Adolescents Who Sexually Abuse

Why Don't They Recidivate?

David S. Prescott, LICSW 2017

CONTACT

David Prescott, LICSW

Clinical Director and Director of Professional Development and Quality Improvement
Becket Family of Services

VTPrescott@Earthlink.net
www.davidprescott.net
www.becket.org

AGENDA

- Background
  - Including developmental aspects
- Six key considerations
- Special Issues:
  - Polygraphy
  - Trauma

THE SHORT VERSION

Most don't recidivate because they don't want to
- Maturity
- Stability
- Occupation
- Supports, bonds, intimacy
- Plans for future
- Everything to lose by doing it again

- Re-offense is underestimated, BUT
  - Science versus science fiction

CONTEXT

SEXUAL AGGESSION IN COLLEGE MEN

- Abbey et al. (2001)
  - 343 college men
  - 33% reported having engaged in some form of sexual assault
  - 8% reported an act that met standard legal definitions of rape or attempted rape
- Koss, Gidycz, & Wisniewski (1987)
  - Found that 24.4% of college men reported "sexual aggression" since age 14
  - 7.8% admitted to acts that met standard legal definitions of rape or attempted rape

SEXUAL AGGESSION IN COLLEGE MEN

- Abbey & McAuslan (2004)
  - 14% reported that they had committed a sexual assault within a 1-year time interval
  - This is close to the rate presented in the only other study to our knowledge that examines sexual assault perpetration among adults longitudinally, which found a perpetration rate of 12.5% between the 1st and 2nd year of college (White & Smith, in press). These results further demonstrate the critical need for effective prevention programs for men in college.
- **Caution:** "sexual assault" not clearly defined

WHAT WE FEAR

REALITY

BOTTOM LINE

- Prevalence and incidence = it is big
- We need a public health perspective over and above psychological and criminological perspectives
- Victim-to-victimizer hypothesis = incomplete
  - Self-report requires behavioral description…
  - See Simons (2007)

Developmental Aspects:
Fundamental to Assessing Progress

FACTS

- People develop
- Average age of first offense is around 14
- People are more convinced by what they hear themselves say than by what others say to them
- Use developmental processes as your ally
  - Meet your client where they dream

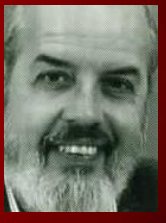
MOFFITT (1993)

- 3 groups of delinquent adolescents:
- **Adolescence-limited**
  - Begins in adolescence; desists by adulthood
- **Early onset, life-course persistent <u>with</u> neuropathology**
  - Pre/peri/post-natal problems, sometimes in combination with family and community adversity
- **Early onset, life-course persistent <u>w/o</u> neuropathology:**
  - *"A discrete class of individuals, a taxon that is different in kind from other antisocial individuals…"*

QUINSEY ET AL. (2004)

Best predictors of juvenile delinquency among general youth (ages 6-11)

- Prior offending
- Substance use
- Being male
- Low socioeconomic status
- Antisocial parent



QUINSEY ET AL. (2004)

Best predictors of juvenile delinquency among general youth (ages 12-14)

- Lack of strong prosocial ties
- Antisocial peers
- Prior delinquent offenses

THERE IS DEVELOPMENT…
And then there is developmental <u>TRAUMA</u>

TBI, TOXINS, ETC.

Headline: Group warns almost 500 food products contain chemicals found in yoga mats

THE PROBLEM

- Smith, Goggin, & Gendreau, 2002
- Meta-analysis
- 117 studies since 1958
- 442,471 criminal offenders (including juveniles)

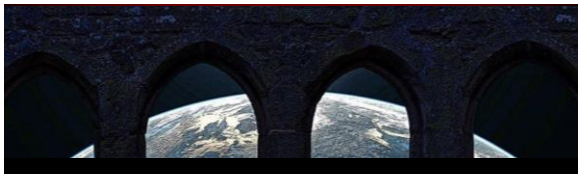
No form of punishment reduced re-offense

Two other large-scale studies have since confirmed

A REAL PROBLEM

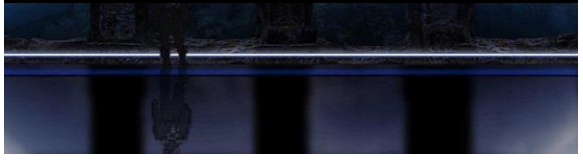
Prisons and intermediate sanctions **should not** be used with the expectation of reducing criminal behavior

- Includes intensive surveillance, electronic monitoring, DARE, Scared Straight, etc.
- Some indication of increased risk for low-risk criminals
- www.ccoso.org



What Do We Know?

What Research Shows



6 PRINCIPLES

1. Adolescents, not "little adults"
2. Most do not re-offend sexually
3. Assessment measures help, but are not stand-alone instruments
4. Resiliency and protective factors and processes
5. Assess the program: Not all treatments are alike
6. Assess the provider: The qualities of the professional influences outcomes

LETOURNEAU & MINER (2005)

Three Realities:

1. Opportunity to intervene
2. More in with other "juvenile delinquents" than adult sex offenders
3. Re-offense rates very different from adults


SETO & LALUMÈRE, 2010

- Adolescent sexual offending not a simple manifestation of general antisocial tendencies.
- Compared with non-sex offenders, adolescents who abused had less extensive:
  - Criminal histories
  - Antisocial peers
  - Substance use problems

SETO & LALUMÈRE, 2010

- Compared with non-sex offenders, adolescents who abused had more extensive:
  - Sexual abuse history
  - Exposure to sexual violence
  - Other abuse or neglect, social isolation
  - Early exposure to sex or pornography
  - Atypical sexual interests
  - Anxiety
  - Low self-esteem

SETO & LALUMÈRE, 2010

<u>Not</u> different between groups:

- Attitudes and beliefs about women or sexual offending
- Family communication problems or poor parent–child attachment
- Exposure to nonsexual violence
- Social incompetence
- Conventional sexual experience, and low intelligence


SETO & LALUMÈRE, 2010

Largest Group Differences:

- Atypical sexual interests
- Sexual abuse history
- Criminal history
- Antisocial associations
- Substance abuse


IMPLICATIONS

- Letourneau & Miner (2005) observed that adolescents who sexually abuse have more in common with other delinquent teens than they do with adult sexual offenders
  … and this is correct
- There are still differences between populations of adolescents who sexually abuse and other teens who get in trouble with the law

IMPORTANT!

- The findings of Seto & Lalumiere (2010) suggest that risk factors for **BOTH** general delinquency and sexual offending behavior contribute to juvenile sex offenses

CARPENTIER, LECLERC, & PROULX (2011)

WHO PERSISTS?

WHO DESISTS?

CARPENTIER ET AL. (2011)

- Examined correlates of onset, variety, and desistance of criminal behavior
- Confirmed that most of those who persist commit a variety of offenses and do not specialize



CARPENTIER ET AL. (2011)

- Sex-only versus sex-plus aggressors
- Sex-only have lower rates of CD and fewer antisocial traits
  - Less likely to have experienced traumatic physical and sexual victimization
  - Less likely to have been placed in outside care
  - Half as likely to have consumed alcohol and drugs prior to age 12
  - In adolescence, had less drug/alcohol, aggression, delinquent peers, and consensual sex

CARPENTIER ET AL. (2011)

- Persistence
- Desistance
  - Fewer antisocial traits
  - Less ADD
  - Less physical and sexual victimization
  - Less parental negligence
  - Fewer out-of-home placements
  - Fewer learning disabilities, behavior problems, and school failures
  - Fewest consensual sexual experiences

CARPENTIER ET AL. (2011)

- Stable Highs (sexual or violent re-offense)
- De-escalators (re-offense, not sex or violence)
  - Less ADD
  - Less physical and sexual victimization
  - Less parental negligence
  - Fewer out-of-home placements
  - Less involvement with delinquent peers
  - Fewer officially recorded crimes

CARPENTIER ET AL. (2011)

Adolescents who exhibited antisocial traits ran an almost threefold risk of committing both sexual and nonsexual offenses

CARPENTIER ET AL. (2011)

"Adolescents with poor self-control tend to avoid situations of social control (supervision, discipline) and consequently tend to associate with peers who resemble them and who, like them, are likely to offend. These young people also tend to experience school difficulties (behavioral and learning difficulties), leading to school failure and dropping out of school in favor of less constraining environments." (p. 867)

CARPENTIER ET AL. (2011)

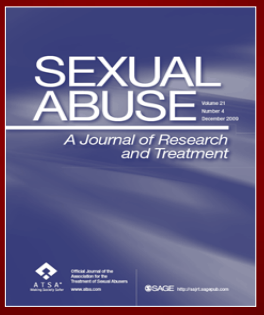
"The severity of the offenses committed by both these groups appears to be more influenced by childhood trauma than by variables related to adolescent development. However, only two variables related to childhood development (sexual victimization and long-term paternal absence) predicted membership in the stable high group rather than the de-escalator group." (p. 868)

CARPENTIER ET AL. (2011)

Implications

- Early intervention with trauma survivors
- We need to build resilience and protective factors to produce desisters
- Trauma treatment is vital
- Comprehensive assessments are key

Reitzel & Carbonell (2006)



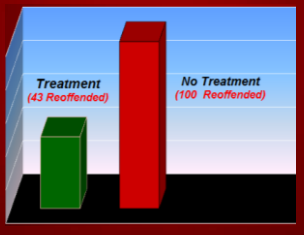
REITZEL & CARBONELL (2006)

- Summarized 33 studies on sexual re-offense by adolescents
- Follow-up averaged 4.5 years
- 9 studies contained either a treatment control group or a comparison treatment group
- Treated adolescents recidivated sexually at a lower rate (7.37%) than untreated adolescents (18.93%; Total *N* = 2986)

REITZEL & CARBONELL (2006)

Average weighted effect size of **0.43**

(*N* = 2986, 9 studies, *CI* = 0.33-0.55)



IMPLICATIONS & A CAUTION

- Treat the entire youth
- The right treatment approaches with the right client = Positive impact
- Our job is to create willing partners in change

WORLING ET AL. (2010)

- Followed 148 juveniles for 12-20 years
- Prospective study
- 16.22% sexual re-conviction rate (24 of 148)
- More likely to commit other crimes

"Relative to the comparison group (*n* = 90), adolescents who participated in specialized treatment (*n* = 58) were significantly less likely to receive subsequent charges for sexual, nonsexual violent, and nonviolent crimes."

CALDWELL (2010)

- Meta-analyzed 61 juvenile data sets
- 11,219 juveniles - weighted average 59.4 months
- Weighted mean sexual recidivism rate is 7.08%
- General recidivism 43.4%

"Studies that examine sexual recidivism during adolescence find monthly sexual recidivism rates that are more than 4 times higher than those found in studies that rely only on adult recidivism records. Neither the level of secured placement (community, residential, or secured custody) nor the use of arrest versus conviction as an outcome significantly influences sexual recidivism rates."

CALDWELL (2016)

- Meta-Analysis
- Studies since 2000
- Recidivism = 2.75%

VILJOEN ET AL. (2012)

VILJOEN ET AL. (2012)

- Examined predictive validity of JSOAP-II, ERASOR, JSORRAT-II, and Static-99 with adolescents
- AUC scores ranging from .64 to .67
- Moderate to high variability across studies

VILJOEN ET AL. (2008)

- Examined recidivism among 169 male YSA in residential programs
- Base rate 8.3% sexual recidivism
- Avg. time to recidivism was 100 months
- Neither JSORRAT-II nor SAVRY, nor J-SOAP—II predicted sexual recidivism (total scores)

HAGAN EL AL. (2008)

- Studied 12 juveniles in Wisconsin recommended by experts for civil commitment, but who ultimately were not committed
- 42% sexual recidivism among these individuals, with a 5-year at-risk period
- This contrasts with the low rates of sexual recidivism reported in the literature
- Evidence that the capability to assess the risk in juvenile sexual re-offending may at times be higher than previously estimated

WORLING (2006)

Measurement of sexual arousal and interest among adolescent males who acknowledged having sexual abused:

1. A computerized analysis of how long the adolescent looks at each of a series of pictures of clothed people of both genders and varying ages
2. A self-report rating form for each of the same photographs
3. A simple graph in which the adolescents rated their sexual arousal for eight age categories, with one graph for each gender

WORLING (2006)

- Similar patterns of responses to all three techniques
- The two self-report procedures distinguished those adolescents who abused children from those who abused peers or adults

WORLING (2006)

- The computerized assessment was able to distinguish those who had abused male children, but no technique accurately identified adolescents who had abused female children exclusively
  - Earlier research into techniques such as the plethysmograph did not examine adolescents' experiences of the procedure itself
  - In this study, Worling found that the adolescents typically did not find any of the methods upsetting

IMPLICATIONS

- Adolescents can be truthful
- Get back to the basics
- Ensure person-centered practice
- Assessment and treatment should address the person, not the behavior
- There is much we don't know about adolescent sexual interest and arousal

4. RESILIENCY AND PROTECTIVE FACTORS (& RISK FACTORS)

DEFINED

- Factors associated with desistance/low probability of offending
- Factors that:
  - Enhance personal competencies
  - Ameliorate the effects of specific risks directly or by interacting with them
  - Serve a stabilizing or enhancing function

(Langton & Worling, 2015)

TWO KINDS?

1. Factors on the other end of a continuum from risk
   (e.g., young versus older age; interpersonal competence versus isolation)
2. Factors with no corresponding risk
   (e.g., religiousness; sex education/knowledge)
   - Also known as "promotive factors"

VRIES ROBBE ET AL. (2015)

- Medication
- Empathy
- Secure attachment in childhood
- Intimate relationship
- Motivation for treatment
- Attitude toward authority
- Self-control
- Coping skills
- Work and leisure interests

VRIES ROBBE ET AL. (2015)

Desistance Factors:

- Treatment as a turning point
- Social network
- Personal agency
- Internal locus of control
- Finds positive outcomes in negative events

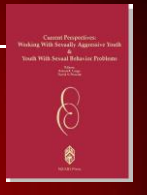
VRIES ROBBE ET AL. (2015)

Best Outcomes:

- Goal-directed living
- Good problem-solving
- Constructive employment/leisure activities
- Sobriety
- Hopeful, optimistic, motivated attitude towards desistance

RISK

Schwartz, Cavanagh, Prentky, & Pimental (2006)



PROTECTIVE

Bremer (2006)
Benson, Scales, & Roehlkepartain (2011)
Gilgun (2006)

PROTECTIVE FACTORS

- Supportive families
- Education
- Stability in one's daily life
- Adequate knowledge about human sexuality
- Having a confidante
- Ability to regulate emotions
- Opportunities to explore one's interests
- Hope
- Plans for the future

RISK FACTORS

First Offense

- Impulsivity
- Breaking other laws
- History of sexual victimization
- Witnessing domestic violence
- Neglect
- Psychological abuse
- Physical abuse
- Having antisocial caregivers
- Attachment problems

Subsequent

- Self-management
- Attitudes (?)
- Interpersonal competence
- Contextual factors, including peer groups and family environment
- Abuse-related interests (subject to change without notice!)

CASE EXAMPLE

- "Chris"
- Serious sexual behavior problems
- Speech therapy
- Interpersonal competence
- Cognitive transformation, not risk reduction

"SEXUAL DEVIANCE"

- Understand sexual arousal in the broader context of emotional and physiological development
- Understand the context of the harmful sexual behavior
- Understand the developmental history of the youth, including harmful behaviors, as well as experiences with trauma or other developmental disruptions
- Be careful with interventions targeting sexual deviance
- Remember that all adolescents are sexual beings

AROUSAL RECONDITIONING

McGrath, Cumming, & Burchard (2003)

- **Male Adolescent Residential:** 56.4% of programs use 1+ behavioral techniques
- **Male Adolescent Outpatient:** 49.4% of programs use one or more
- **Female Adolescent Residential:** 48.5% of programs use one or more
- **Female Adolescent Outpatient:** 37.2% of programs use one or more

WHAT IS MISSING?

Little, <u>if any</u>, research basis for...

- Remorse/Shame/Guilt
- Empathy
- Psychological Maladjustment
- Denial
- Clinical presentation
- In youth: Uncertain sexual arousal

(Hunter & Becker, 1994)

THE PROBLEM WITH TREATMENT

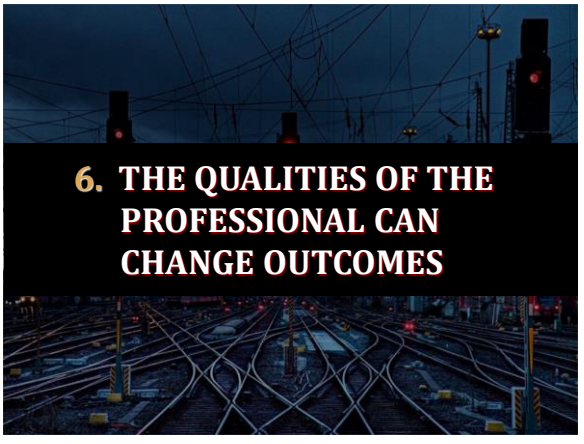
- Putting adolescents who have engaged in misconduct together can actually increase their risk of committing further harm
- "Iatrogenic" effects (Dishion et al., 1999)
- Weiss et al. (2005) Examined published and unpublished studies of antisocial youth

WEISS ET AL. (2005)

- Antisocial peer groups ≠ ⬆ likelihood of future misconduct
- While the evidence is convincing that misbehaving youth can influence each other in general settings ("deviancy training"), this negative influence is not necessarily seen in group treatment situations
- Outcomes are less severe than arrest for a serious crime (e.g., smoking, classroom misconduct)
- In one well-known study, the purported effects of these peer groupings were not apparent until 30 years later, and "treatment" involved mentoring and case management

IMPLICATIONS

- The impact of peers is important
- Positive peer and adult influence
- One study does not a reality make



MARSHALL (2005)

MARSHALL (2005)

- Warm
- Empathic
- Rewarding
- Directive

Problem: Many people think they have these qualities, but do not

EMPATHY

- Hojat et al. (2009)
  - Empathy among doctors
- Empathy scores did not change significantly during the first two years of medical school
- However, a significant decline in empathy scores was observed at the end of the third year which persisted until graduation
- Patterns of decline in empathy scores were similar for men and women and across specialties

HOJAT ET AL. (2009)

Conclusions

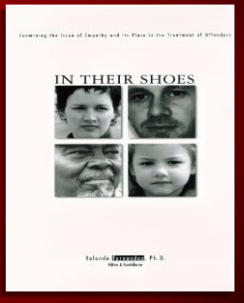
It is ironic that the erosion of empathy occurs during a time when the curriculum is shifting toward patient-care activities; this is when empathy is most essential

IMPLICATION

- Motivational Interviewing
- Emphasizes Compassion over "empathy"
- Think:
  - Intention
  - Attitude
  - "Heartset"
- Capacity for measurement
  - MITI (Motivational Interviewing Treatment Integrity)

FERNANDEZ (2002)

- Examining the issue of empathy and its place in the treatment of offenders
- Responsivity factor



SPECIAL ISSUES

Treatment Plans, Polygraph, and Trauma

WHAT IS TREATMENT?

- Producing people with reduced risk?
- Assisting those harmed?
- Preventing future victimization?
- "Outing" those who have not disclosed their victimization?
  - Do all who have been harmed want our help?

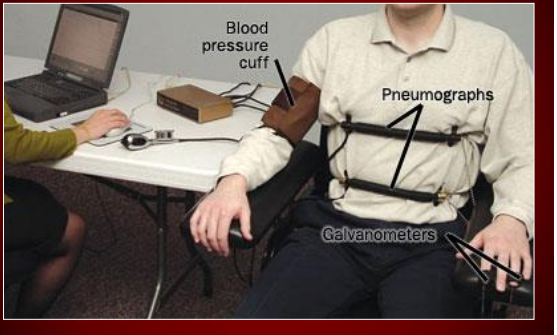
WHAT IS DISCLOSURE?

- Process *vs.* Event
- Can it be encouraged, forced… or nudged?
- We can force kids to disclose, but can we force them to become honest people?
- How do people view themselves after they disclose (or are compelled to disclose)?

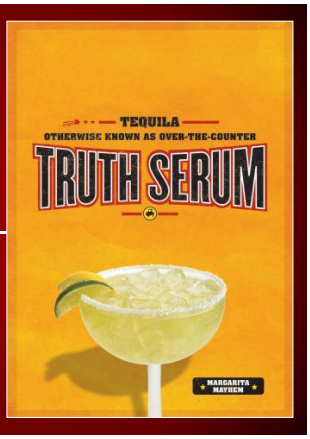
FINALLY…

- Do we have the right to force someone to disclose?
- At what point does forcing someone become an abuse dynamic itself?
- Despite our efforts, is our message "you must… or I will hurt you?"

POLYGRAPH



OBSESSION



POLYGRAPHY

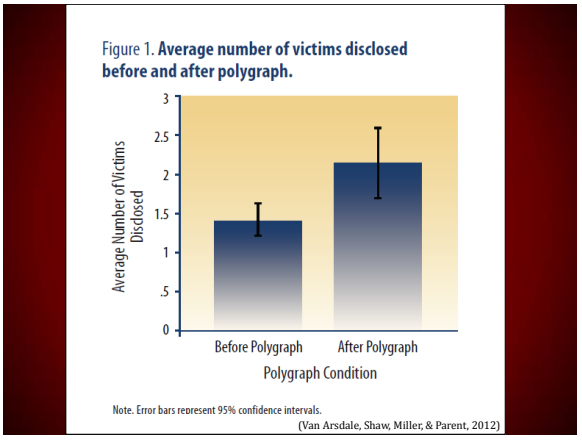
- Safer Society 2009 Survey
  - Over 50% of the responding programs claim to use polygraphy with adolescents
- Lack research to recommend use with adolescents beyond number of victims
  (data to follow)

WHY NOT POLYGRAPHY?

- Hindman & Peters (2001)
  - Adolescents who had sexually abused and participated in polygraph examinations reported twice as many victims as those who did not
  - Touted "the power of the polygraph to elicit withheld information"
  - Findings were less dramatic than the results for adults, who reported five to six times as many victims as their adolescent counterparts
- Results similar to those of an earlier study by Emerick & Dutton (1993)

VAN ARSDALE, SHAW, MILLER AND PARENT, 2012

- Increase in the number of victims disclosed
- Victims disclosed tended to be younger and male
- 1.42 victims before polygraph (average)
- 2.15 victims after polygraph (average)



COOK (2011)

- Offenders admitted more male victims, stranger victims, and unrelated victims previously on the Static-99R
- However, this additional information did not significantly improve the predictive accuracy of the Static-99
- When the polygraph was used in its traditional manner to determine whether or not the offender has reported all of his victims, the SHPE did not predict recidivism

CHAFFIN (2010)

Suggests that we should only use polygraphy ***IF*** it can be proven to…

- Lead to better tx outcomes
- Prevent future victimization
- Protect abusers from all the consequences of abusing again

Such research is currently lacking

CHAFFIN (2010)

"Procedures to extract confessions seem to hold a particular sensitivity in the health care ethics literature, especially if the procedures are coercive or harsh. The World Medical Association (WMA, 1975) held that a breach could exist for health care providers by simply being present during harsh interrogations." (P. 318)

ROSKY (2012)

- "Correctional quackery"
- "(f)utility"

1979: EDWARD S. BORDIN

Therapeutic Alliance:

- Agreement on relationship
- Agreement on goals
- Agreement on tasks
- (Norcross, 2002 would add client preferences)

Over **1,100 studies** have since emphasized the importance of the alliance in psychotherapy

(Prescott & Miller, 2015; Orlinsky, 1994)

ASK YOURSELF

- How good is our therapeutic alliance with clients, really?
- If a client fails to progress because we adopt a more intrusive approach, how would we explain this to future victims?

TRAUMA

Ford et al. (2012)

- Approximately **90%** of youth in juvenile detention facilities reported a history of exposure to at least one potentially traumatic event in two independent surveys of representative samples
  - E.g., being threatened with a weapon (**58%**), traumatic loss (**48%**), and physical assault (**35%**)

TRAUMA

- Two complex trauma sub-groups:
  - **20%** some combination of sexual or physical abuse or family violence
  - **15%** emotional abuse and family violence (but not physical or sexual abuse)
- The resultant combined prevalence estimate of **35%** for complex trauma history is about three times higher than the **10-13%** estimates of polyvictimization from epidemiological study of children and adolescents

(FORD ET AL., 2012)

TRAUMA

- Interviews with clinicians treating 40 JSOs found that 95% had a documented history of at least one past traumatic event, and 65% were determined to have met diagnostic criteria for PTSD
- Clinicians viewed the trigger(s) for sex offending as related to a prior trauma in 85% of the youth, including intense trauma-associated fear for 37.5% of the youth, helplessness for 55%, and posttraumatic horror for 20%
- 1 in 7 JSOs → Dissociative Disorder
  - Physical abuse → Elevated levels

(FORD ET AL., 2012)

POLYGRAPHY: CAUTIONS

- Youth are different in their treatment needs and willingness to disclose information
- *More* information is not always *better* information
- Polygraph examinations have the potential to be re-traumatizing and may contribute to dysfunctional beliefs
- Young people may have long-term treatment needs, but the polygraph may only have short-term utility
- Disclosure is not always the same as honesty

IMPLICATIONS

- **More research and discussion is needed**
- Professionals will want to ensure that they are protecting the rights of their clients as well as those of people the client may have harmed
- There are many considerations in using the polygraph…

CONSIDERATIONS

- Think twice before using a polygraph
  - **Kids are more vulnerable than adults**
- Consider the potential downside impact
  (e.g., are we undermining our own efforts to build rapport and provide guidance?)
- Explore what other alternatives may be available
- Decide whether it is clinically appropriate

PERHAPS MOST IMPORTANTLY

Acquiescence

- Kids sometimes make things up in order to get through an interview
- This can be a problem with our without the polygraph

CONCLUSION

- There is almost no research on the polygraph and its most effective use with adolescents
- Just because professionals can use it with a given adolescent does **NOT** mean that they should use it
- Policies that require polygraph examinations for every adolescent will likely do harm by neglecting the individual differences and vulnerabilities of each adolescent

WHAT IS TRAUMA?

- PTSD
- Complex PTSD
- DESNOS
- Complex trauma
- Developmental Trauma Disorder

WHAT IS TRAUMA?

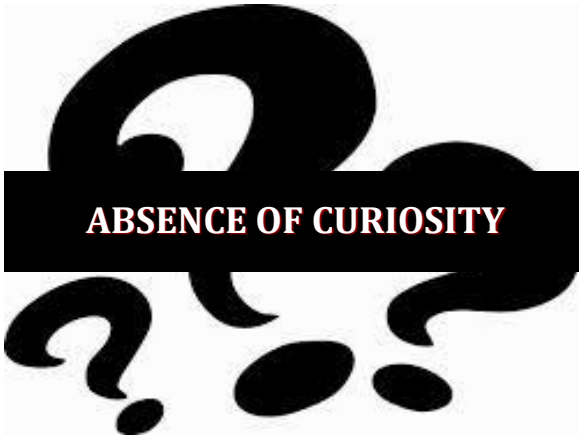
"Trauma is the desperate hope that the past was somehow different"

~Judith Hindman, MD

WHAT IS TRAUMA?

"**Trauma** is an emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives. Psychologists can help these individuals find constructive ways of managing their emotions."

~American Psychological Association



KEY THEME IN WORKBOOK

- Just notice
- See what happens next
  - Not just mindful…
  - Investigating each experience

The goal of (trauma) treatment is to help people live in the present, without feeling or behaving according to irrelevant demands belonging to the past

~Bessel van der Kolk

CASE EXAMPLE

- EBT roll-out
- JCCO directed client into treatment
- Client reluctant to attend
- Harm



BENISH ET AL. (2008)

- Treatment for PTSD is effective
- "Bona fide psychotherapies produce equivalent benefits for patients with PTSD"
- Much controversy

SEPTEMBER 11

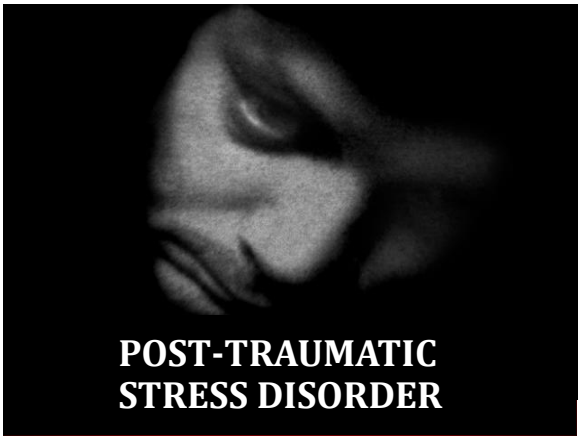
- Critical Incident Stress Debriefing
- Some treatments cause harm
- Lilienfeld (2007)

ULTIMATELY

"No intervention that takes power away from the survivor can possibly foster her recovery, no matter how much it appears to be in (his or) her immediate best interest"

~Judith Herman, MD

Reframe: Interventions that empower survivors foster recovery



POST-TRAUMATIC STRESS DISORDER

POST-TRAUMATIC STRESS DISORDER

- **Traumatic event including…**
  - Actual or threat of death or serious injury
  - Threat to physical integrity
  - Response of intense fear, helplessness, horror
- Persistent re-experiencing of events
- Persistent avoidance of associated stimuli & numbing of responsiveness
- Persistent symptoms of increased arousal
- Duration >1 month, significant disturbance in functioning

POST-TRAUMATIC STRESS DISORDER

- **Re-experiencing distress**
  - Recollections, images, thoughts, perceptions
  - Dreams
  - Flashbacks, illusions, hallucinations
- **Avoidance of related stimuli**
  - Thoughts, feelings, conversations
  - Activities, places or people

POST-TRAUMATIC STRESS DISORDER

- **Numbing of general responsiveness**
  - Inability to recall important aspects of event
  - Diminished interest/participation in activities
  - Detachment/estrangement from others
  - Restricted range of emotions (e.g., love)
  - Sense of foreshortened future
- **Arousal symptoms**
  - Insomnia
  - Anger
  - Hypervigilance
  - Difficulty concentrating
  - Exaggerated startle response

POST-TRAUMATIC STRESS DISORDER

- **Events**
  - Military combat
  - Violent personal assault (physical, sexual, mugging)
  - Kidnapping, terrorism, torture, incarceration, disasters, auto accidents, terminal diagnosis)
  - Witnessing fatal accident, body parts
- Typically worse when event is of human design
- Typically worse when stressor is repeated, chronic