Diagnosing Adults who Experienced Sexual Trauma as Children

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Workshop Overview

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Part 1

New Trauma- and Stressor-Related Diagnosis Chapter

DSM-5 Trauma- and Stressor- Related Disorders

(At a glance)

- **Reactive Attachment Disorder (RAD)**
- **Disinhibited Social Engagement Disorder (DSED)**
- **Posttraumatic Stress Disorder (PTSD)**
  - **Posttraumatic Stress Disorder for Children 6 years and Younger**
- **Acute Stress Disorder (ASD)**
- **Adjustment Disorders**
- **Other Specified Trauma- and Stressor-Related Disorder**
- **Unspecified Trauma- and Stressor-Related Disorder**

Details – Specifiers next slide

Quick Glance: Overview of Trauma- and Stressor- Disorder Chapter

Same specifiers

- (F 94.1) Reactive Attachment Disorder (DSM-p. 265)
  - Specify if: Persistent
  - Specify current severity: Severe
- (F 94.2) Disinhibited Social Engagement Disorder (DSM-p. 268)
  - Specify if: Persistent
  - Specify current severity: Severe
- (F 43.10) Posttraumatic Stress Disorder (DSM-p. 271) – was in Anxiety Disorders chapter in DSM-IV (TR)
  - (includes Posttraumatic Stress Disorder for Children 6 years and Younger)
  - Specify whether: With dissociative symptoms
  - Specify if: With delayed expression
- (F 43.0) Acute Stress Disorder (DSM-p. 280) – was in Anxiety Disorders chapter in DSM-IV (TR)
- (__.__) Adjustment Disorders (DSM-p. 286) – was its own chapter in DSM-IV (TR)
  - Specify whether:
    - (F 43.21) With depressed mood
    - (F 43.22) With anxiety
    - (F 43.23) With mixed anxiety and depressed mood
    - (F 43.24) With disturbance of conduct
    - (F 43.25) With mixed disturbance of emotions and conduct
    - (F 43.20) Unspecified
- (F 43.8) Other Specified Trauma- and Stressor-Related Disorder (DSM-p. 289) – which replaced "NOS" diagnoses throughout DSM-5
- (F 43.9) Unspecified Trauma- and Stressor-Related Disorder (DSM-p. 290) – which replaced "NOS" diagnoses throughout DSM-5

Part 2

Using the DSM-5

Fundamental Changes to DSM-5's Diagnostic Approach

- No more 5-axis diagnosis
  - 1, 2, 3 - combined
  - 4 - expanded list of Z codes (DSM-5)
  - 5 - new assessment tools (free)
- Increased specificity
  - No longer using "NOS" diagnosis
    - "Other specified"
      - Does not meet threshold for diagnosis
    - "Unspecified"
      - Not information has been gathered
- Increased dimensionality
  - Severity ratings
    - But retains categorical diagnosis
- Developmental organization
  - Overarching
  - Within chapters
- Standardized assessments
  - "Cross-cutting" across chapters
  - Symptom Severity assessments available
  - Others assessments available (free)
  - http://www.psychiatry.org/practice/dsm/dsm5/online - assessment measures found here

Part 3

Rationale for Changes

Rationale for New Chapter on Trauma

- New chapter reflects updated conceptualization of these disorders in at least 2 ways

- First:
  - Groups disorders that share the requirement that there be a specific stressful event preceding the symptomology
  - These stressors occur on a continuum

  - Stressor necessary (but not sufficient)
    - Different than typical approach to DSM diagnosis – while it used be considered an Anxiety Disorder, is thought to encompass much more than that
    - Stress reactions typically manifest more than anxiety
    - Note: ICD-10-CM also groups these disorders together

- Second:
  - Specifically asserts that the typical reactions to these stressors involve more than anxiety symptoms
  - Much of the research and discussion here has focused on Posttraumatic Stress Disorder
    - But much heterogeneity (difference; diversity; variation) in posttraumatic symptomatology
      - Fear
      - Depression/dysphoria
      - Anger
      - Dissociation
      - Guilt
      - Shame
      - Changed cognitive schemes about self and world
      - Risk-taking behaviors
  - Therefore, thought more useful to group by common etiology rather than by symptom presentation

Part 4

Brief Overview of Neurobiological Research Findings

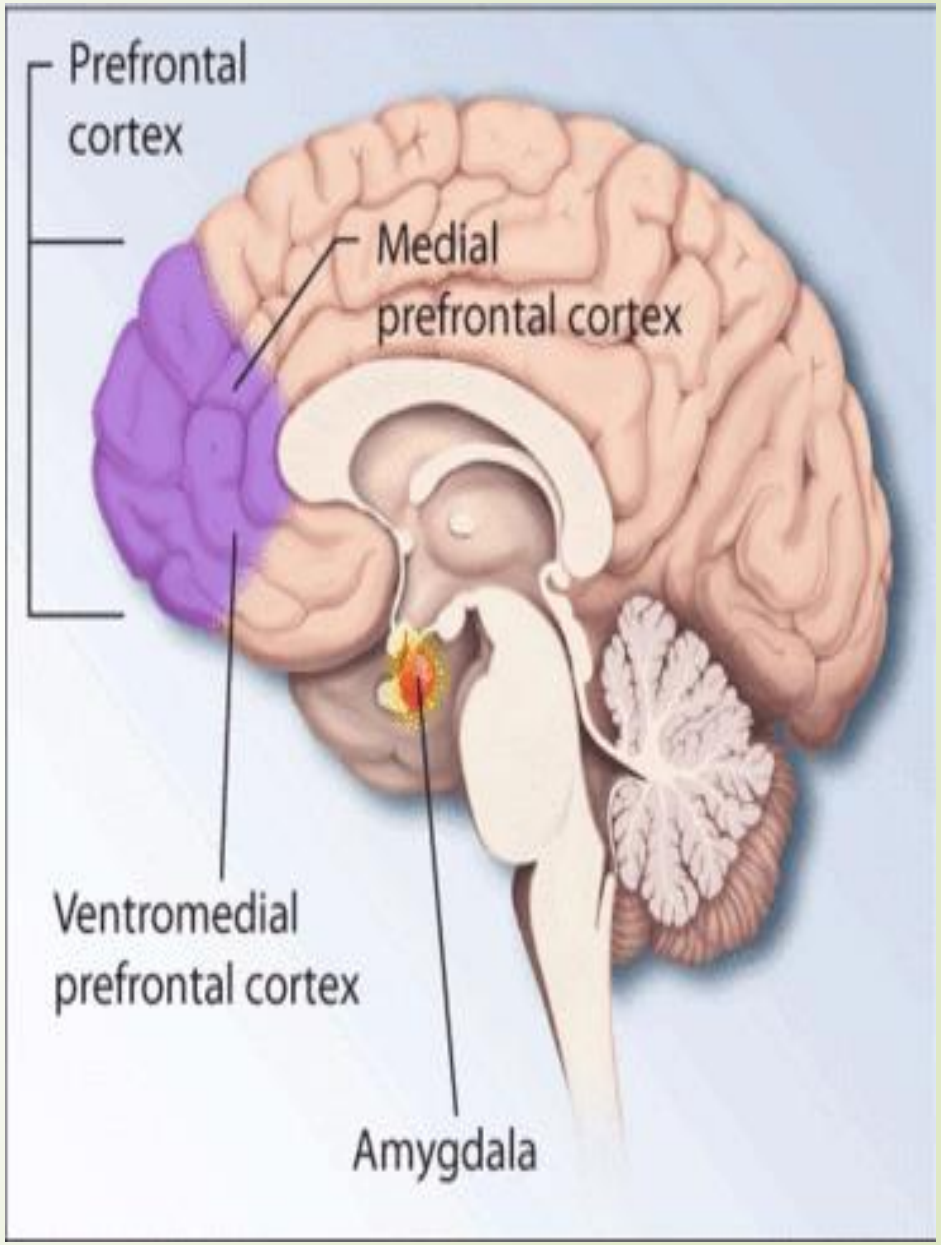
Neurobiological Findings on PTSD

- Interestingly – the form and function of the brain changes due to long-term stress
  - Much research has been conducted since DSM IV (TR)

- Most consistent finding: There is a fear circuit involved
  - Amygdala is disinhibited, overreacts

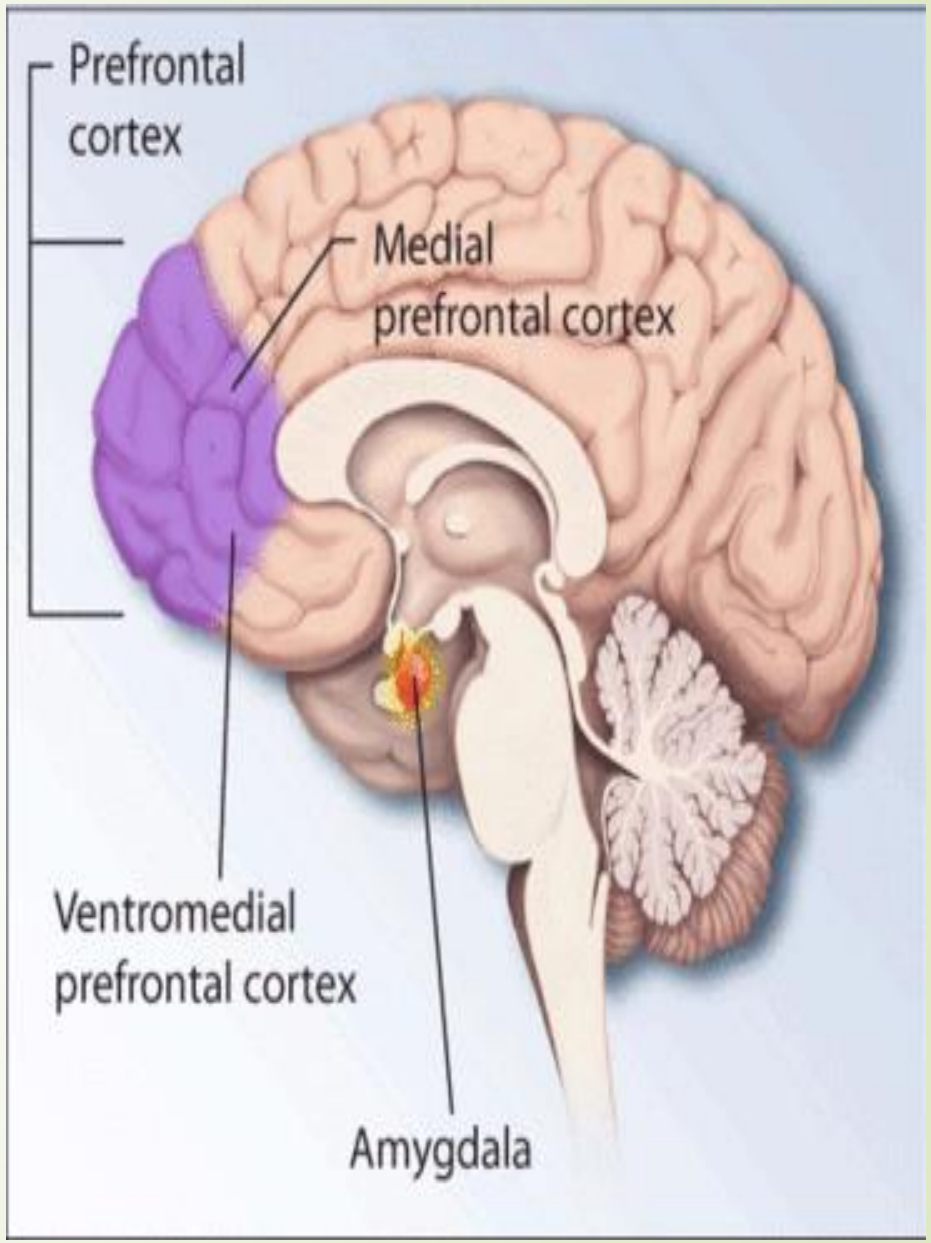
  - Stress causes excessive activation of the Amygdala
    - Amygdala - part of the brain that perceives threats
      - Excessive activation of Amygdala means the primitive parts of the brain are working
      - Which means there are impairments in…
        - Adaptation
        - Cognition
        - Behavioral flexibility

  - Because normal medial prefrontal cortex restraint is weakened – becomes less active
    - Prefrontal Cortex regulates…
      - Executive function
      - Working memory
      - Reasoning
      - Decision making



Neurobiological Findings on PTSD

- Many possible abnormalities (variables) due to long-term stress have been studied
- For example:
  - An increase in cortisol levels
  - Why is it not good to have higher levels of Cortisol?
    - Cortisol – is one of the principal chemicals necessary for fight or flight
      - Cortisol - narrows arteries while epinephrine increases heart rate, both of which force blood to pump harder and faster
  - Parasympathetic nervous system
  - Sympathetic nervous system – remember with these two systems we get "fight or flight"
  - Volume and function of hippocampus changes
    - Hippocampus – part of the brain that helps with memory processing
- Researching the effects of Posttraumatic Stress Disorder has been difficult
  - Why? Because Posttraumatic Stress Disorder is quite varied according to expression



Part 5

Overview of Diagnoses

Reactive Attachment Disorder / Disinhibited Social Engagement Disorder

- Appear first in chapter; reflects DSM-5's within-chapter developmental organization
- In DSM-IV-TR, one disorder ("Reactive Attachment Disorder of Infancy or Early Childhood") with 2 subtypes
  - Inhibited type
  - Disinhibited type
- Share basic feature of developmentally inappropriate social behavior with adults/caregivers, due to social neglect
- But found useful to distinguish as 2 distinct disorders
- Due to much different presentations, correlates, responses to intervention

DSM-5 "Reactive Attachment Disorder"

- Child shows absent/very minimal attachment behavior toward adult caregivers
- Ongoing social-emotional disturbance
- Child has experienced extremely insufficient care
  - Which is presumed responsible for child's behavior
- Frequent comorbidities
  - Cognitive and language delays
  - Depressive symptoms

DSM-5 "Disinhibited Social Engagement Disorder"

- In interactions with unfamiliar adults, child shows inappropriate, overly familiar behavior pattern, e.g., goes off with unfamiliar adult, doesn't check in with caregiver
- Behavior violates social boundaries for the culture
- Not just about impulsivity
- Child has experienced extremely insufficient care
  - Which is presumed responsible for child's behavior
- Child might not have disordered attachment

DSM-5 “Posttraumatic Stress Disorder” & “Acute Stress Disorder”

- Time frame same as DSM-IV-TR
  - 1 month
- Must have experienced traumatic event
  - Definition revised
- PTSD
  - 4 symptom clusters, not 3
  - PTSD and PTSD for children 6 and younger
  - Addition of a dissociative subtype

DSM-5 "Adjustment Disorders"

- Had been its own chapter in DSM-IV (TR)
- Change in DSM-5
  - Initially, DSM-5 did not include "acute" and "chronic" specifiers
    - APA accidently omitted "Acute" vs. "Chronic" Specifiers – still included
  - DSM-IV (TR) subtypes are maintained, but now classified as "specifiers"
    - For example:
      - With depressed mood
      - With anxiety
      - With disturbance of conduct
      - With mixed disturbance of emotions and conduct
      - Unspecified
  - No attempt to limit the conditions under which Adjustment Disorder can be diagnosed
  - Example conditions mentioned in DSM-5
    - Termination of romantic relationship
    - A natural disaster
    - Leaving a parental home, becoming a parent, retirement
  - Adjustment disorders thought of as capturing the variety of responses that can occur after a stressor

Part 6

Specifiers and Severity Ratings

New DSM-5 Specifiers/Severity Ratings for Trauma- and Stressor-Related Disorders

- Purpose and use

- For RAD and DSED
  - New specifier: "Persistent" = >12 months
  - Rate as "Severe," when all symptoms are displayed, all at high levels

- For PTSD, 2 specifiers
  - With dissociative symptoms
  - With delayed expression

DSM-5 Specifiers/Severity Ratings Relevant to Trauma- and Stressor-Related Disorders

- "Panic attack" specifier
  - Can be used with any DSM-5 disorder
  - Use is encouraged because panic attacks are markers for poorer functional consequences and greater morbidity
  - Same symptoms list as described in DSM-IV-TR
  - Should be distinguished from other emotional states such as anger or grief
- If diagnosing a Mood Disorder, be aware of new "with anxious distress" specifier
  - 2 or more of 5 symptoms
  - Rate severity

DSM-5 Addition to PTSD Diagnosis: "With Dissociative Symptoms" Specifier

- **Rationale:**

- **A substantial minority (perhaps 20-33%) of individuals who meet criteria for PTSD also experience dissociative symptoms**
  - **Dissociation more commonly found with sexual trauma and childhood abuse/neglect**
  - **More common in women**
  - **Dissociative symptoms found in PTSD found across 16-nation study**
    - **Not just a Western phenomenon**

- **DSM-5 language refers only to depersonalization and derealization subtypes**

- **Different neurobiological findings –**
  - **Often amygdala is under- reactive**

DSM-5 Changes to Acute Stress Disorder Diagnosis

- Same changes to definition of qualifying traumatic event as for PTSD
- Similarly, reaction of helplessness, horror, etc. no longer required
- In DSM-IV (TR), at least 3 dissociative symptoms were required
  - In DSM-5, dissociation not specifically required
  - Recognition that acute stress responses can consist of a variety of symptoms
- DSM-5 requires 9 or more of 14 symptoms, divided into 5 categories
  - Intrusion, negative mood, arousal, avoidance, dissociation
- As in DSM-IV, this diagnosis is used when sxs have lasted at least 3 days but no longer than 1 month

Diagnosing "PTSD in Children 6 Years or Younger"

- One PTSD criteria set for children 6 years and younger
- For children 7 years and older use regular PTSD criteria
  - But it's noted that symptoms may be expressed differently
  - E.g., intrusive memories may emerge in play re-enactment
- 6 and under criteria set
  - Fewer symptoms required
  - Avoidance OR negative alteration in mood, not both
- Specifiers
  - Both dissociative subtype and delayed expression specifier may be used with children

Part 7

Complex PTSD (C-PTSD)

Complex PTSD (C-PTSD)

- Once again, has not been added to DSM
- Debate about this matter, see:
  - Journal of Traumatic Stress, Volume 25, June, 2012
- C-PTSD usually a result of chronic, interpersonal trauma
- PTSD symptoms, as well as problems with somatization, affect dysregulation, self-perception, memory and attention
- Arguments for adding to DSM-5
  - A valid entity
  - With important treatment implications
  - Parsimony

Complex PTSD (C-PTSD); Dissociative Disorders

- Arguments against adding to DSM-5
  - Rare for someone to have C-PTSD and not qualify for PTSD diagnosis
    - A new diagnosis does not add enough that's useful to justify a discrete disorder
  - Difficulties in assessing this construct
    - Insufficient research base
- DSM-5 has broadened its conception to include some, but not all, of what is included in C-PTSD
- Dissociative disorders, while generally preceded by trauma, do not require traumatic event for diagnosis
  - So kept in separate chapter

DSM-5 Expanded List of V-Codes (Z-Codes in ICD-10-CM)

- With any diagnosis, many issues to assess and problems to manage
- Movement to improve quality care assessment
  - Led to expanded list of Z-codes in DSM-5
  - Makes it easier for clinician to note circumstances
  - Financial incentives
- Examples of codes relevant to Trauma- and Stressor- Related Disorders
  - Personal history of sexual abuse in childhood
  - Child physical abuse, confirmed
  - Victim of crime
  - Victim of terrorism or torture
  - Problem related to current military deployment status

Part 8

Differential Diagnosis

Differential Diagnosis: Posttraumatic Stress Disorder/Acute Stress Disorder or Mood Disorder

- How do you determine a diagnosis of Posttraumatic Stress Disorder over a diagnosis of Major Depressive Disorder?
- Here are some points to consider:
  - Major Depressive Disorder may, or may not, be preceded by a traumatic event
    - You could diagnose Major Depressive Disorder if other Posttraumatic Stress Disorder symptoms are not present
    - Although, a Major Depressive Disorder diagnosis does include a few symptoms from the Posttraumatic Stress Disorder symptom list, upon further review you realize that most Posttraumatic Stress Disorder symptoms do not overlap
    - Specifically, Major Depressive Disorder does not include any PTSD Criteria B or C symptoms
      - Furthermore, not does it include a number of symptoms from PTSD Criteria D or E

Differential Diagnosis: Posttraumatic Stress Disorder/Acute Stress Disorder or Anxiety Disorder

- How do you determine a diagnosis of Posttraumatic Stress Disorder over a diagnosis of an Anxiety Disorder?
  - Once again, ask yourself – "Did a traumatic event occur?"
  - Upon further review of the DSM-5, you will see that panic attacks are quite common in people diagnosed with Acute Stress Disorder
  - But you should not diagnose a Panic Disorder unless additional criteria for that diagnosis are met
    - Neither the arousal and dissociative symptoms of panic disorder nor the avoidance, irritability, and anxiety of generalized anxiety disorder are associated with a specific traumatic event

Differential Diagnosis: Posttraumatic Stress Disorder or Traumatic Brain Injury

- This can be difficult when attempting to determine the most appropriate diagnosis
- Why?
  - 1.) Because an event that causes head trauma can actually be a qualifying event for Posttraumatic Stress Disorder or Acute Stress Disorder
  - 2.) This is a slight overlap in symptomology (e.g., irritability, concentration problems)
- So here are some points to consider:
  - With Posttraumatic Stress Disorder, the client will often manifest symptoms of:
    - Avoidance
    - Re-experiencing

    → These are not effects of Traumatic Brain Injury
  - With Traumatic Brain Injury, the client will often manifest symptoms of:
    - Confusion
    - Disorientation

    → These are linked to Traumatic Brain Injury much more than to Posttraumatic Stress Disorder

Part 9

Working with DSM-5's New Assessment Measures

(Initial assessment and symptom/disability tracking)

Using New Assessment Tools for Clients w/Trauma/Stress Disorder Diagnoses

- **Why has DSM-5 added these?**
  - Global Assessment of Functioning (GAF; Axis 5) deemed insufficient
  - Research suggests we should assess symptom severity and disability separately
  - Importance of assessing and monitoring symptoms common in many disorders ("cross-cutting symptoms")

- **Why might you want to use these?**
  - Formal assessment can be therapeutic
  - Good practice to monitor client symptomatology and disability over time; empirical support
    - See, e.g., Lambert & Hawkins, 2004
  - Increase chances of reimbursement for particular tests and/or treatments

DSM-5 Assessment Tools

- Recommended, not required, for DSM-5 diagnosis
- Third-party payers might eventually require some or all of these
- All can be freely used by clinicians with clients
- All are available at:
  - http://www.psychiatry.org/practice/dsm/dsm5/online - assessment-measures

Practical Considerations

- When to use written standardized assessment inventories?
  - Ideally, complete level 1 cross-cutting symptom measure and disability measure (WHODAS 2.0) at first session
- Assessing specific symptoms
  - Cross-cutting domain, or
  - Symptoms of a particular disorder
  - First assessment should be very early (1st or 2nd session)
- Track regularly
  - As often as weekly, at first
  - Rationale
  - Approximately monthly for longer-term clients

Basic DSM-5 Assessment Procedure

- Symptomatology assessment
  - Client completes "Level 1" Cross-Cutting Symptom measure
  - Parent or informant can complete
- Clinician reviews for areas of concern
- Client can then complete "Level 2" measure for area(s) of concern
- Some are completed by clinician, e.g., psychotic symptom severity
- Additional disorder-specific symptomatology measures
- Disability (impairment)
  - WHODAS 2.0
- Other types of measures are available online
  - Personality, cultural formulation, early development and home background

Example: Adult PTSD Client

- Client completes Level 1 cross-cutting symptom assessment
  - 23 questions, 0-4 scale, 13 domains, past 2 weeks
  - Example domains: Suicidal ideation, Sleep, Anger, Anxiety
- Clinician reviews for areas of concern
  - Suggest follow-up if any question within domain is endorsed at "2" (mild; experienced on several days) or above
  - Lower threshold for 3 of the 13 domains
- We'll assume client meets or exceeds threshold in 3 domains:
  - Anger, anxiety, substance use
- Client could then complete "Level 2" measures for these 3 domains
  - Measures have 5-10 questions, 5 point scale
  - Focus on past week or two
  - Most indicate cutoff scores for "mild," "severe," etc.
  - If you want a client-completed measure for symptomatology of a particular DSM-5 disorder
    - i.e., not "cross-cutting" symptoms
  - There's a severity measure for posttraumatic stress symptoms
  - 9 questions covering major symptom clusters
  - E.g., hypervigilance, negative emotional state, flashbacks, avoidance
  - 0-4 scale, past 7 days

Example: Adult PTSD Client

- Client completes measure of disability (impairment)
  - World Heath Organization Disability Assessment Schedule (WHODAS 2.0)
  - Applies to patients with any health condition
  - Ease of comparability
  - 36 items, past 30 days, 1-5 scale
  - 6 domains, including
    - Getting along with people, getting around, life activities (housework, school, work)

- Other tools you might want to use
  - Personality inventory (maladaptive traits only)
  - Cultural formulation interview
  - Child clients: Early development and home background form

Hermann (1977)
(Commonly Referenced Text)

3 Stages of Treatment

- **Stage One – Establish Safety**
  - **Work on coping strategies & seek out support system**
- **Stage Two – Remembrance and Mourning**
  - **Client tells her story while carefully balancing safety, restructure story, create testimony, mourn for losses**
- **Stage Three – Reconnect with Ordinary Life**
  - **Gain understanding of the role PTSD has played, find a mission, continue to strive for**

Part 10

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