By My Own hand: Act and Impact in PTSD

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Aims of the presentation

- To outline the case for presenting a more inclusive approach to events and activities currently considered in Criterion A of PTSD that also take into account how our own actions can lead to developing PTSD
- To outline assessment implications
- To outline treatment implications, especially in relation to shame and guilt
- To consider implications for research

DSM 5 PTSD Diagnosis: Criterion A (APA, 2013)

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

- Directly experiencing the traumatic event(s).
- Witnessing, in person, the event(s) as it occurred to others.
- 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.
- 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.

A number of studies demonstrate that 'Non-Criterion A' events can lead to PTSD, however.

Part 1

Instructions: Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)						
2. Fire or explosion						
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)						
4. Serious accident at work, home, or during recreational activity						
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)						
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)						
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)						

Who did **What?**

Note that the LEC-5 asks about 'Things that happened to me' (as in being a 'victim' of) and not 'caused by me'

Victims, witnesses and 'perpetrators'

- Research that has explored events that can lead to PTSD have almost exclusively focused on incidents where people have been 'victims' or witnesses, rather than 'perpetrators' of the event / action, which has led to them developing PTSD from their own behaviour

- ***'… a broad summary of the research literature available on traumatic stress suggests that the research has almost exclusively focused on victim impacts after the event. In comparison, less research is available on how to assess and treat distress associated with being responsible for causing traumatic events to occur (Steinmetz, Gray and Clapp, 2019: my italics).***

ACTS (e.g., rape) versus Events (e.g., tsunami)

- ‘After intentional human-caused acts, survivors often struggle to understand the motives for performing the act, the calculated or random nature of the act, and the psychological make-up of the perpetrator(s)’ (SAMHSA, 2012)

- **What if YOU are the ‘perpetrator’?**

Cognitive Model of PTSD

- **Ehlers and Clark's (2000) model of PTSD has recently been empirically supported in a large study (see Beierl et al, 2019)**
- **Central to this model is that '… individuals [with PTSD] are characterised by idiosyncratic negative appraisals of the traumatic event and/or its sequelae that have the *common effect of creating a sense of serious current threat' (italics in the original).***
- **Further, Ehlers and Clark (2000) *argue that '… appraisals of the way one felt or behaved during the event can have long-term threatening implications'* .**
- **Thus, it is important, for example, to consider shame, guilt, incompetence, a sense of being bad/evil as having an important role in maintaining current threat in a wider range of human experience than that suggested by 'Criterion A' of the DSM V**

Negative appraisals leading to threat (Ehlers and Clark, 2000)

What occurred?

- Trauma happened
- It happened to me
- Emotions during trauma
- Other people reactions
- Physical consequences

Appraisal

- ‘Nowhere is safe’
- “I attract disaster” world isn’t safe
- ‘I deserve bad things that happen’
- ‘Nobody cares’
- ‘My body is ruined’
- ‘I will never be able to live a normal life again’

Potential negative appraisals leading to threat in ‘Perpetrators’

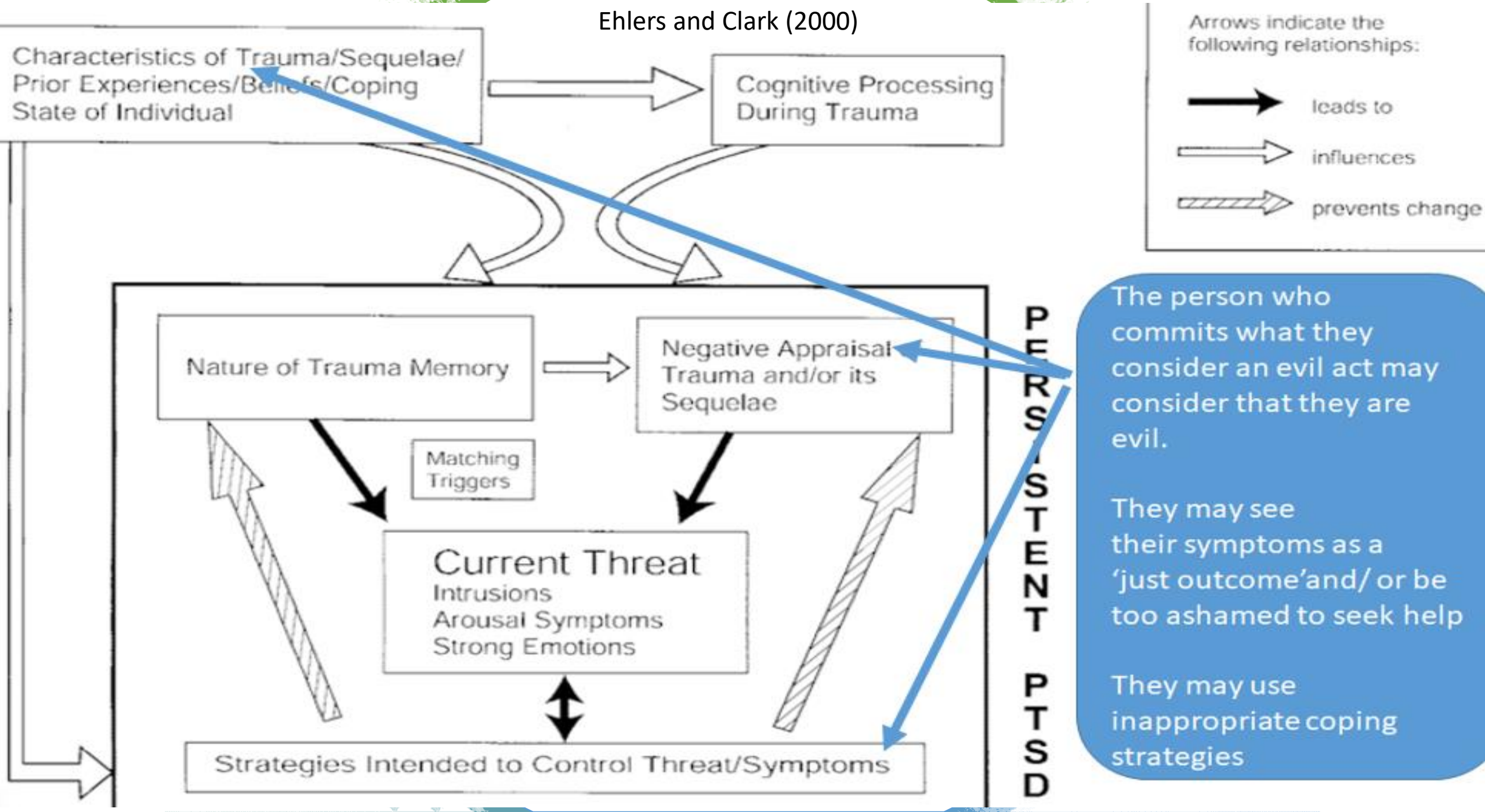
What is appraised?

- Event happened
- I did it
- Emotions during trauma
- Irritability/outbursts
- Emotional numbing
- Other’s reactions
- Loss of liberty

Negative appraisal

- I am dangerous (what if it happens again), ‘I was weak’
- ‘I am bad, evil’, ‘I am dangerously incompetent’
- ‘This is more proof that I am bad, evil’, ‘I am a risk to self/others’
- ‘More proof that I am nasty, bad’
- I’ am strange, why don’t I feel more after doing it’
- ‘Others will hate me for this’. ‘Others will not want to have anything to do with me’
- ‘I will never get out’

Ehlers and Clark (2000)

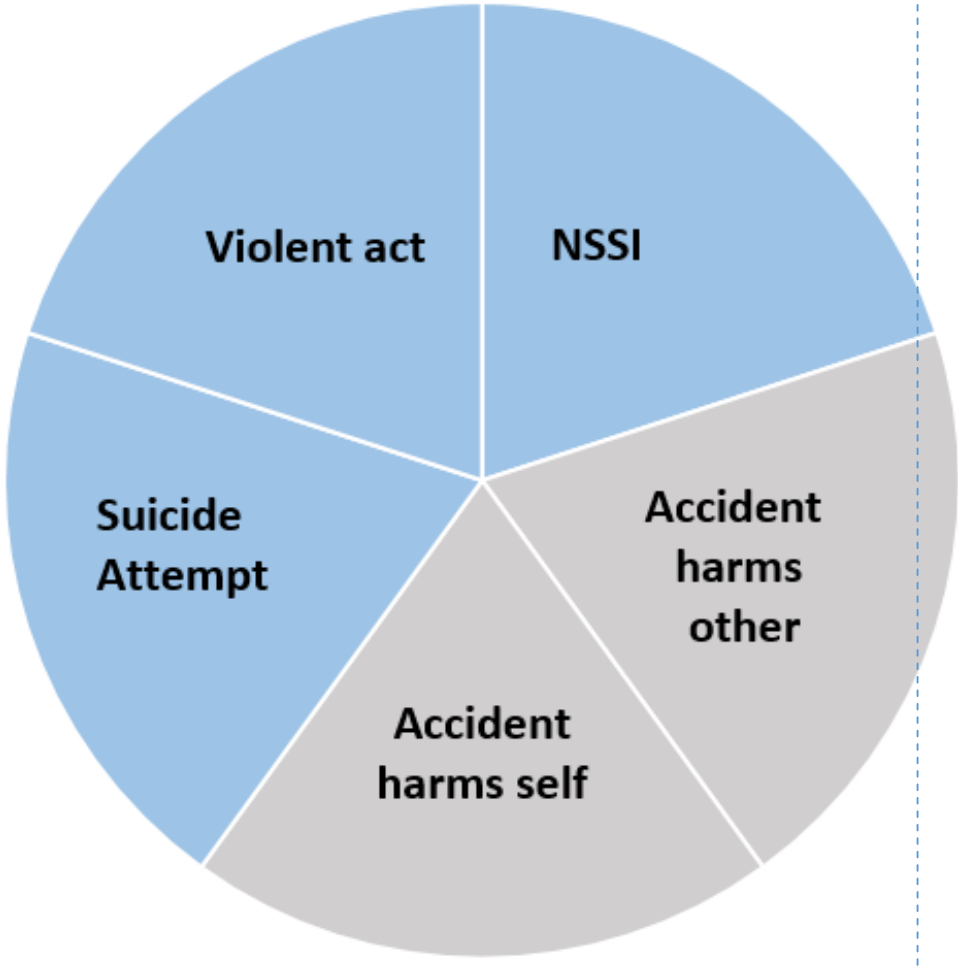


The person who commits what they consider an evil act may consider that they are evil.

They may see their symptoms as a 'just outcome'and/ or be too ashamed to seek help

They may use inappropriate coping strategies

'Perpetration': Acts that may lead to PTSD



Violent acts

- Good evidence that perpetration of violence is associated with PTSD in *the perpetrator*

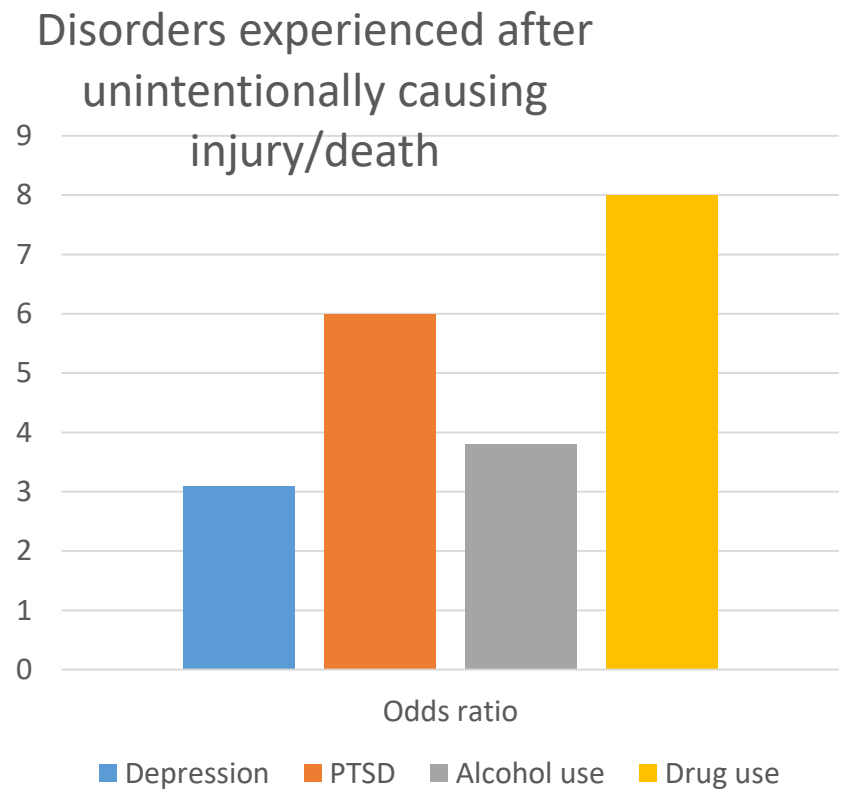
Studies have shown that

- 52% of **homicide perpetrators** met criteria for PTSD (**Reactive violence** accounted for 95% of PTSD cases and in **82% of these cases the offence was reported as traumatising:** Pollock, 1999).
- Forty-five patients in a low-secure unit - offences ranged from attempted robbery to manslaughter/murder (plus sexual offences): **40% with PTSD** (Crisford, Dare and Evangeli, 2008)
- Regression data found that guilt and offence severity were significant predictors of PTSD symptoms (but ethnicity and trauma history were not)

Accident harms others

- National survey data (n= 5692). 110 respondents had **un**intentionally caused injury or death to another person and these persons had higher rates of mental health problems (Connorton, Miller, Perry and Hemenway, 2011)

- This included an elevated risk of developing PTSD



Accident harms self

Evidence that ‘self-inflicted’ needle stick injury can lead to PTSD in doctors (Naghavi et al, 2013).

There are likely many instances where people have developed PTSD based on accidental acts that have harmed them. This is likely under-researched.

Acting against the self: Direct/Indirect self-harm and High-Risk behaviours (Green et al, 2017) - Role in PTSD

INDIRECT self-harm and HIGH RISK BEHAVIOURS and their relationship to PTSD is much less researched than DIRECT self-harm. INDIRECT self-harm/HIGH RISK BEHAVIOURS may pose a risk to self, but also to others (e.g., reckless driving).

*	Bodily harm	Intention	Examples
Direct self-harm	**Immediate**	**Desire to hurt self**	**Cuts, burns**
Indirect self-harm	**Not always, but often**	**Ambiguous**	**Provoking fights**
High-risk behaviours	**May occur, error could lead to serious harm or death**	**Often unclear**	**Reckless driving Unsafe sexual behaviour**

* Minor adaptations from Green et al (2017)

Non-Suicidal Self-Injury: Direct self-harm

- NSSI can be extreme and involve cutting, burning, inserting objects, enucleation and amputation
- In themselves, these events can be described as traumatizing (required for Criterion A)
- If sufficiently severe, they can also be experienced as life threatening (regardless of intention)
- NSSI offers (at least) two possible pathways to PTSD
- (1) The event itself
- (2)Even if the act does not in and of itself lead to PTSD any necessary admission to ICU may lead to PTSD (see Griffiths et al, 2007 for PTSD and ICU admission)
- Thus far unable to find research on this (this may be due to a lack of research interest in the topic – see PTSD and attempted suicide)

Indirect Self-Harm: High-Risk behaviours (O'Hare and Scherrer, 2009)

High-Risk behaviors in 276 people with severe mental illness attending outpatient service

Risky behaviours and Events Scale
(O'Hare et al, 2006)
Attempted suicide
Self-Mutilation
Ran away/unaccounted for
Overdosed on medication
Had unprotected sex

Experience of trauma had a large, significant effect on High- Risk behaviours

High-Risk behaviours – significant mediator between lifetime trauma and PTSD symptoms

'Rather than a linear view from trauma to PTSD it is reasonable to consider interactive and reciprocal relationships amongst trauma, high-risk behaviours and PTSD symptoms'

Acts against the self: Attempted Suicide

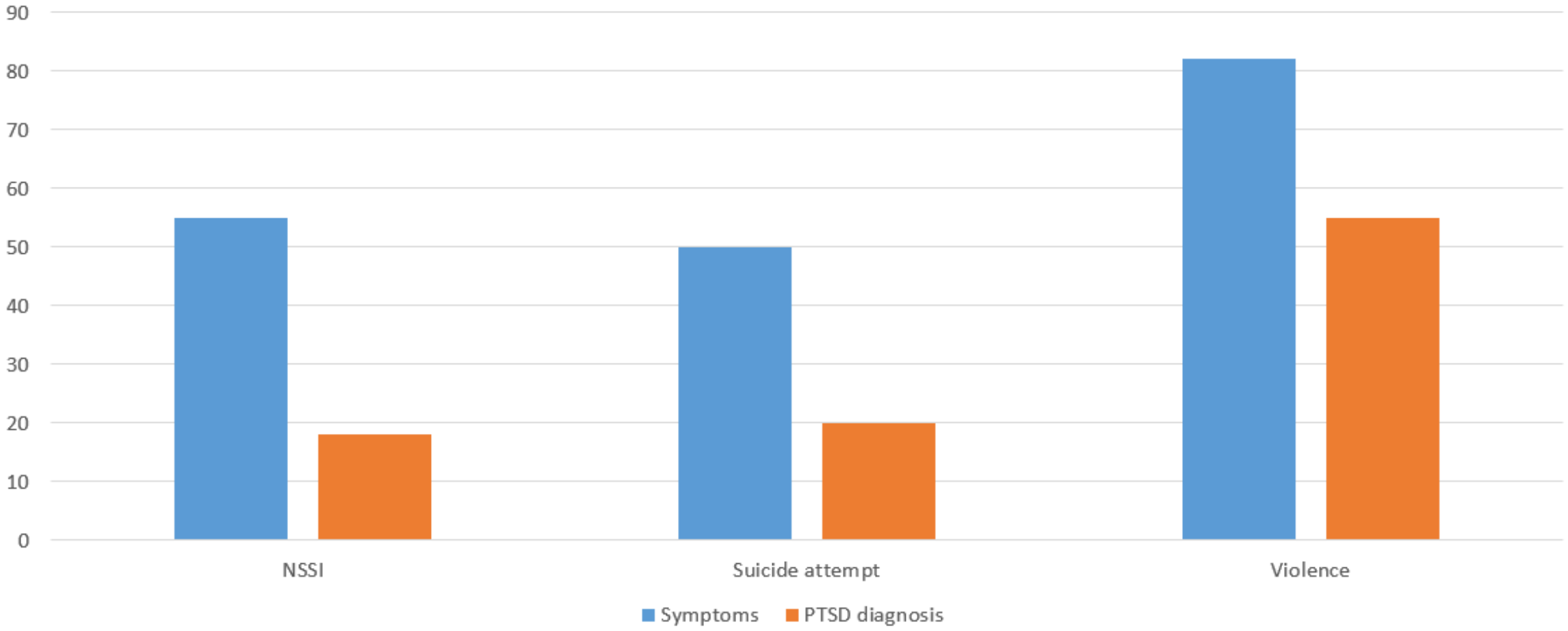
- Suicide attempts are, by definition, life threatening, and therefore arguably meet the 'Criterion A' requirement diagnostic nosology
- Also reasonable to argue that they are traumatic?

(Stanley et al, 2019)

- Participants (n= 386) with a history of suicide attempt recruited over the internet
- **28%** 'screened positive for a probable SA-related PTSD diagnosis'
- Significantly higher scores on a measure of suicidal intent in persons with a probable SA-related PTSD diagnosis

- Bill et al 2012
- Evidence of PTSD in psychiatric sample that was related to their suicide attempt.
- Thus PTSD from suicide attempts, may, be overlooked in service users as we focus on PTSD independent of this – and may not explore further than the reported incident

Survey of Psychologists (n=11) at STAH
Per cent of Clinicians who have encountered trauma symptoms/PTSD diagnosis in patients who have engaged in NSSI or Suicide Attempt or Violence



Clinical Implications: Assessment

- We need to assess the potential for PTSD in wider circumstances (e.g., suicide attempt) and be mindful of the possibility of delayed onset PTSD
- Service users may not, for a variety of reasons report PTSD from own actions (lack of recognition as a symptoms of PTSD, shame and guilt) so clinicians will need to ask rather than assume it will be volunteered
- We need to assess for High-Risk behaviours more often and have good tools to do so as the relationship between high risk behaviours
- We need improved screening tools for PTSD that, at a minimum, include items related to accidental behaviour and suicide attempts. These need to be mentioned explicitly rather than be covered under a generic ‘any other event’ as they would be good prompts and add ‘legitimacy’ / validation to the experience
- Important for clinicians to consider that PTSD from own actions in service users that have pre existing PTSD for other events, and who also engage in high risk behaviours including self harm, suicide attempts and who engage in violence towards others.

Clinical Implications: Therapeutic interventions

- We need to better understand the role of shame and guilt in PTSD and the optimal therapy for same (see Lee, Scragg and Turner, 2001: see also Norman, Allard, Browne, Capone and Davis (2019)
- We may also need to assess a wider range of factors such as a sense of incompetence
- It may be useful to train personnel in aspects of blame, hindsight bias and so on before they assume key responsibilities – could this reduce the incidence of PTSD?

Research

- We need new assessment tools for PTSD
- We need better assessment of high-risk behaviours
- Better understanding what leads to PTSD from our own actions (self, nature of the action / intentionality/ severity / outcomes etc.)
- Epidemiologists/theorists should not assume a causal direction (e.g., PTSD *leading to* suicide attempt)
- We need to know if ‘self vs other cause’ differentially affects treatment seeking, treatment dropout and successful outcome of treatment.

Summary

- PTSD from own actions arguably does meet expectations for Criterion A for PTSD. This can be from intentional and unintentional acts.
- Existing psychological models can be used to formulate the psychological mechanisms that underpin PTSD
- Suggests the relationship between self harm and PTSD is more dynamic - we can't assume that PTSD triggers self harm, as self harm may very well trigger PTSD.
- PTSD from own actions is perhaps likely to be overlooked and not assessed for in Mental Health Services.
- Considerably more research is needed to understand this phenomenon, its relationships to other types of trauma (complex PTSD and Moral injury) and to guide clinical activities (assessment and intervention)