PTSD Information Booklet

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Introduction

Posttraumatic stress disorder, or "PTSD", can develop in individuals who are exposed to trauma, regardless of gender, age, culture, or other demographics. PTSD is more complicated than it may appear. In fact, our reactions to traumatic or stressful events vary and are influenced by many factors.

The purpose of this booklet is to offer insight and understanding into the concept of PTSD. Our goal is to provide relevant information starting with the stress experience, mechanisms of PTSD, treatment for PTSD, and other sources of intervention. By doing so, we also hope to open pathways for respectful and supportive communication, and facilitate access to treatment, if required.

When someone experiences PTSD symptoms, the individual themself and the people around them will inevitably be affected. The PTSD Information Booklet can therefore offer information for the individual experiencing PTSD, as well as their social support system (e.g., family members, friends, colleagues) to better understand it.

This booklet can be read and discussed together, or individually, in its entirety or in sections, depending on personal preference.

It is not the intention to provide an exhaustive list of symptoms, or to completely describe all relevant scientific knowledge related to the topic.

There are risks and harm related to self-diagnosis or diagnosing others in an individual's direct or indirect environment based on the knowledge gained in this booklet or anywhere else. Communicating a diagnosis is the responsibility of a licensed and registered professional, under controlled and regulated circumstances using the proper diagnostic tools. This booklet is not to be used as a substitute for seeking professional help.

PTSD belongs to the so-called "trauma- and stressor-related disorders" category in the 5th TR-edition of the Diagnostic and Statistical Manual of Mental Disorders, the official diagnostic tool used by designated health care professionals. Therefore, as a first step in explaining what PTSD is, this document will start with a short explanation about stress, then we will provide some information on trauma- and stressor-related disorders. As a next step, we will explain what trauma means, and then we will discuss PTSD in greater detail. By the end, we aim to have answered the most common questions related to PTSD and to have offered a relevant list of resources.

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STRESS

Stress is a normal, non-specific response of the body to any demanding situation.

A non-specific response means that the physiological stress response is the same whether it is a positive stress (known as **eustress**) or a negative stress (known as **distress**), which the person has to adapt to.

Stress affects individuals on a physical and psychological level. To relieve it, we either need to change the stress-causing factors or manage the effects of the stress itself.

Stress can mean different things to different people. Something that is stressful for one person could be a neutral event or a positive challenge to another. Despite the differences in the experience of stress and the stress response, there are still some common features. Let's start with the types of things, known as stimuli or stressors, that cause stress.

POSITIVE STRESS
EUSTRESS

Challenging
Growthful
Constructive
Beneficial

NEGATIVE STRESS
DISTRESS

Harmful
Demanding
Damaging

Stressors

Stressors can be anything that an individual perceives as a source of stress (e.g., noise, time pressure, etc.) and that induces a stress response. What is defined as a stressor is based on individual perception, so it can be different for everyone. Everyone has events or circumstances in their lives that trigger a stress response more quickly or more intensely. Even the anticipation of a stressor can cause a stress reaction that is as real as any actual exposure.

Types of stressors

Everyday hassle (e.g., commuting, housework, etc.)

Significant life changes or turning points (e.g., starting a new job, divorce, etc.)

Catastrophes or traumatic events (e.g., unpredictable large-scale events, major accidents, natural disasters, violence, etc.)

Catastrophes or traumatic events are the most direct triggers for PTSD; however, exposure to a traumatic event does not necessarily lead to the development of PTSD. Some factors can create a vulnerability to experiencing PTSD. In other words, the connection between traumatic stressors and the development of PTSD is essential, but not causal.

Characteristics of stressors

Salient events: Events that may affect major life domains such as work and family, especially when they are negative.

Overload: Multiple stressors can build up (or compound) and become overwhelming.

Ambiguous situations: Unclear events may lead to a stress response more often.

Uncontrollable events: Unpredictable and uncontrollable events may be more challenging.

Length of stressors

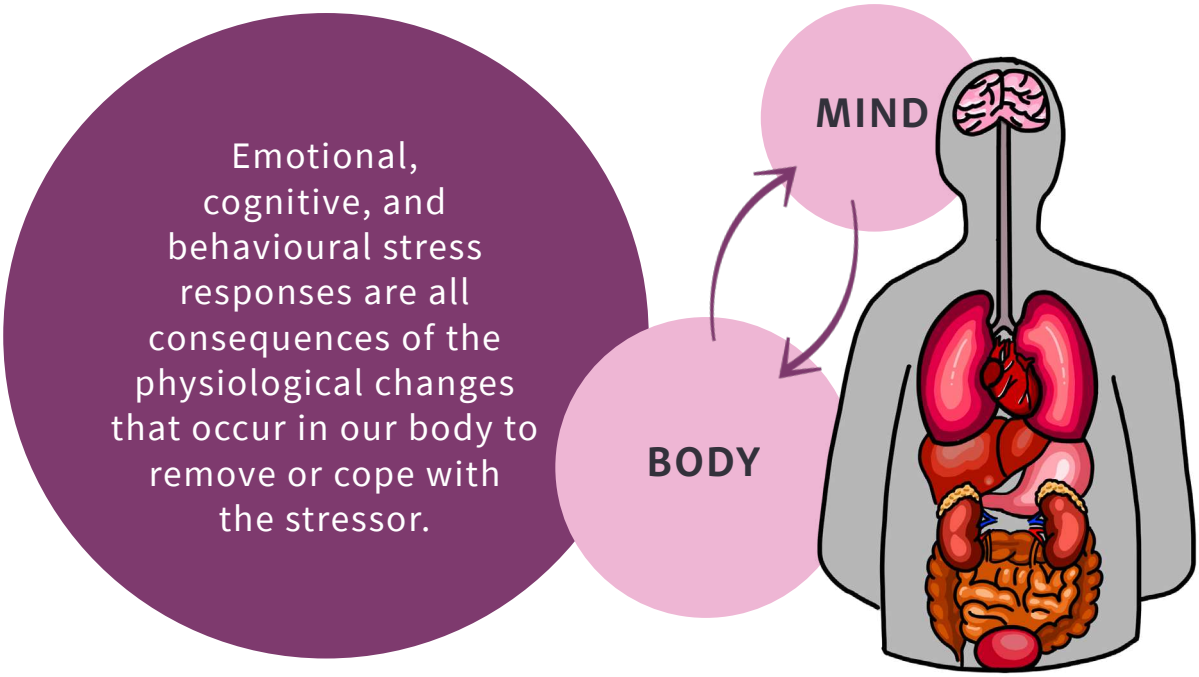
Acute Stress
Triggered by a short-term stressor, which disappears quickly

Chronic Stress
The result of a long-term stressor, such as a demanding job

Stress reaction

The stress reaction can be emotional, cognitive, behavioural, and/or physiological. Some might experience changes at each of these levels with high intensity, while others might only experience a few of these or have a very minimal response. Alternatively, some might only experience changes that affect certain areas of the stress reaction, while others might not even be aware that these reactions are happening to them. Various situations can provoke different and individual patterns of response, regardless of the person's awareness.

Experiencing a stress response during or after exposure to a stressor can be the healthy, adaptive, and protective response the body takes to prepare itself to cope with the situation. Following exposure to short-term, acute stressors, a stress response is part of the adaptation process. On the other hand, exposure to an intense, severe, uncontrollable, and chronic stressor can lead to psychological distress. However, experiencing some symptoms does not necessarily indicate that there is a mental health issue or problem.



Did you know?

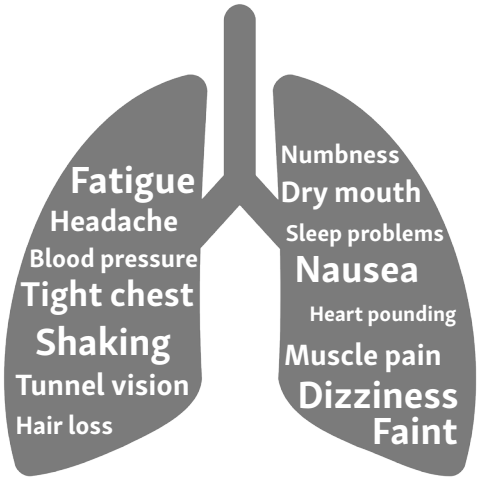
Usually, we are not merely passively responding to stress. We typically undergo a **cognitive appraisal** process, whereby we assess the demands of the stressor and the resources available. Our stress experience can be influenced by the outcome of our appraisal process. Researchers have defined four ways of initially appraising a stressor:

1. irrelevant
2. benign or positive
3. harmful and threatening
4. harmful and a challenging

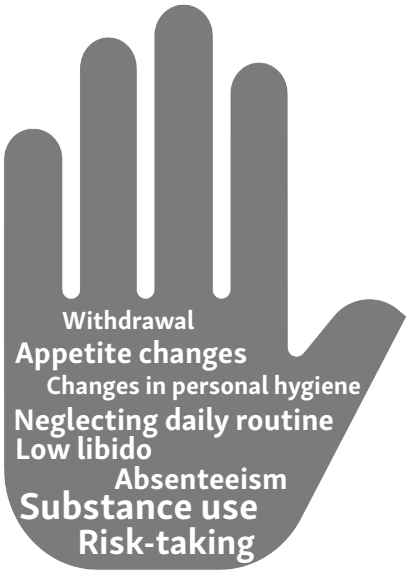
Effects of distress response

Emotional effects

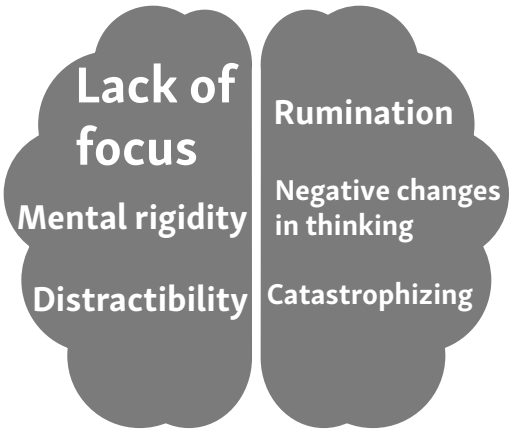
Physiological effects



Behavioural effects



Cognitive effects



Did you know?

Protective factors can buffer the negative effects of stress even under extreme circumstances. Examples of protective factors are effective coping skills, social support, optimism, self-esteem, and finding meaning.

Physiological stress response

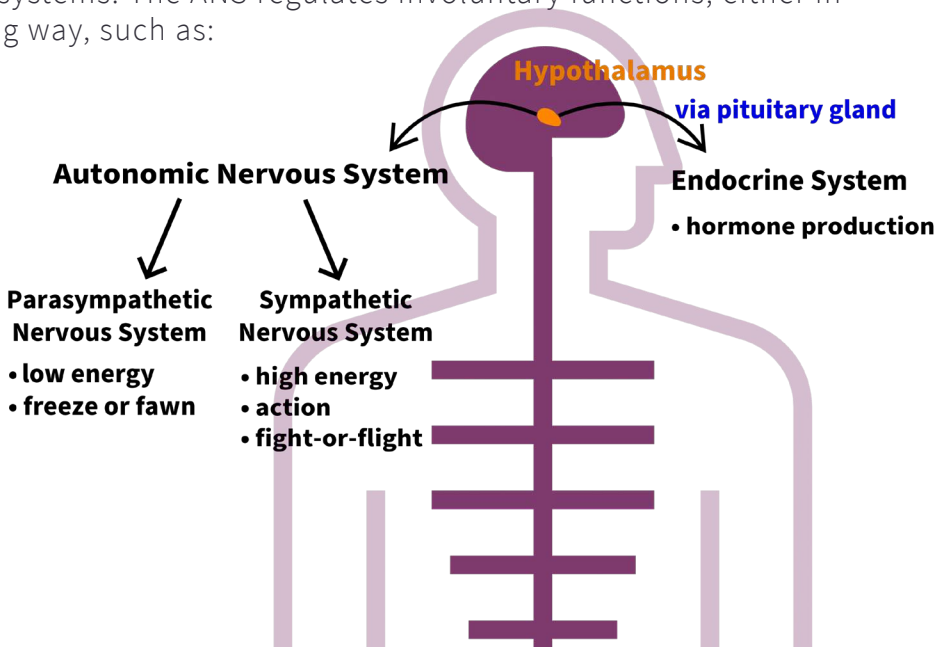
When we experience a risky or dangerous situation (e.g., a bear jumps out of the woods in front of us), our brain and body typically react to it, which is known as a physiological stress response. This response prepares us to "fight, flight, freeze or fawn" by energizing the brain and the muscles to take action. Getting excited about something or being afraid of a dangerous situation are registered in the same area of our brain, called the hypothalamus.

The hypothalamus is responsible for many functions in our brain, such as:

- creating a link to emotions and interest in rewards
- connecting the autonomic nervous system (ANS), which is the first, and fast reacting component of the stress response system
- helping to regulate the endocrine system (which controls the endocrine glands that secrete hormones) via the pituitary gland. This way it activates the hypothalamic-pituitary adrenal (HPA) axis (page 9), which is the second, slower reacting part of the stress response system

The **autonomic nervous system** has two parts, called the sympathetic and parasympathetic nervous systems. The ANS regulates involuntary functions, either in an increasing or decreasing way, such as:

- heartbeat
- blood pressure
- breathing
- digestion
- urination
- pupillary response
- fatigue
- circadian rhythm
- sleep
- body temperature
- involuntary control of smooth muscles
- thirst, etc.



When we encounter a hazardous situation, the hypothalamus signals part of the autonomic nervous system called the **sympathetic nervous system (SNS)**. The SNS is responsible for enhancing our arousal and expending energy. It creates the physiological part of the stress reaction (page 8).

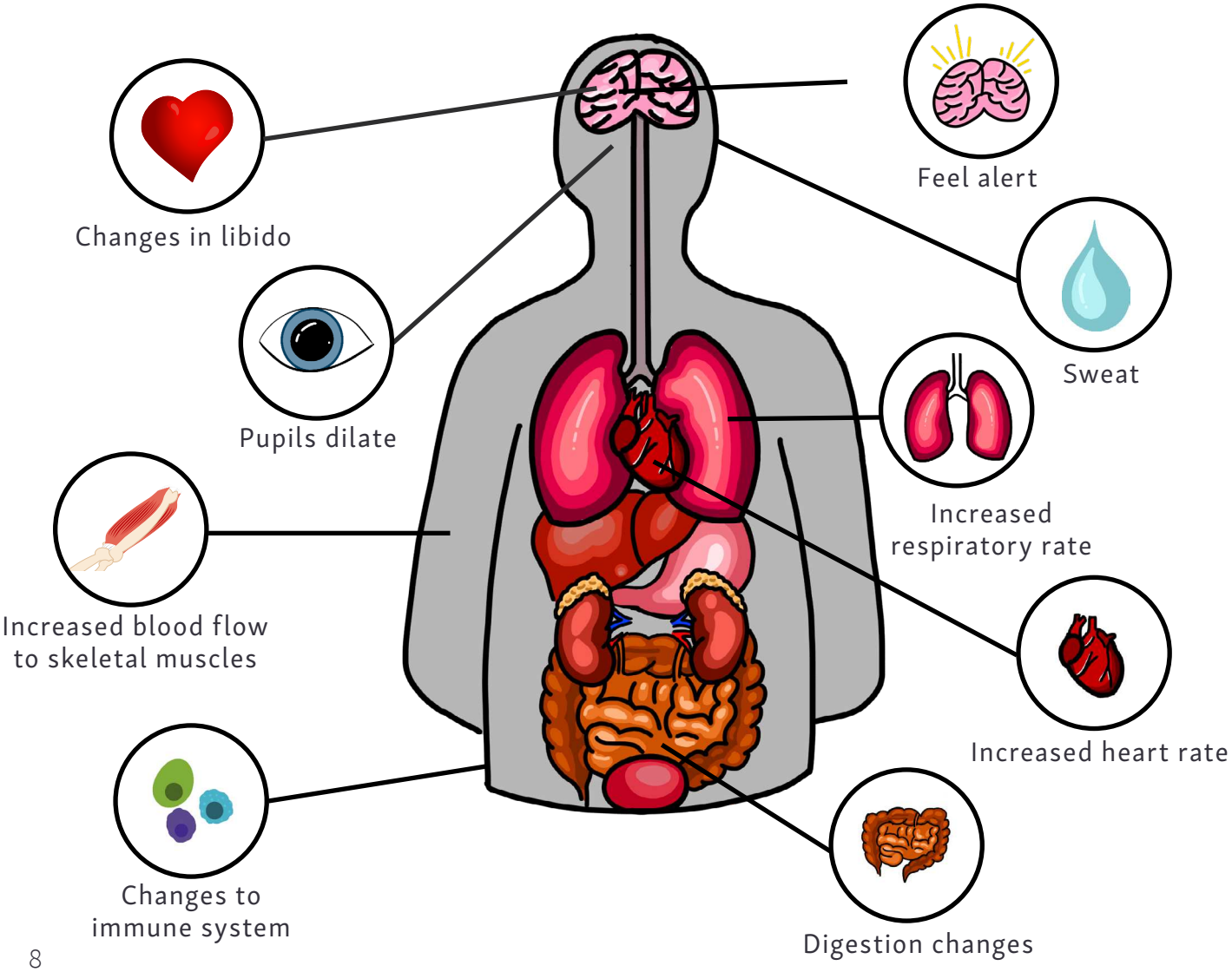
The SNS has a complex connection to organs like the liver, pancreas, and adrenal glands. The adrenal glands, for example, produce adrenaline and noradrenaline. These chemicals help to control alertness and arousal. However, when the body produces an excess amount, we experience more intense feelings (e.g., fear, anxiety). After dealing with the stressful situation, the **parasympathetic nervous system (PNS)**, the other part of the ANS responsible for conserving energy, can assist with calming us down.

Sympathetic nervous system

In the presence of stressors, the sympathetic nervous system is in charge of arousing the body and producing the necessary energy to react. It is a priority for our body to adapt to stress because it enhances our chances for survival. Our brain handles stress as a temporary "emergency situation" where energy needs to be reorganized to protect our body. Some examples of biological responses to stressors include:

- Blood sugar, or glucose (a source of energy), is produced with the help of cortisol.
- Heart rate increases to pump blood quickly to the skeletal muscles and deliver the glucose in preparation for physical and mental activity.
- Muscles tense up.
- Functions that are not critical, such as digestion, are adjusted, whereby diarrhea or constipation may be experienced as a result.
- The immune system goes through several changes.

When the stress response is not temporary because of continuous stress exposure, the alarm reaction may change into resistance and finally it may lead to exhaustion.



Hypothalamic-pituitary adrenal axis

The hypothalamic-pituitary adrenal (HPA) axis connects the brain's reaction to stress to the endocrine system, which responds to stress several seconds slower than the nearly instantaneous response provided by the direct pathway through the SNS. The hypothalamus reaches the adrenal glands through the pituitary gland to produce a group of stress hormones such as cortisol, adrenaline, and noradrenaline. These stress hormones can travel through the body and alert the whole system. Furthermore, endocrine hormones can stay in the body from minutes to hours after the stressful event occurred. This means that while the situation may be resolved, the person may continue to experience anger, fear, or irritability due to the lasting effects of endocrine hormones. Moreover, stress hormones can influence immune system-related functions (e.g., fighting or inducing inflammation, creating more vulnerability to infection), and their long-lasting circulation can damage neurons in the hippocampus, which can negatively impact memory, for example.

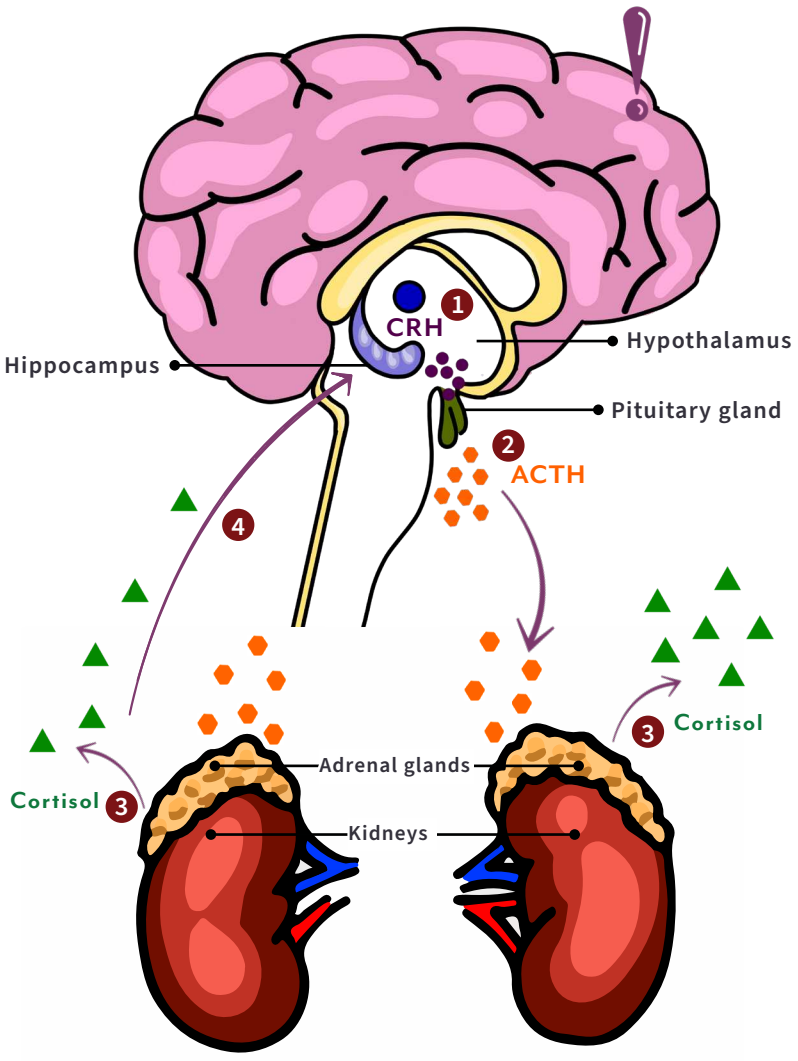
1) Getting excited or being afraid is registered in the hypothalamus, which releases the corticotropin-releasing hormone (CRH).

2) The CRH reaches the pituitary gland which, in turn, releases the adrenocorticotropic hormone (ACTH).

3) The ACTH travels through the body to the adrenal glands. The adrenal glands release cortisol, which is responsible for the "fight-or-flight" response.

4) Cortisol travels throughout the body, including the brain, where it can cause short-term memory loss because of its impact on the hippocampus. Cortisol has other effects including (but not limited to):

- changing how the body manages fat, sugar, and protein
- changing appetite/sleep rhythms
- narrowing arteries to help the blood circulate faster
- suppressing inflammation and the immune system



Arousal

Arousal can be defined as a normal and alert state of the nervous system used to pay proper attention to the environment and to know and process what is happening around us. The whole body is alerted by the nervous system, and it offers the chance to respond and interact with the surrounding environment.

Stress reactivity

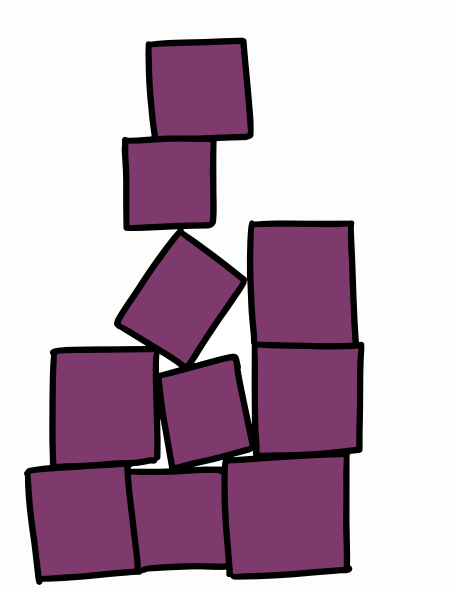
Stress reactivity is an individualized, unique capacity to respond to different stressors. The threshold, the extent, and the intensity of the physiological reaction to stressful or dangerous experiences is unique and varies from individual to individual.

Individual factors

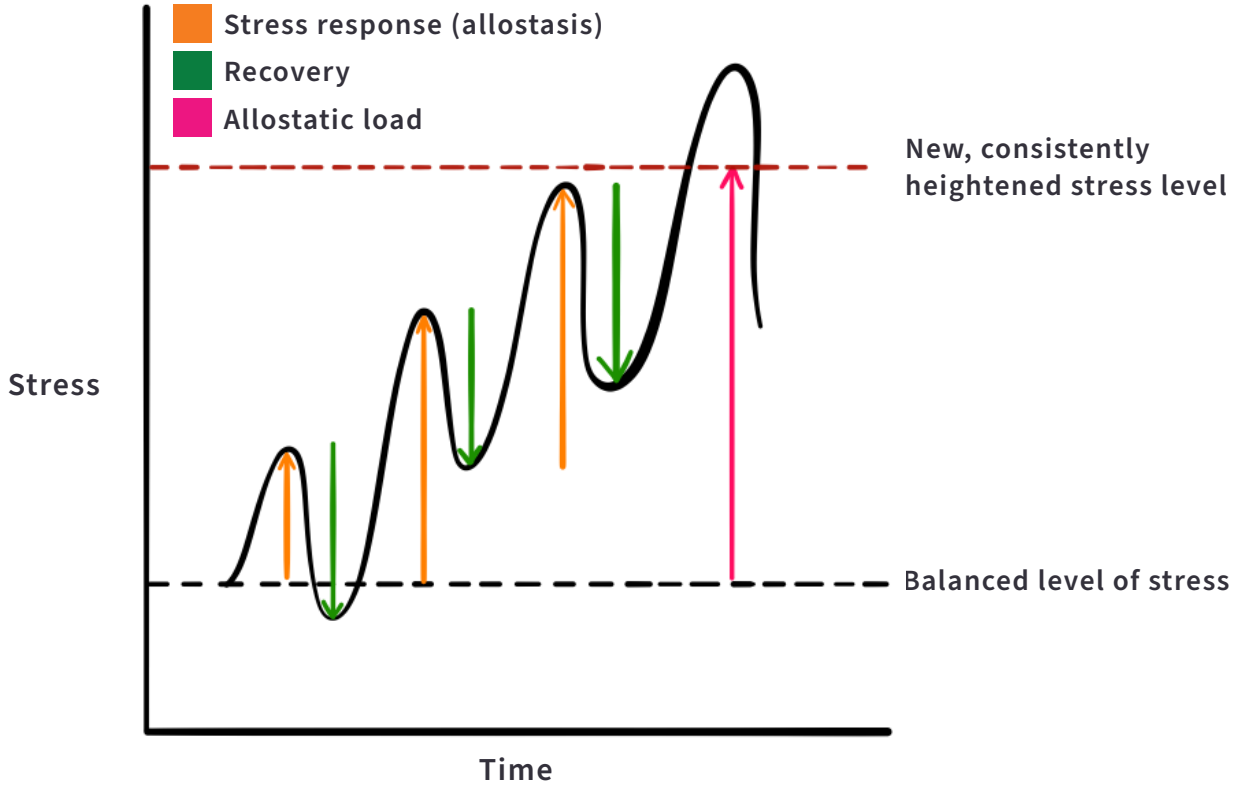
Physiological reactions to demanding situations can vary based on many factors, like gender, genetics, and previous or early childhood experiences. Individual appraisal of the situation can have some modifying effects.

Allostasis and stress recovery

When an individual experiences distress, the reaction involves the person's full being. The state of dealing with stress is called **allostasis**. With chronic or repeated distress exposure, the physiological changes can build up into something called an **allostatic load**.



After the physiological response to stress (when the fast and slow stress responses stop, and the parasympathetic nervous system has allowed the individual to calm down), the body can begin recovering; however, recovery can be cut short by another exposure to a distressing situation. Over time, the body may never reach full recovery if it experiences repeated stress stimuli.



Some researchers think that humans constantly fluctuate between dealing with distress and working on recovery. Over time, each fluctuation can be experienced with more difficulty and the recovery can be less effective.

Some indicators of a heightened allostatic load can include: decreased immunity (e.g., increased number of infections/illnesses); continuous cortisol production; changes in the hippocampal volume, which relates to memory problems; changes in learning processes; high blood pressure; and a higher level of adrenaline production.

Stress resistance

Based on differences in physiological stress reactivity, individuals can differ in their stress resistance. Some individuals may be more resistant in times of adversity (whereby they may remain healthy), while others may be less resistant to stress.

Resistance to stress can be influenced by many psychological factors such as:

- stress appraisal (how the stressor is evaluated)
- coping skills (how the person manages or adapts to stress)
- personality traits (e.g., optimism, hardiness, resilience)
- quality of and access to social support (e.g., spouse, friends, professional help), etc.

This may partially explain why some people are more resistant to stress, but can also be used to help people become more resilient to stressors.

The challenges that we solve and cope with can improve health, while the situations with negative outcomes may contribute to health problems, such as headaches, digestive problems, and blood pressure issues. People who are exposed to stress frequently can be more vulnerable to mental health problems (e.g., anxiety, mood changes, sleep difficulties, substance use, or trauma- and stressor-related disorders) and physical problems (e.g., diabetes, cardiovascular disease, etc.). Even emotional reactions can affect the brain by triggering the autonomic nervous system and the endocrine system, which release stress hormones. Stress hormones may, in turn, influence many areas of functioning, such as the immune system, sleep, mood, cognitive processes, or the cardiovascular system (heart rate and blood pressure changes).

Although stress may not directly cause illness, it can create vulnerability because of its influence on physiological and behavioural reactions. With respect to behavioural reactions, we may see changes in health habits such as smoking, drinking, eating (overeating or poor nutrition), and sleep patterns. Negative changes in health behaviour usually decrease the likelihood of, or may create delays in, seeking help and/or following care.

Stress reactions have a specific purpose; namely, they can motivate us, help us focus, or prepare us to overcome a challenging situation. Healthy habits (e.g., healthy nutrition, exercise routine, sleep routine, etc.) to a certain extent, may be able to compensate and balance out the stress reaction that is caused by daily hassles. If an individual wants to pursue learning strategies to manage stress, they can consult with different types of professionals that are available in their area.

Chapter summary

- Stress is a normal, human response.
- Eustress refers to positive events that require adaption.
- Distress refers to negative events that require adaption.
- The stress response can support survival and enhance performance.
- The physiological stress response involves many different bodily systems, causing wide-spread changes in the body, brain, and emotions.
- A stress reaction can be experienced on emotional, cognitive, behavioural, and/or and physiological levels.
- Stress resistance can be improved.
- The extent to which an individual experiences any of these changes is highly variable. This makes it hard to compare one person to another, because they may have very different symptoms, even though they are both having a stress response.
- Protective factors can reduce the negative effects of stress.
- Different people see stressors in different ways, such that some people will have a stress reaction from a certain stressor and others will not.
- Learning and changing how one sees and understands a stressor can help one change and therefore manage one's stress response.
- Social support can be an important protective factor against the negative effect of stress.
- Changing one's activities or routine (e.g., exercise, having a sleep routine, etc.) may help one to cope better with the experienced stress.

MENTAL HEALTH

What is mental health?

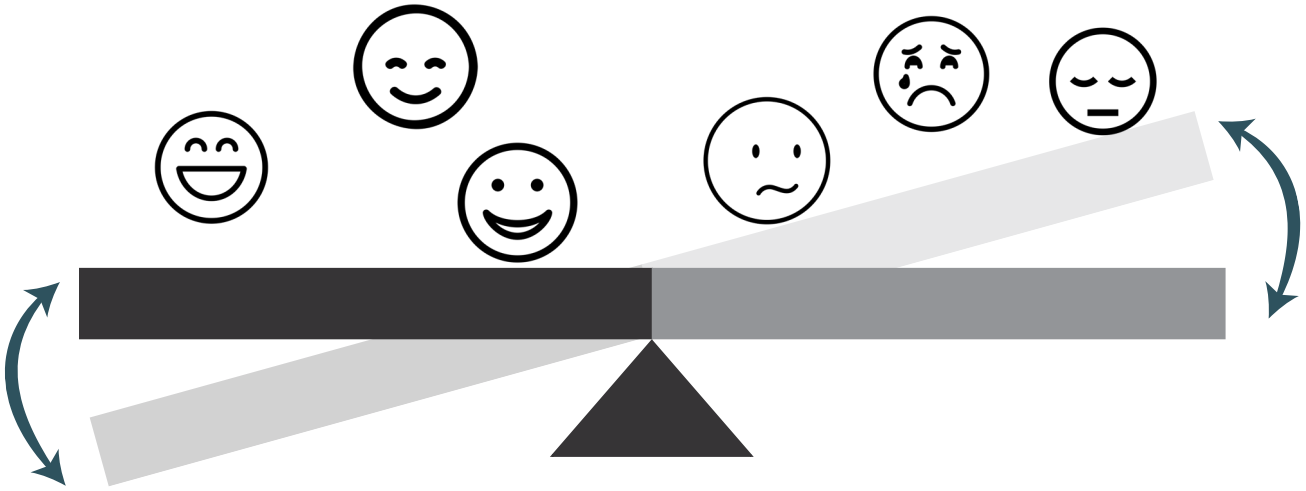
Mental health is an integral part of overall health. Mental health is determined by multiple factors that interact with each other, and its connection to physical health, behaviour, thinking and emotions is undeniable.

The meaning of mental health can change across cultures and varies by age. For example, we have different expectations for toddlers, adolescents, and adults in terms of abilities, coping strategies, and productivity.

> *"A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community"*
>
> (WHO, 2001, p.1)

Mental health and mental well-being

Health and illness are not exclusive terms, rather they can co-exist. Pleasant emotions (such as happiness and satisfaction) are important, but that does not mean that we cannot be sad, shy, disappointed, etc. when we are emotionally healthy, and it is appropriate for the situation. We aim for balance on individual, social, occupational, and environmental levels.

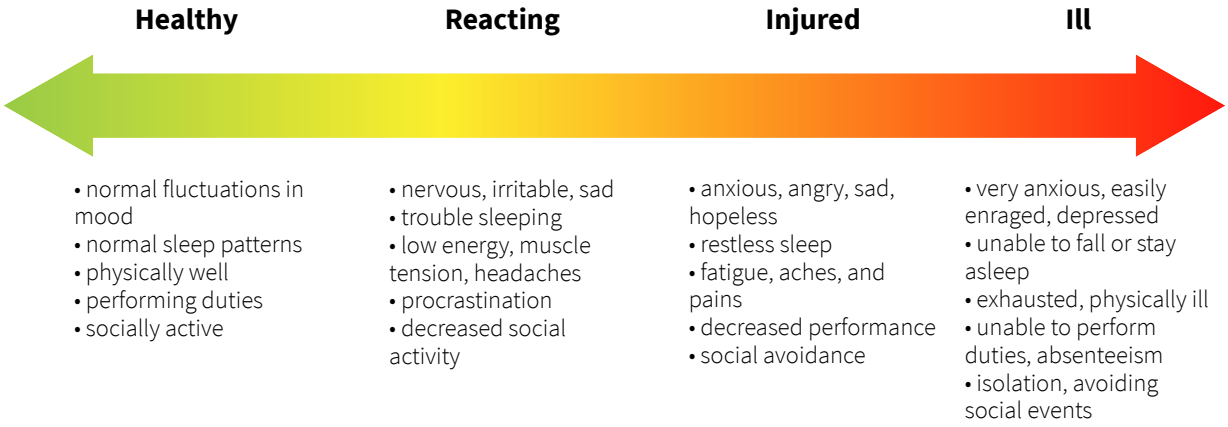


Mental health is a continuum

The mental health continuum model demonstrates different phases of mental health on a linear sequence. It is possible to move in either direction along this spectrum at any point in time depending on the dynamic interplay of several internal (e.g., biological, psychological) and external (e.g., situational, environmental) factors that may affect the person in continuously changing situations.

It is possible to identify with different points on the spectrum in different areas of life. For example, even if an individual is struggling with their occupational functioning and productivity, they could still be thriving on a social level and positively contributing to the community.

Understanding that we can deal with a mental health issue(s) and still be functional and mentally healthy in other areas are key concepts when we explain, interpret, or accept a mental health-related diagnosis. Poor mental health may not imply mental illness and vice versa. The presence of mental illness may not affect every area of human functioning.



What does "mental disorder" mean?

Mental health issues are just like any other health issue, such as high blood pressure, diabetes, or heart issues. They have biological, psychological, social, and cultural elements interacting with each other creating a unique combination of vulnerability and resilience. The mental health continuum model illustrates that one definition cannot capture all the detailed elements of a mental health issue; however, the American Psychological Association (APA) has offered an official definition.

> *"A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social,* occupational, *or other important activities."* (APA, 2022, p. 14)

Mental illness can affect anybody

Mental illness can affect anybody regardless of age, gender, geography, culture, socioeconomic status, ethnicity, or spirituality. Mental illness can affect us directly, or indirectly through a friend, colleague, or family member living with a mental health issue.

1 / 5
Canadians
will be **directly** affected by mental health problems at any given time
(CMHA, 2020)

50%
of Canadians
will have had a **personal experience** with mental health problems by age 40
(CMHA, 2020)

Mental health issues can impact cognitive ability, emotional regulation, and behaviour

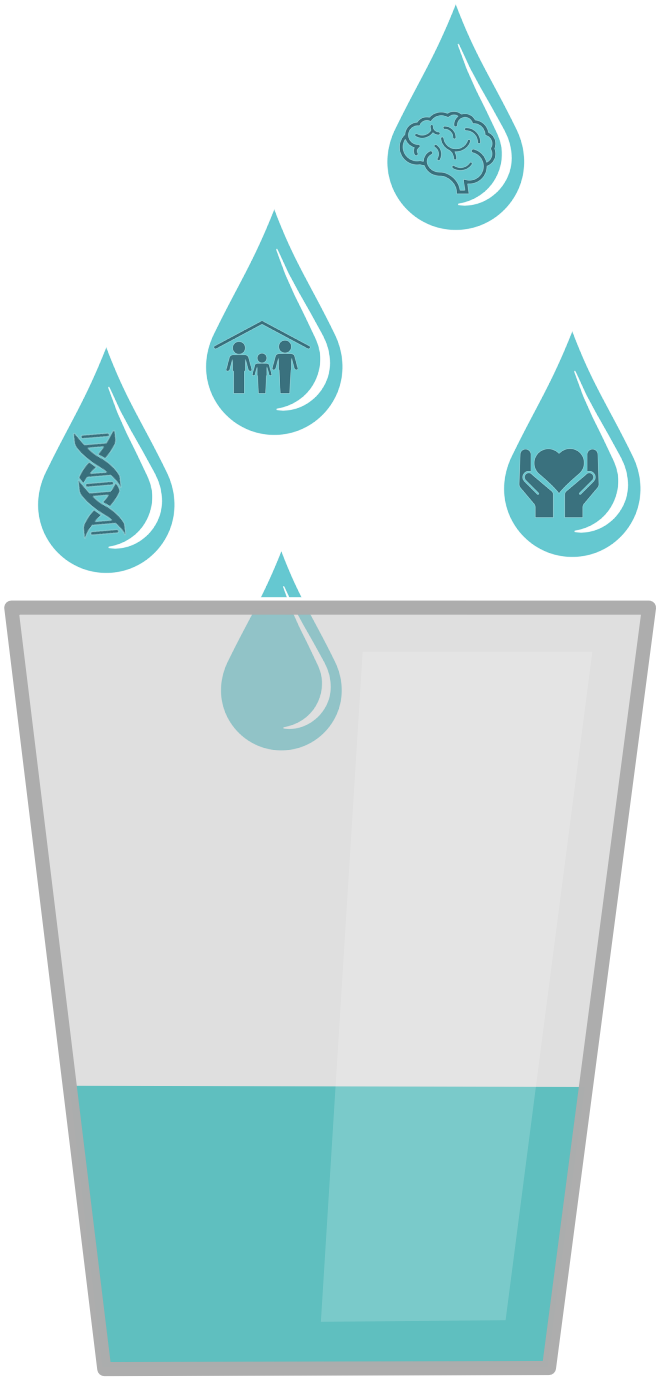
- thinking
- memory
- concentration
- focus
- decision-making

- shakiness
- changes in appetite
- changes in sleep patterns
- startle response

- fear
- anxiety
- sadness
- difficulty managing emotions

Mental health issues never have a single cause

According to the BPS+ model, even when it may be possible to pinpoint a trigger (which is not always the case), mental health issues are still caused by a complex interaction that involves genetic, physiological, psychological, social, environmental, cultural, and temperamental factors.



What does "being diagnosed" mean?

Usually, individuals who are diagnosed with a mental disorder are affected by their symptoms to a degree that interferes with their social relationships (e.g., marriage, friendship, etc.), occupational functioning (e.g., attending a job, paying attention at work) or other activities, or that causes clinically significant distress. Being diagnosed with a mental health issue(s) usually offers knowledge on what the person is dealing with. It may open up the door to resources (e.g., individual-, couple-, family-, or group therapy; medication; taking time off from work; and other community-based resources) to deal with the problem.

Did you know?

Based on the Controlled Act of Communicating a Diagnosis, only **regulated and authorized health professionals** (e.g., medical doctors, clinical psychologists) can give a diagnosis after completing a thorough assessment process.

What are the benefits of a diagnosis?

- A diagnosis can help individuals to access resources and different sources of support.
- A diagnosis can help individuals to understand more about their symptoms, treatment options, or future health risks.
- A diagnosis might help the clinician understand the expected duration of the mental health problem, which they can use to propose and implement an accessible treatment plan.
- A diagnosis can help an individual's social circle understand and learn more about what is going on, and how they can help the person who lives with a mental health issue.
- A diagnosis can be the first step to coping with the situation more effectively, and can help break the isolation.

What are the challenges of a diagnosis?

Mental health and mental illness are receiving more and more public awareness; however, people still deal with judgment and barriers because of the lack of knowledge related to mental health. Some report that the stigma around mental health problems creates another source of stress that needs to be addressed. Stigma can come from others, but a person can self-stigmatize as well. An example of how self-stigma could be experienced is when people cannot accept their mental health issues and may be afraid to seek help because they assume that it is a sign of weakness, or they blame themselves for developing symptoms in the first place. Shame is an emotion that is often experienced as a result of stigma and self-stigma. In this way, stigma can lead to rejection (e.g., employers not hiring somebody with a mental illness), or avoidance (e.g., not applying for a job, isolation, avoiding treatment).

Did you know?

Stigma is a negative stereotype that is not evidence-based, and causes assumptions and negative beliefs that are hard to change.

Discrimination is the behaviour that results from the negative stereotype and is seen when people are treated differently without reason or purpose.

Prejudice occurs when somebody agrees with negative stereotypes about a group and has an emotional response towards individuals who are perceived to be members of that group.

Accurate information can help fight stigma

It cannot be emphasized enough that stigma and stereotypes are the result of misconceptions that ignore facts. Educating people about mental illness and providing reliable, evidence-based information is one of the most effective ways to change the negative stereotypes and misconceptions associated with it and prevent discrimination.

Chapter summary

- Mental health is a complex phenomenon, which is determined by the interaction of multiple factors such as physical health, behaviour, thinking, and emotions.
- Mental health is a continuum, whereby mental health and illness are the two poles on this spectrum.
- The mental health continuum model helps to identify at which point a person may be situated at any given time.
- The presence of mental illness may not imply the absence of mental health and vice versa. Their co-existence may differ in degree and functional consequences for each person. Moving between the two poles of the mental health continuum is a normal process for human beings.
- Understanding where somebody may be situated on the mental health continuum in terms of different levels of functioning (social; interpersonal; occupational, etc.) may help them to access different sources of professional help offered in health care.
- Access to proper and accurate information about mental health can help to reduce stigma.

TRAUMA- AND STRESSOR–RELATED DISORDERS

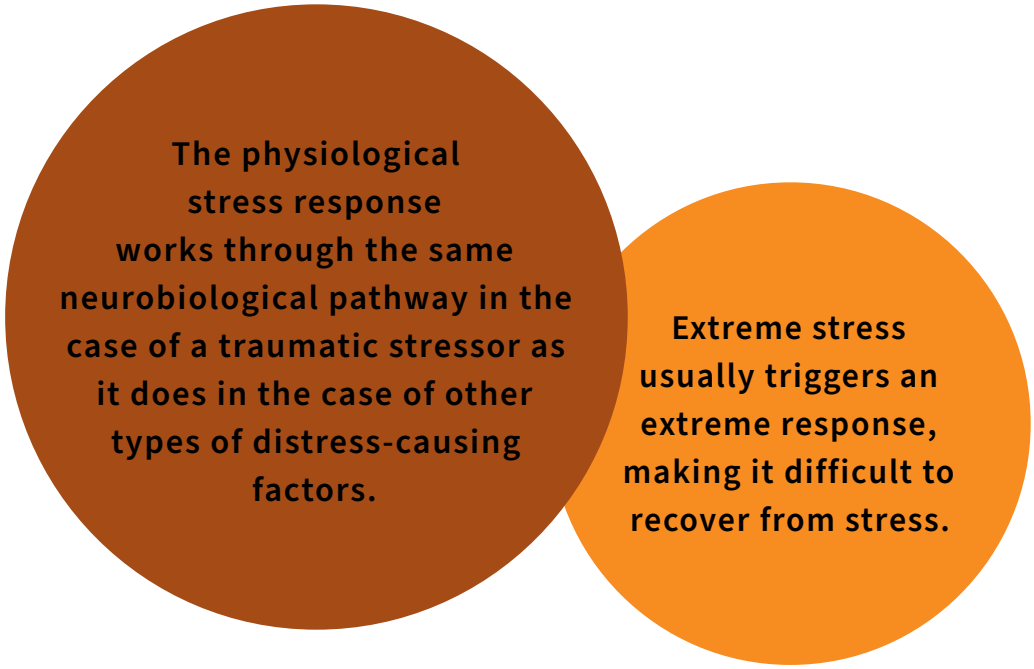
How are stress and PTSD related?

PTSD is a mental health issue and it belongs to the group of conditions called **trauma-and stressor–related disorders** in the DSM-5-TR (APA, 2022). The previous section on stress helped to identify some of the overlap between stress and PTSD. Some factors like stress reactivity, stress response, and allostatic load can clearly play a significant role in one's vulnerability to PTSD.

The physiological stress response works through the same neurobiological pathway in the case of a traumatic stressor as it does with other types of distress-causing factors. The differences can be identified in the extent, intensity, duration, and intrusiveness, and for that reason stress, chronic stress, and traumatic experiences are conceptualized as a continuum and viewed as a process. That process is reflected when Trauma- and stressor-related disorders were grouped together in the DSM-5-TR. When we have a better understanding of how stress and stress reactions affect us, it is easier to transfer that knowledge and make sense of what happens when we are exposed to more extreme and intensive stress stimuli, namely traumatic experiences.

Did you know?

The DSM-5-TR (Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition, Text Revision) is published by the American Psychiatric Association. It is the standard handbook used by mental health professionals to assess and diagnose mental disorders.



What are the trauma- and stressor-related disorders?

This set of disorders refers to a group of mental health issues that all develop after life events that are relatively and significantly stressful or, for some, even traumatic. They were classified based on their relation to a stressful experience(s).

The different mental health problems that can occur after experiencing a significantly stressful or traumatic event(s) are:

1. adjustment disorder
2. acute stress disorder (ASD)
3. posttraumatic stress disorder (PTSD)

Adjustment disorder

Adjustment disorder is the most common emotional and behavioural reaction to an identifiable and significant negative stressor (e.g., marital problems, financial crises, caregiving, developmental transitions such as leaving home or retiring). In this case, the stressor is not necessarily perceived as traumatic in nature. The symptoms start within 3 months of the stress experience, and are usually present for 3-6 months after the stressor and its consequences are over. Adjustment disorder is characterized by a significant emotional and behavioural response (e.g., impairs performance and/or relationships; challenges the person's abilities to cope and adapt).

Acute stress disorder

Acute stress disorder (ASD) is a reaction that begins after being directly exposed to a traumatic stressor. ASD is different than PTSD in timing, length, and symptom pattern. Symptoms can include negative changes to mood, avoidance, and arousal changes. Symptoms can start within 4 weeks of the traumatic exposure, and they last anywhere from 3 days to one month. Symptoms lasting less than 3 days do not fall under the criteria of ASD.

Did you know?

About 20% of those who experience traumatic event(s) develop acute stress disorder.

ASD is not a necessary "phase" to develop PTSD; however, 50 to 80% of those who develop PTSD may experience the symptoms of acute stress disorder (APA, 2022; Comer, 2015).

Posttraumatic stress disorder

Posttraumatic stress disorder (PTSD) is a mental health issue that can develop after directly experiencing or witnessing a traumatic, life-threatening event, or series of events in person.

PTSD can also develop if a person learns that a traumatic event (actual or threatened death that is either violent or accidental) happened to a close family member or close friend.

When these types of events happen to a person, it is normal to feel upset, on-edge, and to report stress-related symptoms. For some people, these stress-related reactions might fade away shortly after the trauma is over. For others, symptoms can persist a month after the trauma, and they might develop ASD. For others, symptoms continue to be present longer than a month, and they might develop PTSD.

In the case of PTSD, symptoms can occur immediately, but they usually, begin within 3 months of the traumatic exposure. When symptoms are present, it is worth seeing a trained professional to assess them.

Four groups of PTSD symptoms (see page 33) have been defined:

1. re-experiencing the traumatic event
2. avoidance
3. negative cognition and mood
4. arousal

Groups of PTSD symptoms

Re-experiencing the traumatic event

Re-experiencing usually happens in an intrusive form, such as repeated, uncontrolled memories, dreams/nightmares, and flashbacks. These events are involuntary, usually upsetting, and provoke some physical reactions. The experience can be so vivid that the individual might think the event is happening again.

Avoidance

The person puts in effort to avoid memories, thoughts, feelings, and external reminders (sounds, places, conversations, etc.) that could potentially provoke memories, thoughts, and feelings related to the trauma. Avoidance can manifest itself in many forms, such as staying busy, moving away from the scene where the traumatic event happened, avoiding crowded places where people are loud or where it is hard to manage visual control over the situation, and avoiding certain events because of noises, such as fireworks or beaches where children are yelling, etc.

Negative cognition and mood

There are a wide variety of symptoms for negative cognition and mood. Some individuals have difficulties remembering, some have negative beliefs and thoughts about themselves (e.g., “I am useless,” “I am dumb”), the world (e.g., “The world is dangerous”), others (e.g., “People are cruel,” “I cannot trust anybody”) or the future (e.g., “Things are never going to change for me”); some have unrealistic ideas about the cause or the consequence of the traumatic event, which can result in blame or self-blame (e.g., “I should have known better,” “I should have quit that job earlier”). The same variety applies to emotions like sadness, shame, guilt, anger, helplessness, numbness, or fear.

Arousal

Changes in arousal and reactivity can include excessive alertness, hypervigilance, startle response, irritability, angry outbursts, or sleep related problems. People find it difficult to relax; they might be afraid that something will happen and they will not be prepared to react.

Chapter summary

- Stress reactions, especially when they are lengthy in duration or happen repeatedly, may create vulnerability to some psychological disorders.
- Extraordinary stress or trauma experiences can play a significant role in the onset of some mental health issues.
- Trauma- and stressor-related disorders refer to mental health problems in which the reaction to stress may become severe, and can negatively affect social, occupational and other important areas of functioning.
- Trauma- and stressor-related disorders can be easier understood with greater awareness of the nature of stress and how it affects the person.
- PTSD can be experienced after exposure to one or more traumatic events.
- Symptoms of PTSD are usually grouped into four categories: re-experiencing the traumatic event; avoidance; negative changes in mood and cognition; and changes in arousal.

Condition	Onset	Duration	Typical symptoms	Trauma exposure
Adjustment Disorder	Within 3 months after the exposure of identifiable stressor	6 months after the stress experience or its consequences are over	• Marked distress • Impairment in important areas of functioning	No
Acute Stress Disorder	Within 1 month after the trauma occurs	Between 3 days to 4 weeks	• Distressing memories • Psychological distress or physiological stress • Negative mood • Impairment in important areas of functioning, or clinically significant	Yes
Posttraumatic Stress Disorder	At least 1 month, but usually within 3 months after the trauma occurs	From at least 1 month to years	• Re-experiencing the traumatic event • Avoidance • Negative cognition and mood • Alterations in arousal • Impairment in important areas of functioning, or clinically significant	Yes

PTSD

Is PTSD a mixture of other mental health issues?

Even though it has overlapping symptoms with anxiety disorders, mood disorders, sleep disorders and some personality disorders, PTSD has a very straightforward set of diagnostic criteria, including being exposed to one or more traumatic events. It is important to emphasize that decades of scientific and clinical work proves that PTSD is a mental health issue on its own.

What is a traumatic event?

The word trauma is used more frequently in everyday conversations with different meanings, though it mostly refers to difficult and/or overwhelming experiences that are challenging to cope with (e.g., getting fired, going through a divorce). However, in the mental health context those experiences are usually referred to as distress, chronic stress, or adverse life events.

50-80%
of the population
will go through some type of traumatic event in their lifetime

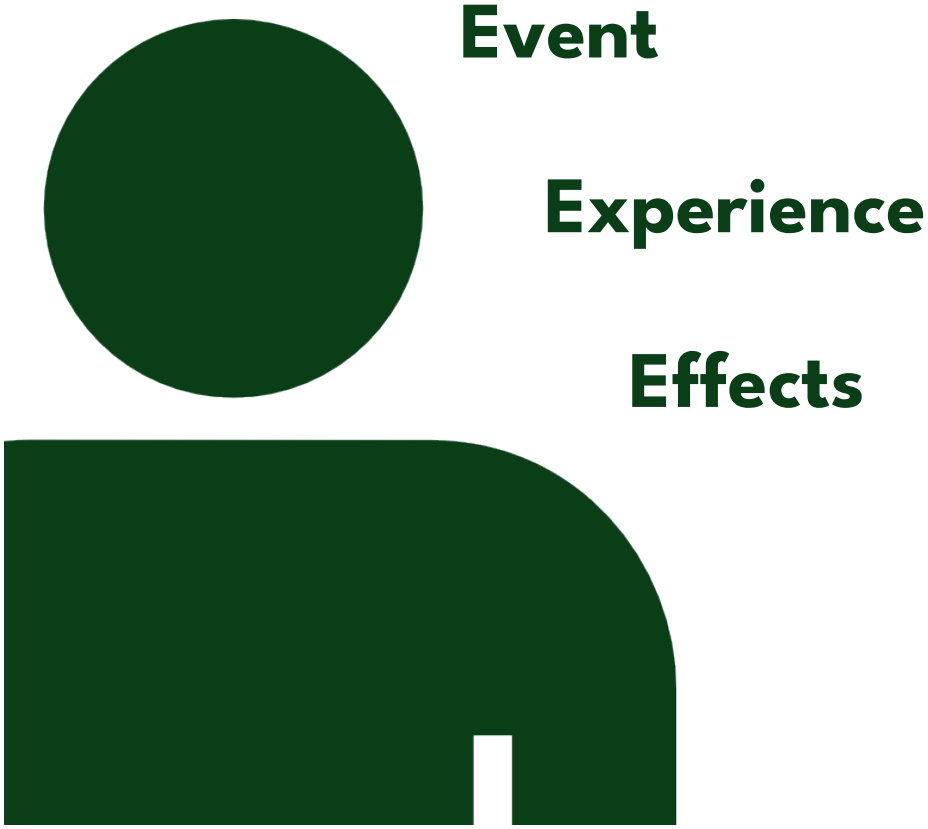
(Kawakami et al. 2014; Kessler et al. 1995; 2017)

It is true that trauma has many forms and what affects a person in a traumatic way can be very different for everyone. However, within the context of PTSD, trauma refers to more extreme events that are uncontrollable, perceived to threaten the person's life or sense of integrity, are physically or emotionally harmful, and have lasting adverse effects.

Traumatic events could mean experiencing or witnessing death, threatened death, serious injury, violence, sexual violence, forced migration, abuse, neglect, natural disaster (e.g., landslide, avalanche, hurricane, flood, tsunami, earthquake, etc.) or other forms of disasters, and accidents. Sometimes when a violent or accidental traumatic event occurs to a family member or a close friend, or we lose a family member or close friend due to violence or accidental death, it can also be considered a significant traumatic event.

Does experiencing traumatic events result in the development of PTSD symptoms?

It seems that the vulnerability to develop PTSD is more determined by the unique and dynamic interplay of pre-, peri-, and posttraumatic risk factors than by the exposure to the traumatic event itself. There are risk factors and protective factors present before, during, and after a traumatic event. Trauma is conceptualized as a process, which is not only the **event** or series of events, but the person's **experience** and its **effects** within and around the individual. The complex interactions of the above-mentioned factors create a unique mixture of individual vulnerabilities and resilience that could lead to PTSD in some cases, and not in others. Event, experience and effects are the three E's of trauma that create a framework to summarize the relevant factors that might influence the potential changes and outcomes in terms of health and mental health.



PTSD–related risk factors

There are multiple sources of risk factors that play some role in developing PTSD symptoms. These factors are grouped into three categories:

Pretraumatic factors

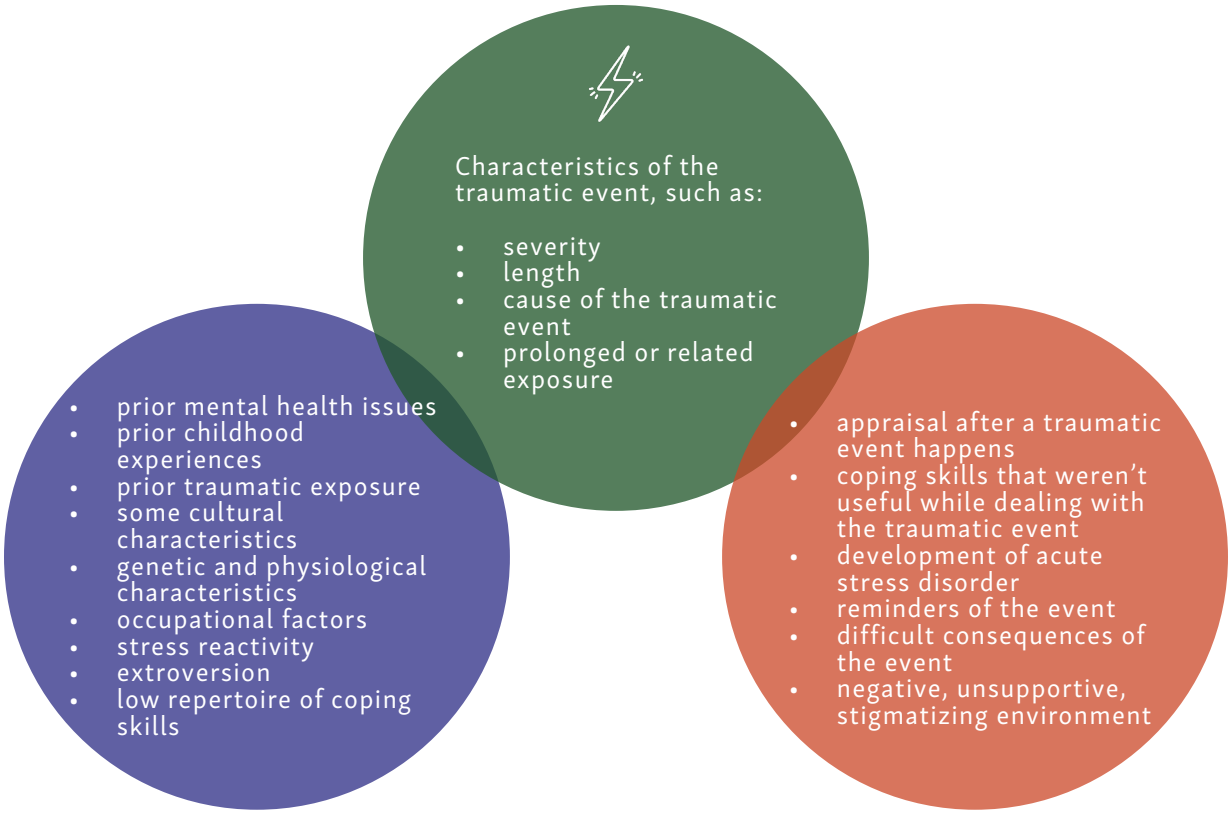
Risk factors that can exist independently of the traumatic event and **before** the traumatic exposure

Peritraumatic factors

Factors may influence the traumatic experience **while it is happening.**

Posttraumatic factors

Mostly temperamental and environmental characteristics that can be relevant **after** the traumatic exposure



The elements in these categories may create a unique and individual mixture in every person, and the traumatic experience opens the door for them to be activated, creating a vulnerability for symptom development.

Some factors on the provided list belong to multiple categories. Some could be risk factors or consequences of PTSD, creating a vicious circle by interacting and amplifying themselves and each other. A good example of this is lack of sleep which can be a risk factor, but is also a symptom and consequence of developing PTSD.

Protective factors for PTSD

There are factors that contribute to protecting us from developing PTSD. They can also be grouped into three categories: before, during, and after the trauma.

Resilience

Resilience is defined as the ability to cope with adversity and trauma, and adapt to challenges or change (SAMHSA, 2018), which is a process that contributes to recovery from adverse experiences. Factors contributing to resilience are protective factors on several levels starting from the individual through the community and society. They contribute to the feeling of safety, perceived control, stability, and sense of self-efficacy, and support healthy relationships and help regulate emotions effectively.

Social support

A positive, supportive, judgment-free, and non-stigmatizing environment created by family members, friends, colleagues and supervisors may be one of the most significant protective factors. It not only helps people to make sense of the traumatic experiences, but can create a buffer against isolation. Moreover, it can help with: 1) dealing with the loss, which is often a consequence of the trauma (e.g., losing the feeling of security, losing physical or mental health; losing a person; losing a home, etc.); 2) staying realistic about the trauma-related memories (helps to avoid catastrophizing, ruminating, and other unhelpful thinking styles); and 3) mitigating negative feelings such as shame or guilt. A sense of belonging, nurturing relationships, community, or camaraderie are related to social support (see page 47).

Acknowledging and naming the problem

Sometimes we describe trauma as something that cannot be talked about or cannot be put into words because it is unspeakable and indescribable. It is not necessary to talk about the trauma, but **acknowledging and naming the problem** can be the first step in restoring control and can lead to healing.

Learning effective coping strategies

Positive coping strategies are protective factors that can be learned and used when dealing with PTSD. Effectively managing even the smallest thing can be the first step to gaining control back.

Why me? Is this my fault?

Developing a mental health problem is never the "person's fault". Mental health problems can be caused by a mixture of different factors, and PTSD is not an exception.

Understanding some of the main PTSD–related risk factors offers additional evidence that developing PTSD is real, and there is nothing "wrong" with the person who has it. It is not a sign of weakness or any other problem. Experiencing a mental health issue is not different from any other health issue. Ursano and colleagues (2012, p. 905) provide a metaphor that offers good perspective on the situation. It "can be like a common cold that resolves without treatment or can progress to pneumonia with severe morbidity. Too often we and the public speak of all psychiatric illnesses as if they were cancer. But psychiatric illness, like most medical illnesses, may be in the form of a bruise or a broken bone – not always cancer."

Who can be affected by PTSD?

Anybody can be affected by PTSD. However, there are some groups and professions that are at a higher risk for developing PTSD. Some groups include:

- Indigenous people, due to unique historical trauma and currently existing factors
- LGBTQ2S+ populations
- refugees

Occupation can also be a risk factor for developing PTSD, especially ones where the people experience repeated or extreme exposure to traumatic events, such as:

- police officers
- firefighters
- paramedics
- medical doctors
- nurses
- correctional officers
- emergency dispatchers
- military personnel
- rescue team workers
- mine rescuers
- transit and railroad police
- volunteer disaster workers
- fire inspectors
- forensic experts
- probation officers
- transcribers of medical notes and documents
- mental health care providers
- those who participate in cleaning places where traumatic and emergency service take place, etc.

However, the development of PTSD is influenced by multiple factors—the (repeated) exposure to traumatic events is an important risk factor, but it is not the only one.

Occupational Risk Factors

- frequent traumatic exposure
- time pressure
- shift work
- poor communication
- job insecurity
- stigma around PTSD
- difficulties accepting help

Occupational Protective Factors

- ability to see stressors as challenges
- personality features that first responder jobs attract (e.g., ambition, confidence to handle critical situations, leadership, cooperativeness)
- training
- job culture (e.g., camaraderie, hierarchy, sense of belonging, social support)
- respect for the job

Did you know?

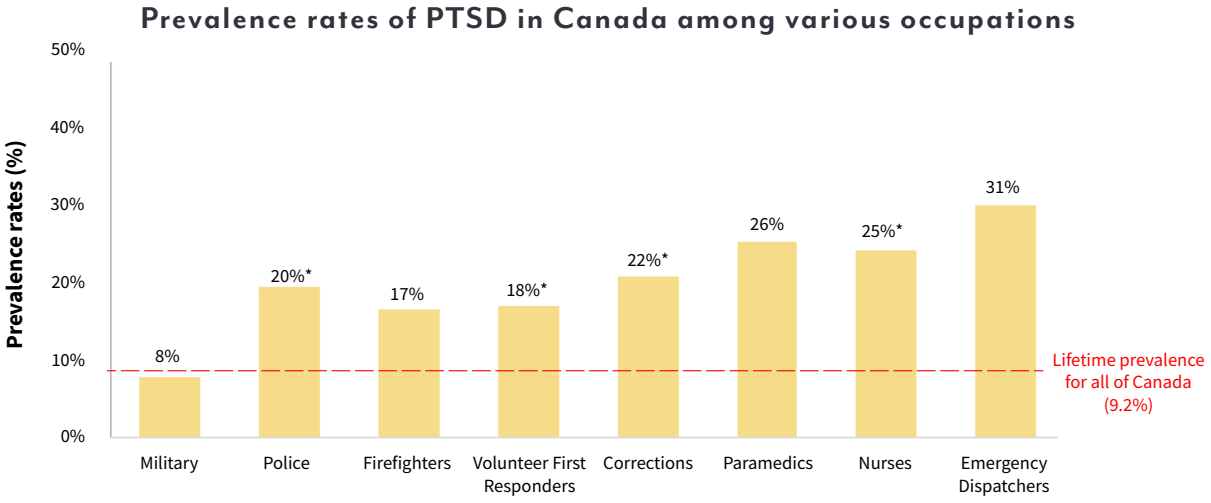
We often hear people say that PTSD in first responders is not an “if”, but rather a “when”.

It is important to highlight that this saying is based on beliefs and not on factual evidence. Despite the common belief, PTSD is not an inevitable consequence or side effect of any job.

As is the case for any other mental health issue, developing PTSD has multiple causes and there are several risk factors that need to be present.

How common is PTSD?

The rate of PTSD can be different depending on the group we look at. In Canada, 9.2% of the population might, at some point in their life, experience PTSD (Van Ameringen et al. 2008). However, the prevalence of PTSD can vary depending on various characteristics. Who can be affected by PTSD can vary based on gender, culture, and occupation. Females are about twice as likely to develop symptoms of PTSD than males (APA, 2022; Comer, 2015), and first responders are twice as likely to develop symptoms of PTSD as the general population (Ontario Ministry of Labour, 2016; Government of Canada, 2020).



* Data with an asterisk represent an average. See full range below for these occupations.

Military

8%

Police

8-32%

Firefighters

17%

Volunteer First Responders

12-23%

Corrections

17-26%

Paramedics

26%

Nurses

8.5-42%

Emergency Dispatchers

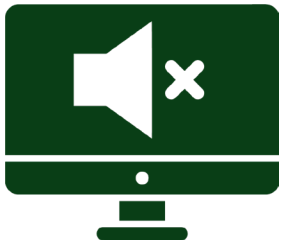
31%

ONA, 2016; Regehr et al. 2013; Wilson et al. 2016

What are the relevant symptoms of PTSD?

Having nightmares about the event

Thinking about the event when you don't want to be



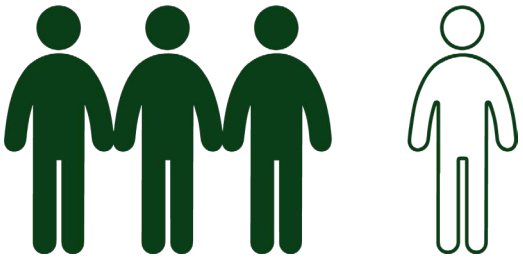
Avoiding any reminder of the traumatic event

Getting easily startled

Needing to guard and screen the immediate environment

Getting irritated or nervous when reminded about the event

Feeling blame or guilt in regards to the traumatic event



Feeling distant from people

How do I know whether I have, or somebody I know has, PTSD or not?

The only way to find out and be sure about who has PTSD and who does not is to consult with a regulated/registered mental health care provider or a medical doctor.

In what cases is it worth seeing a professional?

It is worth considering seeing a professional if somebody experienced or witnessed a traumatic event, and reports **at least three of the most frequent PTSD symptoms:**

- having nightmares about the event
- catching themselves thinking about the traumatic event, even when they do not want to think about it
- catching themselves avoiding any reminder of the traumatic event
- getting easily startled
- feeling the need to guard and screen the immediate environment
- getting irritated and nervous when there is a reminder of the traumatic event(s)
- feeling distant from people
- feeling blame or guilt about the traumatic event

It is recommended that a mental health care professional be consulted about these experienced symptoms. Self-diagnosis or labeling somebody with a diagnosis without consulting a regulated/registered mental health care provider can be dangerous, harmful, and unethical.

Can PTSD be prevented?

There is no known way to prevent PTSD except avoiding exposure to traumatic event(s), which is an unrealistic expectation. Mental health knowledge and resilience training could support preventative efforts; however, there is no evidence that proves they prevent the development of PTSD. Strengthening skills that are protective and resilience building factors (see page 29) including knowing where to get help, being treated fairly, having stable and supportive relationships, community engagement, available resources, trauma-understanding, trust, respect, compassion are some examples of those.

What do I do if I experience, or somebody I know experiences, PTSD symptoms?

Experiencing one or more stress reactions after being exposed to traumatic event(s) can be a normal reaction and it might take time to settle back to normal. Feeling or thinking differently after such significant experiences can be expected. However, when the symptoms last longer than a month, or they negatively affect the person's life, it is recommended to consult with a health care provider (e.g., family physician who can refer the person to a psychiatrist) or mental health care provider (e.g., psychologist, clinical psychologist, or social worker, mental health nurse or trauma-informed practices) for further guidance. Even in cases where full criteria of PTSD are not met, treatment can help.

What other problems might accompany PTSD?

People who have PTSD symptoms can have other mental health problems/ symptoms. The most frequent mental health issues/symptoms than can accompany PTSD are:

- depressive symptoms (e.g., sadness, pessimism)
- anxiety-related symptoms (e.g., nervousness, shaking)
- issues with sleep (e.g., difficulty falling or staying asleep, nightmares)
- alcohol, drug or other (e.g., caffeine, tobacco, energy drinks) substance abuse
- significant changes in eating behaviour (e.g., loss of appetite, eating more than usual)
- being more sensitive to physical pain
- the risk of harming themselves

Addressing these symptoms would be part of the person's individual treatment plan.

Did you know?

PTSD can impact the ability to work, social relationships, and physical health.

In occupational settings, absenteeism, lower occupational success, and lower engagement with work can be observed. Shift work can be extremely difficult for those who have PTSD symptoms.

What does PTSD look like in everyday life?

It is hard to live with untreated PTSD and symptoms can vary from person to person. Research shows that even within a person, symptoms can vary daily, and weekly, so creating a full description that can fit everybody is not possible.

When symptoms are experienced following a trigger, or even without any visible triggers, people might become distracted and unable to focus or explain what is happening to them.

They might have a hard time identifying what is going on and they might feel like they are being caught or trapped in the situation, or even in past memories that seem real and present to them.

In these moments the full variety of stress reactions might happen. The re-experiencing usually happens in an intrusive form causing visible symptoms. The person might be unable to control their emotions (e.g., anger, tearful, upset) and physiological response (such as shaking, sweating, turning pale or red). The person may feel ashamed because they might not be able to control their reaction.

Reliving the traumatic experiences is difficult, and it is also hard to witness when somebody goes through it. It can happen out of the blue because the memory is triggered by internal cues, and sometimes the trigger is external and identifiable, but not avoidable (e.g., the sound of sirens, honking, etc.)

Some people report difficulty falling or staying asleep. Often, they need earplugs to prevent being bothered by noises that can trigger memories during sleep. Some have nightmares and intense physical reactions that can affect their partner's sleep too.

Some people become overwhelmed by crowds and crowded places. Other people can only tolerate social events for a very short period, and are constantly browsing escape routes, or stand/sit toward the wall, close to the exit. Some people won't leave their homes, or only feel comfortable in nature and while outdoors. Being startled by unexpected noises is a common experience, and people express negative feelings toward their own stress reactions (e.g., shame, guilt, feeling disappointed, etc.). Shaking, red flushes, and skin outbursts are frequent reactions in these situations.

People experiencing PTSD symptoms can get overwhelmed easily, and their reaction to it can be very different. Some people start to talk or are hyperactive when feeling overwhelmed, some withdraw or isolate themselves, while others might use alcohol,

caffeine, or tobacco to deal with their symptoms. Others can get irritated, frustrated, or agitated. Others are avoidant, and while trying to avoid trauma-related reminders, they avoid places and people.

Intimacy (feeling close to others) can be a problem for those who develop PTSD; they may experience low libido, and being touched can be an intrusive experience for some.

Being and getting motivated can be a struggle for those who live with PTSD symptoms. Maintaining basic hygiene (e.g., bathing, brushing teeth, having clean clothes, etc.) can be difficult. Eating habits can change significantly (over- and under eating can be equally typical). People can neglect their home environment and their household chores, such as having an empty fridge and piles of unwashed dishes. A chaotic living environment can be a result of these symptoms, especially when they live alone.

People who develop PTSD usually have a hard time focusing or concentrating. Managing competing or multiple tasks, solving problems, or dealing with conflicts can be demanding.

Finding pleasure in previously enjoyed activities can be challenging.

The list could be continued, however, these are only examples, because capturing the full picture and giving a complete description is not possible. It can be stated with certainty that PTSD symptoms will change the person's life and functioning; however, the degree and the impact of those changes can be different for every individual. People who develop PTSD often say, "I turned into somebody I don't know", "I lost myself", or "I am not the same person I was before the trauma".

Are PTSD and PTSI the same?

Yes, and no. How is it possible that the answer is both yes and no?

PTSD stands for posttraumatic stress disorder and PTSI stands for posttraumatic stress injury. They aim to name and define the same issue, though the official name and diagnosis is PTSD, and not PTSI. Using the name PTSI is getting more popular, especially among first responders. There is growing preference to use the expression PTSI, because people find the term less stigmatizing (live with an 'injury' and not a 'disorder') and more reflective of how they experience and feel about their symptoms. Getting injured on the job is more acceptable than talking about any type of disorder. Getting physically injured does not provoke any labels or stigmatization. Getting mentally and psychologically injured because of a traumatic experience seems more acceptable for people who experience symptoms of PTSD than talking about a trauma-related stress disorder. The reasoning is clear and logical; however, at this point, the official term is still PTSD, not PTSI. In health care, being consistent with psychological and medical terms is important for communication between health care providers and helping people to seek the resources they need to get help, including accessing support from insurance companies. While acknowledging the existing preference for talking about trauma-caused psychological injury in some circumstances, using the official terms may be helpful to avoid confusion and misunderstanding.

What is operational stress injury and how does it relate to PTSD?

Operational stress injury (OSI) refers to any persistent psychological difficulties that are a result of operational duties. Law enforcement officers, paramedics, military, or any other work/service-related duties might contribute to those problems. The people who experience high levels of operational stress injury are at higher risk of living with depressive or anxiety-related symptoms, substance use problems, or PTSD. PTSD is one type of OSI that might develop after a service-related trauma experience.

Did you know?

Watching or being exposed to a traumatic event through electronic media can cause significant distress resulting in a stress reaction or anxiety-like symptoms. However, these reactions fade away relatively fast, and they usually don't cause any mental health issues.

An exception can be when it is part of somebody's job to be regularly exposed to detailed documentation of traumatic events, such as for law enforcement officers, medical team members, or forensic experts.

What is critical incident stress?

Critical incident stress (CIS) as a term has been used to describe the physical and psychological symptoms that could result from being involved in a traumatic event. It usually refers to the first set of normal reactions to an overwhelming event such as trauma. The term is used less frequently, and it generally describes the reaction to acute negative stressors.

What are the forms of indirect trauma?

Indirect trauma is an umbrella term describing the experience that results from an indirect exposure to a traumatic event. It refers to vicarious traumatization, secondary traumatic stress, compassion fatigue, and burnout. Specialized training exists and is designed to offer prevention and intervention techniques for those who could be affected by any type of indirect trauma.

Vicarious traumatization

Vicarious traumatization (VT) is usually experienced by mental health and other helper professionals who listen to the traumatic narratives of their clients. The term refers to the cumulative and transformative effect of cognitive schema and perception changes in the world-view, or personal and professional beliefs due to the exposure to traumatic narratives.

Secondary traumatic stress

Secondary traumatic stress (STS) is a unique form of experiencing PTSD-like symptoms (including the major symptom groups such as avoidance, re-experiencing the indirect exposure, negative cognition, and mood and arousal changes) with indirect, secondary trauma exposure such as listening to or being exposed to the graphic details of traumatic exposures. This is a work-related hazard for those who work in fields where indirect, secondary trauma exposure is high such as helper professionals, judges, lawyers, investigators, CAS workers, and many others.

Compassion fatigue

Compassion fatigue (CF) can be experienced by anybody, including friends and family members who interact with the person who went through the traumatic experiences. Being overwhelmed, feeling helpless, and the lack of resources to address the traumatic experience of a victim/survivor can cause compassion fatigue. The most typical symptoms include reduced capacity to empathize, isolation, or feeling helpless, overwhelmed, or pre-occupied by others' traumatic experience. This can easily happen within the social support system of somebody who has PTSD or who was affected by direct trauma experience if they do not receive help or appropriate resources and education about the phenomenon.

Burnout

Burnout (BO) is exhaustion, depersonalization, cynicism, energy depletion, and reduced professional efficacy that can result from any work environment. Indirect trauma exposure may facilitate burnout as well as other unsuccessfully managed chronic stress.

What is moral injury?

When clinicians studied the circumstances of how military personnel were traumatized, they came up with different categories to capture the common shared features in their trauma experiences. One category was called moral injury-based trauma. Moral injury has no straightforward definition, but it usually refers to situations where the person witnesses actions (or lack of thereof), where core beliefs or moral ethical codes are hurt, violated, or betrayed, causing psychological trauma. This was often referred to as a character wound and psychological injury. Even though the original concept was developed based on research with military service personal, first responders found that the concept also matched some of their experiences. Examples include significant betrayal; cases when they could see that innocent people were affected by a traumatic event; somebody violated the chain of command; made another violation within the rank and responsibilities while being exposed to the traumatic event itself. However, while moral injury does not necessarily imply PTSD and vice versa, they do share overlapping symptoms and can amplify each other. Typical feelings are intense guilt, shame, or disgust as a result of moral injury and heightened negative thoughts about others or themselves (e.g., decreased self-esteem, self-criticism).

What is the relationship between PTSD and suicide?

Suicide is one of the leading causes of death in our society worldwide. In Canada, 24% of all deaths in the 15- to24-year old population are due to suicide, and after the age of 25 the number is still 16% (Canadian Mental Health Association). PTSD might double the risk of suicide (Fox et al., 2021). Suicide risk is always assessed and monitored in therapy. We need to emphasize that every suicidal ideation needs to be taken seriously and addressed.

We know that it is scary to learn that somebody we know is thinking about suicide or harming themselves in any way. Sometimes, people have doubts about addressing these situations and it can be difficult to know how to respond. However, the worst reaction may be remaining silent and dismissing the cues. Signs are not always obvious, leading people to question what the best decision or approach may be. But it is always better to be safe, meaning we need to address any related signs.

If you know somebody who is in immediate danger, call 911.

Some more obvious signs of suicide risk include:

- talks about or threatens to harm oneself
- shares that they are looking for a way to kill themselves
- talks or writes about death, dying, suicide, how or it would be better to just fall asleep and never wake up

If you or somebody you know demonstrates any of this behaviour, please go to or escort the person to the nearest crisis centre or hospital. You can also call 911 or an ambulance/police.

Less obvious signs of suicide risk include:

- increased substance use
- reports feelings of helplessness or hopelessness
- cannot see and find any purpose in life
- talks about being a burden
- talks about unbearable pain
- feels trapped, and expresses that there is no solution for the situation they are experiencing
- behaves agitated, anxious, frustrated, or angry
- isolates themselves
- unable to sleep or sleeps excessively
- engages in risky, hazardous or reckless activities
- shows dramatic changes in mood

If you experience any of these signs, please seek help at the nearest crisis centre or hospital, or call a service line nearby. If you know somebody you feel comfortable with to help escort you through the process of seeking help, that can be helpful. However, if you cannot reach that person when you are in crisis, please, still proceed to reach out to the crisis centre or call 911.

Talk Suicide Canada can be reached at 1-833-456-4566.

How do I help somebody who is in crisis?

It is a common mistake to think that talking about suicide will provoke a higher risk for the person. In reality, the opposite usually happens, whereby the person feels better when being able to talk about feelings. A person who is at an acute risk of suicide needs professional help and cannot be left alone until help either arrives, or until the person is taken to a place where care is offered by trained professionals.

Not feeling comfortable listening to somebody who is at risk is common. We list some tips below that can be helpful. The major goal is to break the silence and connect the person with professional help.

What can be done? What is the most effective way to be supportive?

- Be direct but empathic.
- Talking honestly, respectfully, and with dignity is important. Listening and showing concern is helpful in critical situations. Again, listening is not increasing the risk; it helps the person to accept help and creates immediate evidence that somebody cares and that they are not alone.
- It is reasonable to ask the person if they are thinking of suicide, and if the answer is yes, ask the person about the plan and timeline. Remember, questions are not provoking those thoughts, the person may have a plan already.
- Do not minimize the feelings, do not use clichés or try to debate the person, and do not agree to keep it a secret.
- Ask if there is anything that can be done; resources can be drawn from the person's network (someone who can escort them to the hospital or crisis centre, if you cannot offer that support); but mainly contact and connect the person with professional support.
- It is reasonable to call for professional support (crisis centre, 911) to get their guidance.
- Do not leave the person until help is provided and remove any obvious objects that could increase the risk of harm (e.g., sharp objects).

Keep in mind that overwhelming stress, depression, and PTSD can create risk for suicide. However, with help and support it is possible to address these problems. A person who went through a suicidal crisis can learn effective strategies to deal with these issues, and that is why professional support is important. The person who is at risk has reached their limits to cope with their situation and problem. The person at risk cannot cope effectively and cannot find a solution on their own. Suicide risk must always be taken seriously.

As of December 1, 2023, there will be a three-digit phone number in Canada for immediate help with a mental health crisis or suicide prevention. The number will be **9-8-8**. It can be dialed or texted across the country free of charge.

Chapter summary

- Symptoms of PTSD may begin shortly after the traumatic event(s) but in some cases symptoms may develop months or years after.
- The development of PTSD symptoms is usually the result of the unique interplay of the pre-, peri-, and posttraumatic risk factors.
- In presence of symptoms, especially when they interfere with social, occupational, or other important areas of functioning, seeking professional help is advised.
- Anybody can be affected by PTSD, even though members of some groups and professions are at higher risk of developing PTSD.
- Research has identified some protective factors that can prevent or help with dealing with PTSD symptoms, such as social support, training, and developing different coping skills.
- PTSD can increase the risk of suicide.
- When somebody is at immediate risk, call 911.
- Talk Suicide Canada can be reached at 1-833-456-4566.

TREATMENT

Treatment in mental health care

Mental health problems are treatable, and some level of improvement (e.g., healthier habits, more productive life) can be a realistic goal. Treatment or therapy is a process that aims to help people overcome the psychological symptoms and difficulties that they have identified using evidence-based techniques.

- Therapy is usually a systematic, planned process that is executed by a trained professional.
- Therapy refers to a series of interactions, where the goal is to produce the desired changes in behaviour, thinking, attitude, and emotional state of the client.
- There must be transparency between the client and the professional. The client needs to be informed about, and agree with, the goals and the changes.
- Treatment is offered in a supportive, non-judgmental environment, and it is based on collaboration between the client and care provider.

Treatment decision

The diagnosis of a mental health condition does not automatically imply the need for treatment. The need for treatment and the type of treatment are usually determined by the professional/clinician who has the tools, knowledge, and education to decide about the treatment plan while working together with a client. The treatment plan will be a result of a complex decision-making process where many factors are considered based on the individual's unique needs (e.g., symptom severity, risks and benefits, etc.). Information is collected by the care provider through screening and assessment procedures. The decision about the treatment is made individually and collaboratively, and the offered care can be beneficial even when symptoms are minimal.

Types of therapists

Mental health services are usually offered by:

- medical doctors (psychiatrist, family doctor)
- psychologists and clinical psychologists
- counsellors and therapists who often have backgrounds in psychotherapy, social work, nursing, occupational therapy, etc.

Sources of care

There are a range of services available within the health care system starting from emergency services, hospitals, community-based services, and informal non-professional support (peer support, cultural and spiritual support). Even though care is supposed to be offered in a continuum, the continuation between different types of services might be fragmented. However, at any step of services, information may be provided about what form might be the best option for the person based on screening and assessment. Decisions might be made based on length of wait, finances (government funded or private), availability, location, urgency, treatment approach, individual or group treatment, etc. Trauma-informed care (TIC), for example, is offered across settings and sectors in order to support recovery. It means that even those care providers who do not offer trauma-specific treatment options understand the trauma and all aspects of it, and place priority on safety, choice of control, and the need for healing without triggering or re-traumatizing the client. That way they can orient the client to access trauma-specific services from the most appropriate source.

Community agencies

Community mental health centers, family services, crisis intervention centers, and other social agencies.

Private psychotherapy

Individual, private psychotherapy is becoming more available through health insurance plans or employee assistance programs.

Inpatient care

Inpatient care might be more effective for some complex issues.

Treatment effectiveness

Treatment can often help, and effective treatment is available. However, the achievable goals are different for everyone. That is why treatment is tailored to fit individual symptoms and needs. For some people, treatment offers a completely symptom-free life. For others, it offers some relief by making symptoms less intense and more manageable. Treatment offers tools and skills that can be used to manage or cope with symptoms, and deal with triggers more effectively. PTSD rarely goes away or gets better on its own, and symptoms may get worse without treatment. With treatment, PTSD and its related symptoms and their functional consequences (e.g., in social, occupational, and other areas of life) can be improved.

When to seek treatment

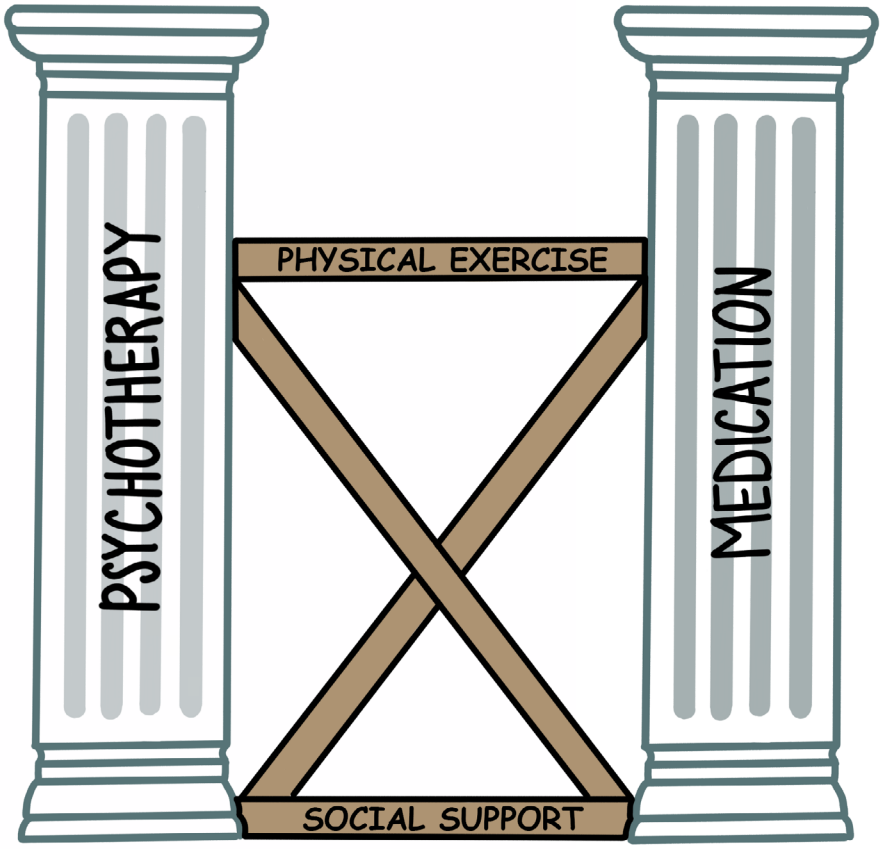
The sooner treatment is accessed following trauma exposure, symptom onset, or diagnosis, the sooner the person can enjoy its benefits. Immediate interventions are offered within 48 hours of exposure to address the initial response to trauma. Those are usually short, focused, and resource-oriented forms of interventions (see page 54). Any other treatment options can be offered at any time after trauma exposure, either as a continuation of immediate intervention or independent from them. Some people, especially those who have experienced the symptoms for a longer period of time, might wonder whether it is too late to get treatment. The answer is no—it is never too late to start treatment. Even if the person received treatment previously that did not provide the desired result, it is worth trying again.

Treatment readiness

A person who experiences PTSD might never feel ready for treatment. Most of the time, they come up with good and very rational reasoning as to why they have not been able to start treatment yet. Avoidance may be experienced as a symptom of PTSD. Knowing this fact could be key to accepting help and dealing with the symptoms. The reason why the person might need treatment is because symptoms are present, and these symptoms may interfere with quality of life. Readiness to change can vary, even when the person realizes that they might have some problems. Barriers and factors that can influence the readiness to change could be addressed with the care provider. When somebody is unsure of ‘how to change’ it is recommended to ask those questions of a care provider as they are trained to know the ‘how’ part. Realistic and step-by-step goal setting may facilitate the readiness for treatment.

What happens during treatment?

Treatment of PTSD usually has two major pillars: Psychotherapy and biomedical therapy (e.g., medication or pharmacotherapy).



Different people may respond differently to various treatments. Psychotherapy and biomedical therapy can be implemented on their own or in combination. The chosen approach is driven by empirically-supported, evidence-based factors that are considered when both the client and therapist discuss the options. The client's personal preference is an important factor. Due to the possible combination of the two major treatment approaches it is common for clients to see at least two different professionals to address the problem: one is usually a medical doctor who primarily prescribes and manages medication, and one usually a health care provider who conducts psychotherapy.

Physical exercise supports the effectiveness of both pillars and is usually part of the treatment plan. When looking back at the description and nature of stress, the stress reaction, and its effect on the body, it is easier to understand why physical exercise play such an important role in dealing with the symptoms of PTSD. Addressing the body's reaction to stress can enhance coping with it effectively (see page 56).

Research suggests that elevated, perceived social support (see page 29) is associated with greater symptom reduction in treatment. A relevant source of social support varies from person to person, but it can include family, friends, colleagues, etc., who can offer assistance, care, interest, understanding, and the like.

What happens during psychotherapy?

Psychotherapy starts with a thorough assessment that helps the mental health professional to understand relevant factors such as symptoms, triggers, the traumatic event(s), the context, the related risk factors, and the protective factors. Assessment usually contains some psychometric testing, which guides the therapist to work in the most effective way and to have an objective baseline at the start of the therapy. In this way progress can be objectively monitored.

Following the discussion about background information, client concerns, and psychometric test results, the client and the therapist come to an agreement. The agreement contains the goals of treatment, the chosen procedure/approach, schedule (time, place, duration), and responsibilities. This is called a treatment contract. Despite the name it is usually a verbal agreement between the client and the therapist.

Psychoeducation is the next step. Here, the therapist guides the client through the process and relevant information about the chosen treatment approach is explained. Every situation is unique, and the individualized treatment plan offers a customized perspective for each person. Questions can be asked at any time. Then the treatment plan is followed to achieve the outlined goals with the chosen therapeutic strategy.

The individualized treatment plan is usually a road map for the client and therapist. It summarizes the client's personal information, relevant history, and demographics. It conceptualizes the diagnosis and summarizes the treatment goals that are part of the treatment contract, with measurable objectives. It offers a proposed timeline for treatment progress and how it is monitored. A treatment plan also reflects on the client's strengths. It might also outline and include different forms of support, such as medication, individual or group psychotherapy, or additional interventions, such as using a Continuous positive airway pressure (CPAP) machine while sleeping or working with a nutritionist. During therapy, different strategies might be taught to the client; for example, how to deal with intrusive symptoms or flashbacks. Addressing these symptoms is an important part of the treatment plan. Dealing with the identified symptoms using different grounding techniques (such as using sensory input) and mindfulness exercises can be implemented, and those strategies might be reflected in the individual treatment plan.

A comprehensive treatment plan is usually a combination of different forms of treatment approaches that can support recovery by using effective coping or life-style changes.

Progress is monitored in the agreed intervals, and the plan is reviewed if needed. There is no rule around the length of the therapy. Usually, the therapy ends when client and therapist agree that they achieved the outlined goal(s). Working on other goals in the future, or getting maintenance sessions, might be possible.

The therapist does not have to have lived through traumatic events in order to treat PTSD. The therapist's job is to offer a safe, non-judgmental environment, where the client can focus on learning new skills and strategies to reach their identified treatment goals, which usually consists of dealing with the traumatic experience and its consequences.

What are trauma-specific services?

The so-called trauma-specific services cover the treatment options that directly address healing and recovery through different types of interventions (e.g., psychoeducation, psychological first aid, CISD, trauma-focused therapies, etc.).

The trauma-focused therapies vary in their approaches, with objectives typically addressing memories, feelings, and thoughts related to the traumatic event(s) or its/their meaning. Some might focus on the past, others on the present, and some trauma-focused therapies combine their focus points. All of them help the client to cope more effectively with their trauma-related symptoms in the present.

The American Psychological Association (2017) recommends the following therapeutic orientations, which are trauma-focused interventions:

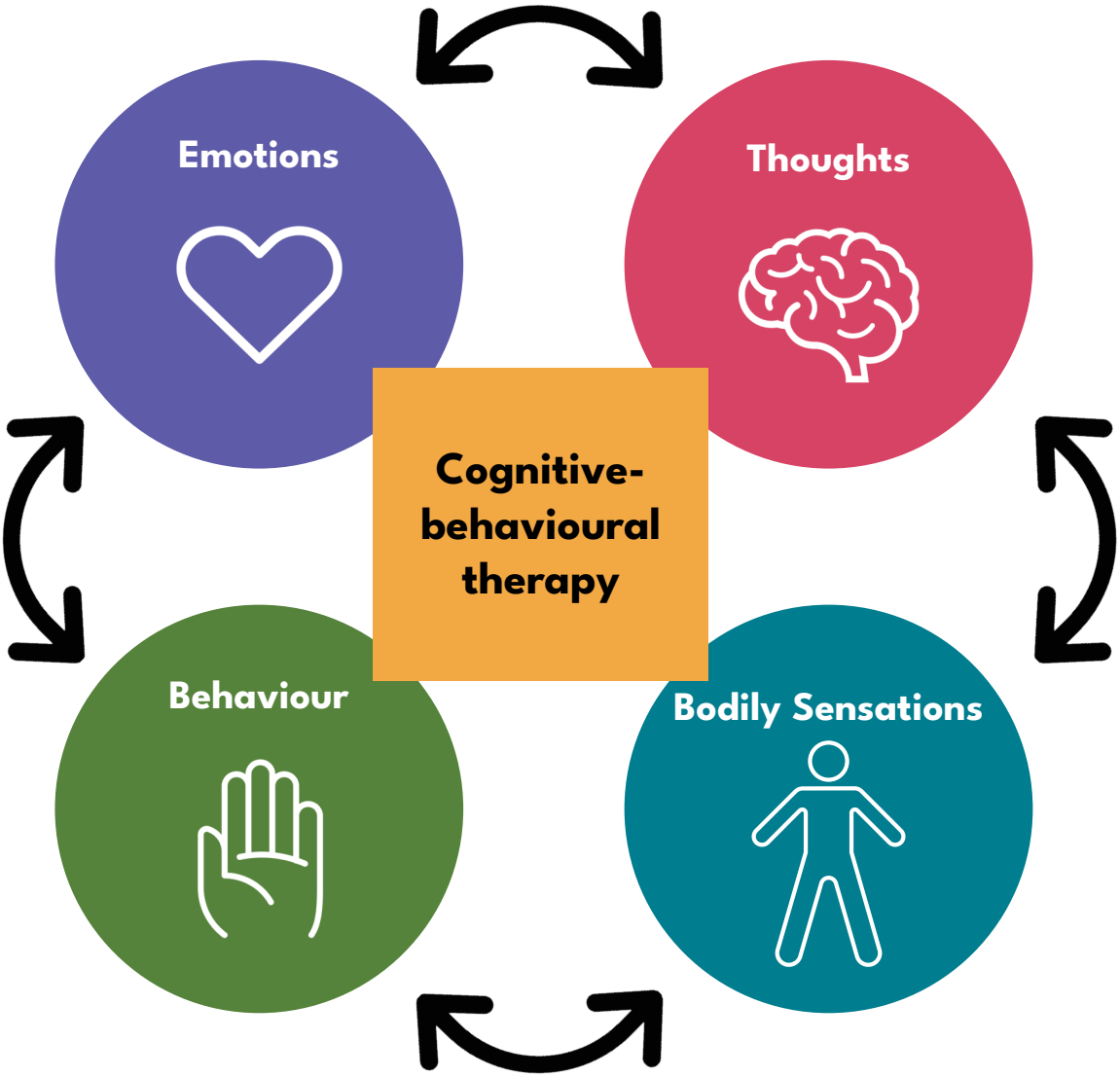
- cognitive-behavioural therapy (CBT)
- cognitive therapy (CT)
- cognitive processing therapy (CPT)
- prolonged exposure therapy (PE)
- brief eclectic psychotherapy (BEP)
- eye movement desensitization and reprocessing (EMDR)
- narrative exposure therapy (NET)

The recommended approach is identified in the early phase of treatment (see page 44). When trauma processing is offered in different and safe ways, the client gets the support to deal with internal and external trauma reminders. Different therapeutic orientations use different strategies to reach that goal, sometimes through imaginal or written exposure, sometimes through real but gradual exposure. Pace and the appropriateness of this treatment approach is carefully monitored.

Talking and thinking about trauma can be difficult. Knowing that therapy addresses the trauma reminders can cause fear and avoidance behaviour. It might feel overwhelming just thinking of these treatments. However, we need to emphasize that these evidence-based therapies work. They work because they offer a gradual, personalized way to deal with the trauma in a safe environment, at the client's pace and with their permission. Instead of avoiding the difficult situations, strategies are taught that can help deal with them effectively. Alternatively, non-trauma-focused treatment options can be offered. They also aim to reduce symptoms of distress caused by traumatic events or PTSD, but without working directly with trauma-related memories, thoughts, and emotions. Those strategies can include relaxation, mindfulness, stress inoculation training (breathing, thought stopping, muscle relaxation), acceptance and commitment therapy (ACT), etc.

Cognitive-Behavioural Therapy

Cognitive-behavioural therapy (CBT) is one of the most effective and widely used therapies addressing PTSD–related symptoms. CBT emphasizes the relationship between thoughts, feelings, bodily sensations, and behaviours in relation to current symptoms.



How long does treatment usually last?

Treatment (both psychotherapy and medication) takes time to have an effect on the symptoms. It is important to discuss the expected time frame with the health care provider; however, duration and frequency are often revisited during the treatment. The treatment type and length are intended to match the client's goal(s) and the nature, severity, and duration of the symptoms. It also varies based on the treatment approach (some are lengthier, while some are more focused, and therefore shorter). Therapy usually ends when the client reaches the previously defined goals. In some cases, new or sequential goals can be negotiated. Scientific evidence shows a positive relationship between the duration of the treatment and its result. It is important to give treatment enough time to address symptoms, and create plans to reassess symptoms during therapy. On average, 15 to 20 psychotherapy sessions were required for 50% of patients to recover based on self-reported psychometric evaluation (APA, 2017). However, some cases require a shorter or longer time frame for improvement. Sometimes, it might be that treatment is needed to maintain therapy results or prevent relapse. Those details might be discussed between the client and therapist. If the client reports insufficient improvement after a reasonable period of time, re-evaluation of the treatment plan can be suggested.

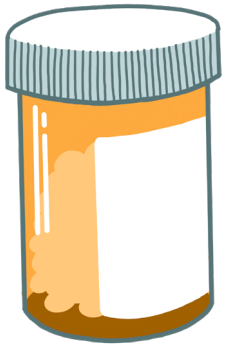
What happens when treatment does not help (enough)?

It may be that the treatment approach was not enough or not effective at the time. There can be several reasons for that; however, if the person still has symptoms, it is important to continue to seek professional help. Trauma-focused psychotherapy has longer lasting effects than medications, to the best of our understanding to date. If we compare psychological treatment to treatment for a physical condition, when a person thinks that they did not receive the help they needed to manage their symptoms, treatment is not given up on and it is not said that medicine is not working. Instead, further help is sought, more specialized professionals are contacted, or different treatments are tried to get relief for our problem. Physical suffering, especially pain, is a good motivator to continue to seek help. Why would the case be any different for mental health issues and for emotional pain? Sometimes, finding the right mental health professional takes time. There is also something special about finding a therapist. Often, we don't necessarily work as closely with our medical doctors as we do while receiving psychotherapy. Feeling comfortable and safe to ask questions or share information with a treatment provider is very important during psychotherapy. Because of this, changing therapists may be part of finding the right fit because feeling comfortable is an important part of the process.

Even if treatment was attempted and did not help as expected, it does not mean it cannot help. We learn more about the brain, body, and mental health every day, and research continues to offer evidence that supports and improves therapy. There are always new approaches and techniques that are worth discovering.

Medication

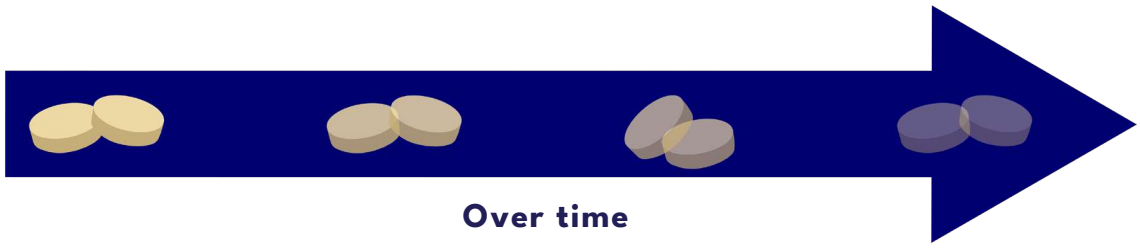
The list of recommended medications is also evaluated continuously. People have some negative beliefs or reservations about taking medication as part of the treatment plan for PTSD. However, as we referred to throughout this booklet, PTSD and stress reactions create physical changes in our body and nervous system that can be addressed with the help of medication. Medication can offer some relief from the symptoms, while psychotherapy supports the changes from another angle. Individual concerns/reservations and potential side effects can be addressed with authorized practitioners.



Did you know?

Medication can be prescribed only by those who are authorized by the Controlled Drugs and Substances Act (CDSA). Authorized practitioners vary between provinces and territories. There is no specific medication for trauma, but certain medications are helpful and recommended for specific trauma symptoms. Most of the time, medical doctors (e.g., psychiatrists or family physicians) can offer trauma-informed guidance on medication-related decisions for PTSD and traumatic distress. Finding the right medication or dosage might take some time, depending on the drug, dosage, and other factors such as age.

Although current guidelines do not recommend medication as "first-line treatment for adults with PTSD" (APA, 2017, p. 69.), medication can support the effectiveness of psychotherapy and vice versa. Medication is regularly monitored by the treating physician, and any changes need to be discussed. The doctor follows evidence-based practice when creating a personalized treatment plan, and also considers the individual's history of side effects, response to medications, other conditions the client has, the use of other medications, etc. In cases when the client does not need medication anymore or there are changes in the dosage, the professional will support those changes according to the relevant guidelines in order to wean them off safely and effectively.



In cases where the person stays on medication for a longer period of time, the reasons for that decision might be discussed with the client by the treating physician. Current guidelines do not recommend treating PTSD with medications alone.

Peer support groups

Peer support groups can be good additions to PTSD treatment, but their goal is not to treat PTSD. Peer support groups allow members to share their experiences in a safe environment. Emotional, social, and practical support can be offered to the group members; for example, how to deal with daily problems when living with PTSD. Usually, these groups can help members overcome doubts and fears about seeking help or treatment, support and encourage their participants to engage in services, and remind members that they are not alone. Peer support groups do not have the aim to resolve symptoms, but they might support improving them when they are delivered in a safe way.

Critical incident stress debriefing as immediate intervention

Critical incident stress debriefing (CISD) is part of a larger stress management program offered by some organizations. CISD is often described as “psychological first aid” after potentially traumatic events occur at work. CISD is offered in a group setting, based on a structured protocol and led by a trained facilitator. Usually, first responders receive this type of support 2 to 7 days after a trauma exposure. This is the most widely used strategy in workplaces to prevent PTSD. However, its effectiveness is controversial. When an intervention strategy does not offer clear evidence for its effectiveness and usefulness, it cannot be recommended. Therefore, official guidelines do not include CISD. It is also important to note that CISD is not associated with harmful effects, either. Most first responders are familiar with this brief, focused process, and many think it fits their culture well and offers social support and some coping strategies, which helps them to find meaning, closure, and support for psychological recovery.

Recovery and resilience

Recovery means that the person can live a mentally healthy, satisfying life with a mental illness that is stabilized. Recovery is not an end state, and it is not static. Even after successful treatment, relapse or deterioration can occur. Dealing with these ups and downs of life is normal.

After treatment is over and recovery is achieved, it does not mean that circumstances in one's life might not change. Adapting to new challenges can sometimes be difficult, but going through the steps of recovery creates pathways to access the needed resources, and manage and adjust to the changes again.

Recovery can allow the person to deal with changes in a stable, hopeful, and flexible way even though there might be minor setbacks while working through the adjustment process that the current situation might require.

Resilience is a person's ability to cope with change and adversity, which develops over time and helps them to adapt to stressful situations (see page 29).

Relapse and relapse prevention

Relapse is when adjustment needed for new challenges or changing circumstances is beyond the scope of the person's skill set and/or current ability. If this happens, it is reasonable to seek help again, just as it would be to revisit a doctor for a recurring physical injury. However, the treatment goals might be different based on the new, circumstantial factors. Experiencing phases of reemerging symptoms may be part of the normal recovery process; it is not a failure, rather, it is the result of changes. Goal-setting should realistically expect some relapse to happen and prepare for its prevention.

One key element of relapse prevention is to know that relapse usually happens gradually, so recognizing warning signs (e.g., isolating, avoiding certain tasks or situations) and developing coping skills accordingly is helpful. Moreover, it is also useful to know that working through relapses can help with further growth, and dealing with relapses may increase efficiency over time.

Supplemental activities/interventions that can help recovery and support treatment

The actions that can be taken to help recovery and support treatment are not substitutes for treatment offered by mental health care providers. However, they can complement and facilitate treatment. Most care providers incorporate the suggestions listed in this section.

Physical exercise

Physical exercise can be defined as a planned, structured activity with intentional movement with the goal to improve or maintain personal fitness. Physical exercise is often the first thing that can be suggested to a person who lives with PTSD (see page 47). In fact, it is helpful in most cases of mental health problems.

People living with PTSD often report that they do not feel motivated to move or start exercising. That is understandable because feeling tired and fatigued are frequent consequences of the physiological stress reaction (see page 7). Insight on how stress affects the body can help with making better and healthier choices.

People often think exercising means at least an hour of dedicated time, so when they do not have a whole hour available, they do not even start. Even taking 10 minutes is a good start. A good goal is 30 minutes a day, but it can be done in three 10-minute blocks, or can be built slowly up to 30 minutes.

Set a low and realistic bar – we are more likely to start exercising if the activity is easy or easily accessible.

Physical exercise can help people focus on something other than their trauma-related thoughts and worries. Focusing on bodily sensations while exercising can be a great way of changing the train of thought.

Grounding techniques

Grounding is a type of coping strategy designed to ‘ground’ the person in the present moment. Grounding can be practiced at any time to manage distress, and is often used as a way to cope with flashback or the dissociation the person might feel when PTSD symptoms are present. The most common grounding technique is breathing, or abdominal breathing. Different strategies are available for breathing but the key

element is focusing on breathing in and breathing out in a pace that is comfortable to the individual. The goal is to create a slower but comfortable pace. Breathing allows the person to immediately redirect their focus to something else.

Sensory input

Generally speaking, we can use our senses (vision, hearing, smell, taste, touch) to relieve stress and calm down. It is good to have a list that can help to remember what works in stressful situations so choices can be made accordingly. Everybody has different preferences such as:

- looking at family pictures
- looking at pictures of natural beauty
- looking at art
- taking a cold or hot shower
- listening to music
- eating mindfully
- using aromatic scents
- petting an animal, etc.

Work against isolation and stay socially connected

Most people dealing with PTSD report some difficulties in social relationships. Staying connected with people does not necessarily mean going to crowded places or meetings where there is a need to engage in conversation. Spending time with others or doing something outdoors might involve only 2 or 3 people at time (e.g., fishing with close friend on a lake, etc.). Joining a PTSD support group could also be an activity where the individual can remain private but still connected with others.

Connecting with others can be difficult, but when meeting somebody, it may help to know that there is no need to share, explain, or talk about the traumatic experience. Most people would not even need an explanation. Yet, sometimes it is reported that the person “feels obligated” to explain what happened to them, or that they should give reasons for why they react differently, or why they are leaving their homes when they are on leave from work while dealing with PTSD. Those expectations might not be the expectations of others, but rather the individual’s. It is perfectly reasonable to share only what one feels comfortable sharing. Some people find it helpful to practice what they would communicate in those situations. Usually, the message can be that being asked what is going on feels good, but at that moment the person who lives with PTSD might not want to disclose anything.

It can be useful to communicate any needs to those who are around. Nobody can read another person's mind, so no one will know what is needed until those needs are expressed. Family members and friends can show care and support; however, as they do not experience the symptoms, they might forget about them more easily. Those situations might be not intentional, just very human. Reminding them of the needs and the way support can be offered is helpful.

Therefore, it might be useful to practice expressing needs out loud. It can be said: "Please, can we change the subject, I am not comfortable talking about this." or "Excuse me, I need a little break, so I am going for a short walk." Situations, needs, circumstances, and people are different, so the requests can also be different.

Taking care of the body

Relaxation

Learning how to relax can be one of the first ways to take care of the body. There are different strategies on how to relax or meditate. It can take time to find a way that works for the person, and different strategies can be explored. There are books, websites, and applications that offer resources to learn relaxation techniques. One effective strategy is progressive muscle relaxation (PMR), which works through the whole body systematically while tensing the muscles when breathing in and relaxing them when breathing out. PMR is very structured and brief.

Decompress

Some people need to find a safe way to get rid of internal pressure (i.e., the pressure a person puts on themselves). Decompressing can involve activities such as doing (intense) physical exercise, singing along with a favourite song, or getting some physical yard work done.

Nutrition

Healthy diet and proper nutrition are a critical part of balanced health; however, PTSD can induce changes in appetite. Some people do not feel like eating or get nauseous because of nervousness and constant tension. In these cases, it might be even more important to put together a plan and experiment with food to figure out what helps with these symptoms. Moods swings and energy fluctuation or frustration because of hunger can be avoided with healthy nutrition. Eating habits (eating heavy food, refined carbs, or caffeinated beverages before bedtime) can also influence sleep and sleep quality.

Sleep

Sleep is often affected by PTSD symptoms, and lack of sleep or a disturbed sleep pattern might make symptoms worse. This vicious cycle can be stopped with proper sleep hygiene. A regular bedtime, developing a bedtime routine, and setting an appropriate bedroom temperature with restricted lighting may be effective strategies. Many people with PTSD are startled by noise, so earplugs can be useful for creating a quiet environment for sleep. Additionally, research has found that sleep can significantly change in PTSD, and a sleep assessment can be useful. Sometimes using a continuous positive airway pressure (CPAP) machine helps to address certain symptoms of sleep-related problems. It is recommended that unhealthy sleep aids (e.g., alcohol, drugs, nicotine) are eliminated. If a sleep aid is needed, a medical doctor can assess and address the symptoms.

Next steps

Learning about PTSD can offer reasons and evidence for seeking help and support. Family members, friends, and colleagues can help to find a mental health professional who has experience and uses evidence-based treatments to address PTSD.

It may also be important to find out what the person's insurance can cover in order to look for the best possible resources (public and community-based resources or private services). Beyond searching the internet for available help in the area, the local hospital or a family physician might be able to provide relevant information.

Sometimes, when the person calls a treatment provider's offices, it can be disappointing if the wait list is long. It may be helpful to expect some delay because of long waits in both public or private services. Wait lists can be frustrating, especially when it is already hard to reach out for services. However, when a person starts the assessment for treatment, it can be reassuring to know that they will also be offered the needed time to address their problems, as others were offered prior to them.

In the case of crisis or emergency, go to the nearest hospital or crisis centre or call 911.

Chapter summary

- Learning about and understanding PTSD is the first step in taking care of the needs of a person who may suffer from PTSD.
- Treatment for PTSD can help in various ways to achieve a better quality of life.
- Different forms of therapies are available to address PTSD-related symptoms.
- Individual treatment plans will be developed with the help of trained professionals.
- Experiencing results with treatment will take time. Understanding the process, as well as asking questions or expressing potential concerns, will be elements of the therapy.
- Finding resources, practicing different strategies such as self-care, and physical exercise routines that support treatment and recovery, can be discussed with the therapist.

TO FAMILY & FRIENDS

A person who has been diagnosed with PTSD will be advised to seek professional help. However, support from family, friends, or others will be essential.

Support may have different forms such as offering comfort, understanding, and space. It may be useful to keep in mind that even though family members and close friends might witness and experience the suffering of a loved one dealing with PTSD, they did not cause the issue and they can only support them within their roles as a family member or friend.

Support may start with learning more about and understanding what PTSD is and what its symptoms mean. Some additional resources are listed at the end of this booklet to educate family members and friends about PTSD, as well as to provide information on how to support a loved one who lives with PTSD symptoms. When this information can be discussed together, it may be easier to identify how family members and their immediate environment might be affected by the person's PTSD. This shared understanding may create better support, more effective treatment, better management of the problems, and may facilitate people to come up with plans together.

PTSD and family life

Family life might be significantly affected when a family member has been diagnosed with PTSD. Symptoms can change the ability of the person to function as a partner, as a sibling, as a parent, as a friend, etc. Changes in functioning can lead to an increased level of distress and frustration with not being able to communicate, understand, or meet each others' needs like before. Other emotions might be present such as guilt, shame, embarrassment, blame, and helplessness, etc. Changes may manifest themselves in:

- behavioural changes (e.g., stop participating in previously enjoyed activities, expressing frustration more often, becoming hostile or overprotective, indecisiveness, avoiding conversations)

- relationship changes (e.g., sense of loss, lack of intimacy, limited expession of feelings)

- changes in activities of daily living (e.g., financial responsibilities, caregiving responsibilities, or caring for basic needs such as preparing meals)

Establishing good communication might be key to encouraging people to share their feelings and overcome the difficulties they experience together. It takes time to learn how to support each other when dealing with the consequences of PTSD as a family. Tips and strategies can be offered, but family members can choose what works for them. Setting small goals and being patient will be helpful in order to avoid disappointment. Couple's therapists might be able to support couples, and family therapists might offer help to the whole family while the affected person heals from PTSD.

The effect of a family member's posttraumatic stress on children

Children may react differently when they live with somebody who has been diagnosed with PTSD. Adaptation and adjustment might be easier and smoother if children are given an age-appropriate explanation of the situation. Children may be able to adjust well, but sometimes they may respond in problematic ways (e.g., acting like their parent; taking over adult responsibilities; acting younger than they are; showing problems at school; showing symptoms of anxiety and depression; behaving more aggressively; significant changes in weight; lack of basic hygiene). There are different ways to support children's coping skills. If their reactions are long lasting, or if they are intensive, it would be advised to seek professional help for them.

Different posttraumatic symptoms may trigger different reactions in children

When children witness their parent having nightmares or flashbacks, reactions can vary from feeling confused and scared to being worried about the parent's well-being; they may worry about how the parent will be able to care for them; or they may become overly protective in these situations.

When the parent avoids social situations (e.g., going out for movies, birthday parties, etc.), children may take it personally, they may feel hurt, neglected, or they may question whether they and their needs are being cared for.

When the parent is withdrawn or uninterested, children may think that they are not loved, or they may worry that the parent will leave them or will leave the family.

When the parent is irritable, angry, or vigilant, the children may feel more anxious, and stressed. These situations can also lead to children losing respect for their parent.

Helping children cope

Children may observe changes in family life in cases where any of their parents deal with PTSD and sharing age-appropriate information might be very helpful for them. In the absence of information, they may feel scared or confused. Sharing feelings, encouragement, and information about what is happening and why it is happening, can help to establish safety. Family therapists can be a great help in guiding the family through these types of discussions.

Children's own behaviour may be inadvertently triggering (e.g., noise, yelling, screaming, shouting while playing, door slamming, running around, etc.). Talking and explaining those situations might be helpful to make changes.

Remember!

Verbal or physical abuse is never acceptable. If it happens, take steps to stop it, such as therapy or anger management, and take actions to avoid that situation.

PTSD and its affect on social life

PTSD, like other mental health issues, might affect social life in general, and most of the time, it starts with how the person thinks about themselves. Going through traumatic experience(s) changes the way a person may:

- regulate emotions (e.g., irritability, sadness, or numbness)
- use cognitive functions (e.g., memory functions)
- think about themselves (e.g., shame, guilt, helplessness, loss of identity)
- think about the world and about relationships (e.g., trust, safety)
- engage in activities (e.g., loss of interest, psychological distance, neglecting duties, absenteeism)
- perceive stimuli (e.g., dreamlike, unrealistic feelings and perceptions)

The listed changes are examples to show how many areas may be affected by PTSD, and they may all contribute to shaping relationships at home or at work. The listed factors can contribute to significant changes in behaviour, as well as trigger conflicts, misunderstandings, enhance isolation, and withdrawal. Adjustment might be needed to manage the changes, as well as to offer support, understanding, and space based on needs. This is one of the major reasons why it might be essential to inform and involve the person's social support system when they are healing from PTSD.

SUPPORTING FRIENDS AND FAMILY WITH PTSD

For those who have PTSD

DO ✔

- Be patient — recovery takes time and everybody's pace is different. Usually, it takes time for symptoms to develop and it mostly happens without our conscious insight. As you can see, multiple risk factors are needed to develop PTSD, so it takes time to reverse their effects. Give yourself space and time to recover.
- Learn about your triggers — get familiar with your possible triggers and prepare for dealing with them. If possible, involve your support system and prepare for different scenarios where a trigger might occur.
- Practice art — whether it is poetry, singing, painting, sketching, playing an instrument, photography, or dancing, art is usually a good way to distract yourself and engage in something that is stimulating and can offer some relief.
- Accept that your trauma is real and unique. It does not matter how others react to similar events. Nobody has the exact same experience, life history, personality, genetics, etc. Your experience and your response to the traumatic event is unique and there is no need for comparison.

DO ✔

- PTSD is not personal — if you live with PTSD understand that it is not your fault, nor is it a sign of weakness.
- If you are a parent living with PTSD, delay disciplining your child when you are irritable or when symptoms are hard to manage. Your child deserves your undivided attention and learns better when explanation is offered in a calm, explanatory, and factual manner.

For those whose family member/friend has PTSD

DO ✓

- Go to at least one education session, if possible. Social support is one of the most significant parts of the recovery process that can help with reaching the treatment goals.
- Be patient — recovery takes time and everybody's pace is different.
- Familiarize yourself with PTSD triggers and anticipate them. Certain sounds, smells, situations, media exposure, television shows, newscasts, funerals, hospitals, loud noise, physical discomfort, or even just being overwhelmed or vulnerable can trigger PTSD symptoms. Be aware of triggers as much as possible, and plan together how to help them calm down or get away from the situation.
- Respect boundaries without avoiding situations altogether. When something concerns you, you can raise that issue. If you cannot figure out a solution, or it is too sensitive a topic, ask for help from professionals.
- Learn to listen —memory and focus might be affected by the symptoms when someone lives with PTSD and they might tell you the same thing repeatedly. Sometimes it is because they cannot remember, sometimes it is because they need to repeat it over and over again while processing it. Listening without expectations is not easy, and listening without advising and directing the person can be difficult. Learning to listen the right way takes time and sometimes guidance is needed to improve this skill.
- Express your commitment to your relationship, if you feel that way. People with PTSD might feel they are not worthy of positive feelings. Express the importance of the relationship and your support.
- Help create a daily routine — structure and predictability are useful strategies to help individuals feel stable and oriented. Helping with everyday tasks may be useful.
- Keep promises as much as possible to regain trust and consistency. When promises cannot be kept, talk openly about the reasons.
- Remember and remind your family member/friend of their strengths and successes.
- Encourage activities that support treatment, but do not push them.
- Avoid sudden movements or noises and speak softly.

DO ✓

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- Be attentive and respectful of their emerging needs. Ask about needs and respect the answer rather than making assumptions because needs can change suddenly. When a sudden change happens, it might not be possible to discuss the situation before grounding strategies are implemented successfully. Giving space or other previously discussed strategies might be useful.
- Ask before touching — those with PTSD can be easily startled. Come to an agreement so everybody can feel comfortable.
- Be patient with their emotions — someone with PTSD might be unable to reflect on their emotions, which can be difficult on relationships. This is part of the illness and not how the person may feel.
- Take care of yourself — living with somebody who has PTSD can be stressful. Acknowledging your own needs and stressors will help you to offer support without risking burnout.
- Involve other friends or/and family members to share the responsibility and have more resources.
- Know your own boundaries and be realistic of your abilities and capabilities.
- Reach out for help when it is needed. It is normal to feel confused, overwhelmed, or however you may feel. Discuss what you are going through with your source of social support.
- Keep communicating — treatment may end, but continue to check in with your friend and family member.
- Keep learning about new resources and tools, such as apps, and try them out.
- If your loved one has PTSD, understand that their behaviour, thoughts, or emotions are not personal. It is important to know that symptoms such as mood swings, shortness in behaviour, or emotional distance have nothing to do with the relationship as they are symptoms of PTSD.
- Try to stay and focus on the “here and now”, especially when frustration arise. Saying hurtful things will not help resolution. Take time outs, leave space for each other, and revisit situations later, if possible.
- Try to solve problems as a team. Discussion and explanations are more effective ways of dealing with a problem. The “I told you so” phrases can create significant barriers instead of offering solutions.

DO ✓

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- Use neutral space when conflicts need to be addressed. Relocating from a private place such as the bed or bedroom to a neutral space might be considered.
- Separating feelings from facts when working on a conflicting situation may be a good strategy and may help to reason more efficiently.
- When frustration and anger is present, acknowledging it may be the first step to address it.
- When it is not possible to talk about feelings, thoughts, and experiences, offer some space. It is not easy to talk about traumatic events. Furthermore, if you are not prepared to listen, the situation can affect the both of you negatively.
- Give advice only when it is asked for. Directing the person on what to do or what not to do may not be as helpful as you think.
- Acknowledge the feelings and symptoms that are present in the moment. Minimizing your family member/friend's feelings or symptoms may lead to more problems. The symptoms are real to them, even though they might not make sense to you.
- Respect the person's experiences. Asking about traumatic experiences because of personal curiosity might not be a good idea. The traumatic experience is not an enjoyable story to share—it is a trigger which creates symptoms and struggles in the person's life. If you have to ask questions, have a goal in mind, such as helping to prepare and deal with triggers.
- Avoid easy phrases like "everything is going to be okay" or "it could be worse". Those general statements might block communication, as they do not reflect personal and honest interest and listening.
- Blaming things on PTSD that are not related to it may lead to further difficulties.
- Think before you speak and do not give ultimatums. Using "I" language (I think, I feel) can change statements positively compared to using "you" statements.
- Accept the person with PTSD even when their symptoms, triggers, reactions, fears, feelings, and thoughts might not make sense to you, but they are real for them.

For children whose family member/friend has PTSD

DO ✓

- Share age-appropriate information with them and try to answer their questions. Over-sharing (scary details) and under-sharing (not answering questions) might not be helpful.
- It might be important to tell children that the symptoms are not their fault. Confirm that finding a solution is a job for adults and share that steps are being taken to improve the situation.
- When the parent who has PTSD avoids certain situations/activities children may feel rejected. Talking about these situations and working on alternative plans might be comforting.
- Encourage the children to share their feelings and check in with them regularly.
- Check in with the children's needs. These needs can be physical needs (e.g., routine, physical activities, sleep hygiene, nutrition); psychological/emotional needs (e.g., communication, affection, safety, leisure time); social development needs (e.g., family and friend/community-related activities); intellectual development needs (e.g., participating in games, hobbies, visiting museums, helping with homework, etc.); or spiritual needs (e.g., family values, sharing, helping others, etc.).
- Recognize that changes in family life due to PTSD may be stressful for children, and be patient.
- Recognize that it can be expected to have mixed feelings about the family member or friend who has PTSD.
- Acknowledge and appreciate children's positive behaviours and reactions.
- Focus on quality time that you can spend together as a family.
- Teach general skills to manage stress.
- Some children may benefit from keeping a journal about their feelings and experiences.
- Involve children in decisions that affect them, when possible.
- Discuss the treatment that the parent with PTSD gets, and share realistic hopes for outcomes. If there is something that they can do to help, ask them (e.g., sharing age-appropriate chores).

DO ✓

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- Maintain regular routines and family traditions, such as celebrating birthdays and bedtime stories.
- Offer regular undivided attention.
- Explain and give reasonings for things age-appropriately (for example, share why slamming doors or unexpected noise can be triggering, and what reactions can be triggered in those situations). Offer tools and new approaches when possible to deal with those situations.
- When a distressing situation happens, another family member or friend can help the children by removing them from the situation and re-establishing safety. When a safe and calm environment is established, explain what happened and talk through their questions. If the children contributed to the trigger of the situation, reinforce the message that it was not their fault. Talk about what to do next time in similar situations. When possible, prepare in advance for these situations.
- Communicate (talk and listen) with children about what is going on. They are sensitive and quick to notice changes. Use body language that shows attention and offers comfort (e.g., eye contact, touch). Simple language may be helpful.
- When children show symptoms of distress (usually long-term changes in usual/normal behaviour), assess them and consider how to support them in coping more effectively.
- Consider consulting with a family therapist about your family situation.

Resources

There are almost endless resources available on the internet that are related to posttraumatic stress disorder, including websites with information on: sources of help such as the availability of specialized treatment centers; lists of coping strategies and online and in-person peer support groups; smart phone applications assisting with symptom documentation, and offering reminders of alternative grounding and coping tools; etc. Usually, these resources can be found on thematic websites that were created to help different groups who may be at higher risk of developing PTSD symptoms. The major groups are: public safety personnel (includes first responders); Canadian Armed Forces Serving Members and Veterans; health care providers; Indigenous Peoples; survivors of disasters; survivors of any type of violence; LGBTQ2S+ youth and adults; and refugees. Despite the fact that online resources might be planned and organized to offer support to specific groups at risk, individuals who belong to other risk groups or who are interested in the topic may also find relevant and useful information on them.

Below, we list some online resources, but it should be noted that internet-based information can be changed, become outdated, or removed at any time without notice. We have no control over the nature, content, and availability of these sites. We do not represent or warrant that information contained on the linked websites is complete or accurate. We suggest that you always verify information obtained from them before you act upon it, and that you view these sites strictly at your own risk.

Resources for the general population

- https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/posttraumatic-stress-disorder
- https://cmha.ca/documents/post-traumatic-stress-disorder-ptsd
- http://www.trauma-ptsd.com/en/ressources
- https://www.heretohelp.bc.ca/infosheet/post-traumatic-stress-disorder
- https://www.apa.org/ptsd-guideline
- https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/healthy-living/federal-framework-post-traumatic-stress-disorder/pub1-eng.pdf
- https://www.canada.ca/en/public-health/services/mental-health-services/mental-health-get-help.html
- https://cpa.ca/sections/traumaticstress/simplefacts/
- https://www.anxietycanada.com/disorders/post-traumatic-stress-disorder/

Resources for first responders

- https://www.bootsontheground.ca
- https://www.firstrespondersfirst.ca
- https://www.pshsa.ca/search?gSeachText=PTSD
- https://homewoodhealth.com/corporate/blog/supporting-first-responders
- https://www.suicideinfo.ca/resource/first-responders-trauma-intervention-suicide-prevention/
- https://projecttraumasupport.com
- https://www.wingsofchange.ca
- https://badgeoflifecanada.org
- https://woundedwarriors.ca
- https://www.thestablegrounds.com
- https://www.mentalhealthcommission.ca/English/working-mind-first-responders
- https://www.firefightingincanada.com/free-online-ptsd-course-for-firefighters-26464/

Resources for Indigenous peoples

- https://thunderbirdpf.org/wp-content/uploads/2015/01/24-14-1273-FN-Mental-Wellness-Framework-EN05_low.pdf
- https://www.itk.ca/wp-content/uploads/2016/07/ITK-National-Inuit-Suicide-Prevention-Strategy-2016.pdf

- https://www.nccih.ca/docs/emerging/RPT-Post-TraumaticStressDisorder-Bellamy-Hardy-EN.pdf
- https://www.suicideinfo.ca/resource/trauma-and-suicide-in-indigenous-people/
- https://www.heretohelp.bc.ca/visions/indigenous-people-vol11/intergenerational-trauma-and-indigenous-healing
- https://www.sac-isc.gc.ca/eng/1576089278958/1576089333975

Resources for Veterans, Canadian Armed Forces

- https://open.canada.ca/en/apps/ptsd-coach-canada
- www.ptsd.va.gov
- https://www.ptsd.va.gov/understand/what/ptsd_basics.asp
- https://www.ptsd.va.gov/apps/ptsdcoachonline/default.htm
- https://www.legion.ca/support-for-veterans/mental-health-ptsd
- https://projecttraumasupport.com
- https://www.veterans.gc.ca/eng/health-support/mental-health-and-wellness/understanding-mental-health/ptsd-warstress
- http://www.ptsdassociation.com/for-armed-forces
- https://www.veterans.gc.ca/eng/health-support/physical-health-and-wellness/compensation-illness-injury/disability-benefits/benefits-determined/entitlement-eligibility-guidelines/ptsd
- https://www.veterans.gc.ca/eng/health-support/mental-health-and-wellness/understanding-mental-health/ptsd-and-the-family
- https://www.veterans.gc.ca/eng/health-support/mental-health-and-wellness/understanding-mental-health/learn-ptsd
- https://www.veterans.gc.ca/eng/health-support/mental-health-and-wellness/understanding-mental-health/understand-ptsd
- https://www.veterans.gc.ca/eng/health-support/mental-health-and-wellness/understanding-mental-health
- https://www.mhfa.ca/en/course-type/veteran-community
- https://www.veterans.gc.ca/eng/health-support/mental-health-and-wellness/understanding-mental-health/centre-of-excellence
- https://www.veterans.gc.ca/eng/contact/talk-to-a-professional
- The VAC Assistance Service is available 24 hours a day, 365 days a year: Call toll-free: 1-800-268-7708 or TDD/TTY: 1-800-567-5803.
- https://www.canada.ca/en/department-national-defence/services/benefits-military/health-support/mental-health.html
- www.ptsd.va.gov
- https://www.ptsd.va.gov/understand/what/ptsd_basics.asp
- https://www.ptsd.va.gov/apps/ptsdcoachonline/default.htm

Suicide or crisis resources

- https://www.crisisservicescanada.ca/en/
- https://www.crisisservicescanada.ca/en/someone-you-know-thinking-about-suicide/
- https://thelifelinecanada.ca/lifeline-canada-foundation/lifeline-app/
- https://thelifelinecanada.ca/help/
- https://thelifelinecanada.ca/lifeline-canada-foundation/lifeline-app/
- https://www.suicideinfo.ca/
- https://www.canada.ca/en/public-health/services/publications/healthy-living/suicide-canada-infographic.html
- https://www.canada.ca/en/public-health/services/publications/healthy-living/suicide-prevention-framework.html

Canada

- https://www.livingworks.net/asist
- Talk Suicide Canada can be reached at 1-833-456-4566. It is available 24/7/365. “Start” can be texted to 45645 from 4 pm to midnight. Standard text messaging rates apply.
- Call or text 9-8-8 (starting December 1, 2023). Free of charge.

Ontario

- ONTX Ontario Online & Text Crisis Service
- https://www.ementalhealth.ca/index.php?m=record&ID=10502
- https://wrspc.ca/about-us/ontario-suicide-prevention-roundtable/
- Crisis Chat (2 pm - 2 am ET): www.dcontario.org/ontx.html
- Crisis Text (2 pm - 2 am ET): 741-741

Québec

- Residents of Québec are encouraged to call 1-866-APPELLE (1-866-277-3553). Assistance is also available through text. Adults can text 741741 and youth can text 686868.

Apps for mobile devices

- PTSD Coach was developed by Veteran Affairs Canada to support PTSD-related symptom management: https://open.canada.ca/en/apps/ptsd-coach-canada
- PTSD Coach was developed by the US Department of Veteran Affairs: https://mobile.va.gov/app/ptsd-coach

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