY PERSON SUFFERING FROM PTSD IS A UNIQUE INDIVIDUAL INTERACTING WITH A COMPLEX SOCIETY