

# Trauma- and Stressor- Related Disorders: Overview, Assessment, Intervention Strategies, Prognoses

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# Today's Presentation

- **Part 1 – Using the DSM-5**
- **Part 2 - Understanding DSM-5's (ICD-10-CM) codes and how they relate to mental health**
- **Part 3 - Brief overview of neurobiological research findings**
- **Part 4 - Brief overview of new chapter creation (Trauma- and Stressor- Related Disorders)**
- **Part 5 - Review of chapter (Trauma- and Stressor- Related Disorders)**
  - **Definition of the disorder**
  - **Client characteristics**
  - **Assessment**
  - **Preferred Therapist Characteristics**
  - **Intervention Strategies**
  - **Differential Diagnosis**
  - **Prognosis**
- **Part 6 - Brief overview of the new DSM-5 assessment measures**
- **Part 7 - Five practice case studies (with criterion-based explanations on comment field)**
  - **(Located in separate Microsoft Word Document)**
- **Part 8 - References**
- **Part 9 - Take Quiz**
  - **(Located in separate Microsoft Word Document)**
  - **(Entire presentation – including practice case studies – worth 3 CEUs)**

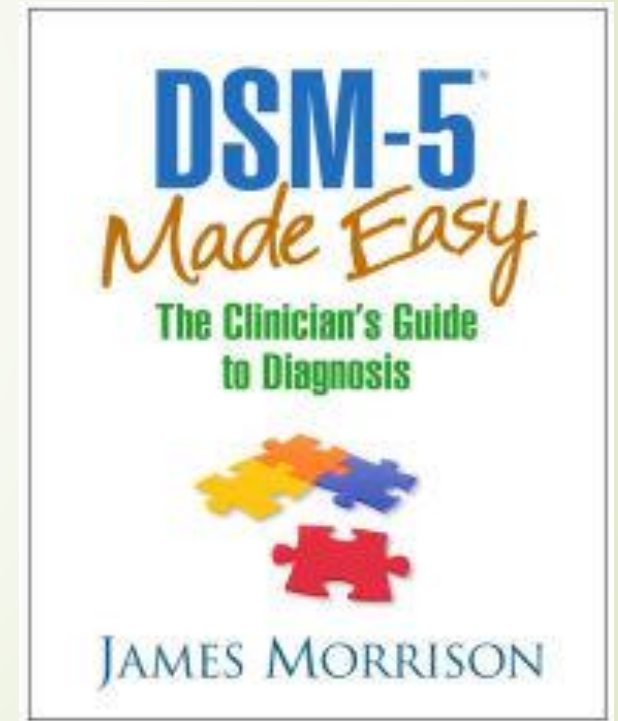
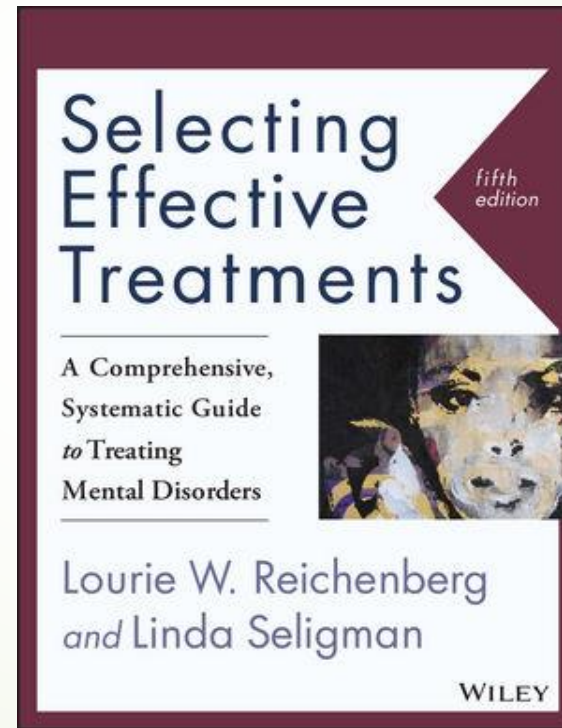
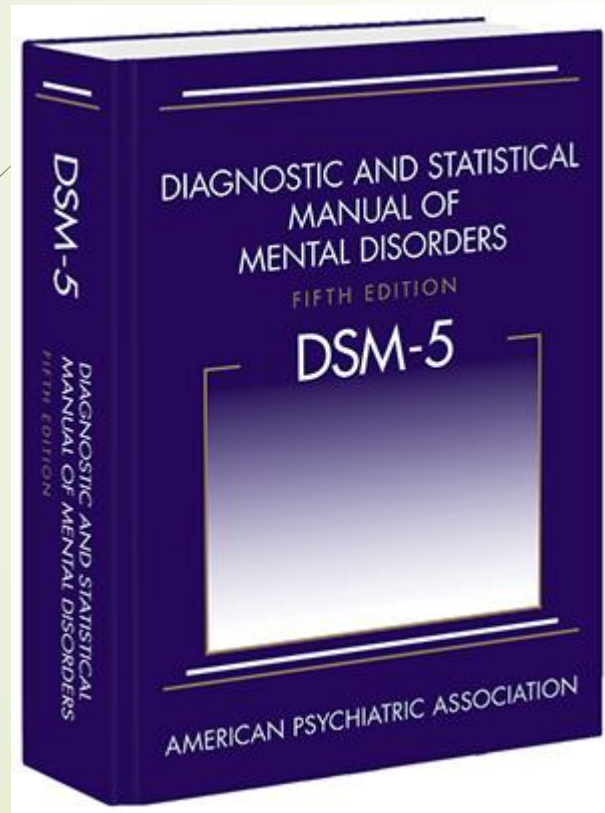
# More Info About the Q U I Z

You will be quizzed  
on material from  
red areas

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## (Some Housekeeping Items) Giving Credit Where Credit is Due

- Below you will find the major resources used in preparing today's presentation
- American Psychiatric Association DSM-5 Development <http://www.dsm5.org/Pages/Default.aspx>
- Detailed sources listed in the *References* section (includes supplemental material – journals, websites, etc.)



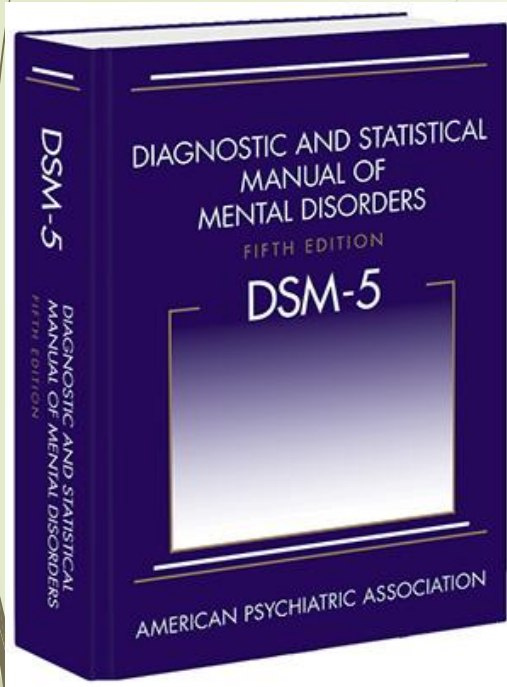


# Part 1

## Using the DSM-5

# DSM-5 Sections

- The DSM 5's new organization includes 3 sections that facilitate clinical decision-making and research:
  - Section 1 – introduces the DSM 5 and how to use the new manual
  - Section 2 – sequences the diagnostic chapters developmentally by age
    - Groups similar disorders in newly created chapters
    - Similar chapters are now adjacent to each other
  - Section 3 – features conditions that require additional research
    - This was called Appendix “B” in DSM-IV (TR)



# Doing Things A Bit Differently Now

## DSM-IV's Multiaxial Assessment

Axis I = reported all clinical, psychological disorders

Axis II = reported personality disorders and mental retardation

Axis III = reported current medical conditions as reported by client (often relevant to understanding or management of the individual's mental disorder)

Axis IV = reported psychosocial & environmental problems that could affect the diagnosis, treatment, and prognosis of mental disorders (Axes I and II)

- Generally, only those stressors from the past 12 months were recorded here

- Goal was to bring DSM 5 into line with international reporting standards (as opposed to just U.S. standards) with the goal of having a global approach to mental health diagnosing

Axis V = used for issuing a GAF (Global Assessment of Functioning) estimate

- GAF score had poor psychometric properties and poor clinical utility

## DSM-5's Assessment

Axis I = combines the first 3 DSM-IV (TR) axes into one list that contains all mental disorders (Including personality disorders, intellectual disability, other medical diagnoses)

The 4<sup>th</sup> and 5<sup>th</sup> axes are no longer reported in a Multiaxial assessment in the DSM 5. What follows below is only here for your understanding

- We still need to report this type of information. Instead, we describe "contributing stressors" through an expanded set of ICD-10-CM, "Z" codes

- These Z codes provide ways for clinicians to indicate other conditions or problems that may be a focus of clinical attention or otherwise affect the diagnosis, course, prognosis, or treatment of a mental disorder (such as relationship problems between a client and their intimate partner)

- GAF score replaced - options available, but not necessary; use new assessment tools

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# Why Change to a new DSM?

- **Purpose:**
  - **clear, concise description of each mental disorder**
  - **explicit diagnostic criteria**
  - **establish common language for clinicians and researchers in the study of mental illness**
  - **DSM-5 offers a brief digest of information about the...**
    - **Diagnosis**
    - **Risk factors**
    - **Associated features**
    - **Research advances**
    - **Various expressions of each disorder**
  - **ultimately helps develop informed interventions**

# Diagnose with Caution

- ▶ **With the DSM-5, you are working with standard labels to a dominant view**
- ▶ **Be careful not to reduce people to their diagnosis**
  - ▶ A common misperception is that a classification of mental disorders *classifies people*, when actually we are diagnosing *disorders that people have*
    - ▶ Note: This is why I used whole names (first and last) in the practice case studies – as a reminder that we are working with “individuals”
- ▶ **It is important that DSM-5 not be applied mechanically by untrained individuals**
  - ▶ The criteria sets offered within the DSM-5 are meant to serve as guidelines to be informed by clinical judgment

# Change: It is for the best

- ▶ The DSM's omission of a disorder doesn't mean it is non-existent
  - ▶ With each edition of the DSM, the # of listed mental disorders has increased
    - ▶ For example:
      - ▶ DSM-IV (TR) = 340 conditions
      - ▶ 120 more than the DSM-III (TR)
    - ▶ We had to create a better system of classification of these disorders
      - ▶ In the DSM III, *chapters were introduced* to help categorize all disorders
- ▶ You work with "What you know?"
  - ▶ In other words, you are limited to diagnosing according to the information given
    - ▶ In the real world – crucial data could be withheld, unknown, or simply unattainable from other family members!

## Always remember how the DSM-5 defines a Mental Disorder?

A mental disorder is a syndrome characterized by **clinically significant disturbance** in an individual's cognition, emotion regulation, or behavior 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

An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder

Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily **between the individual and society are not mental disorders** unless the deviance or conflict results from a dysfunction in the individual, as described above



# Part 2

## Understanding

**DSM-5's (ICD-10-CM) codes and  
how they relate to mental health**

# What do the letters “ICD” stand for in the mental health field?

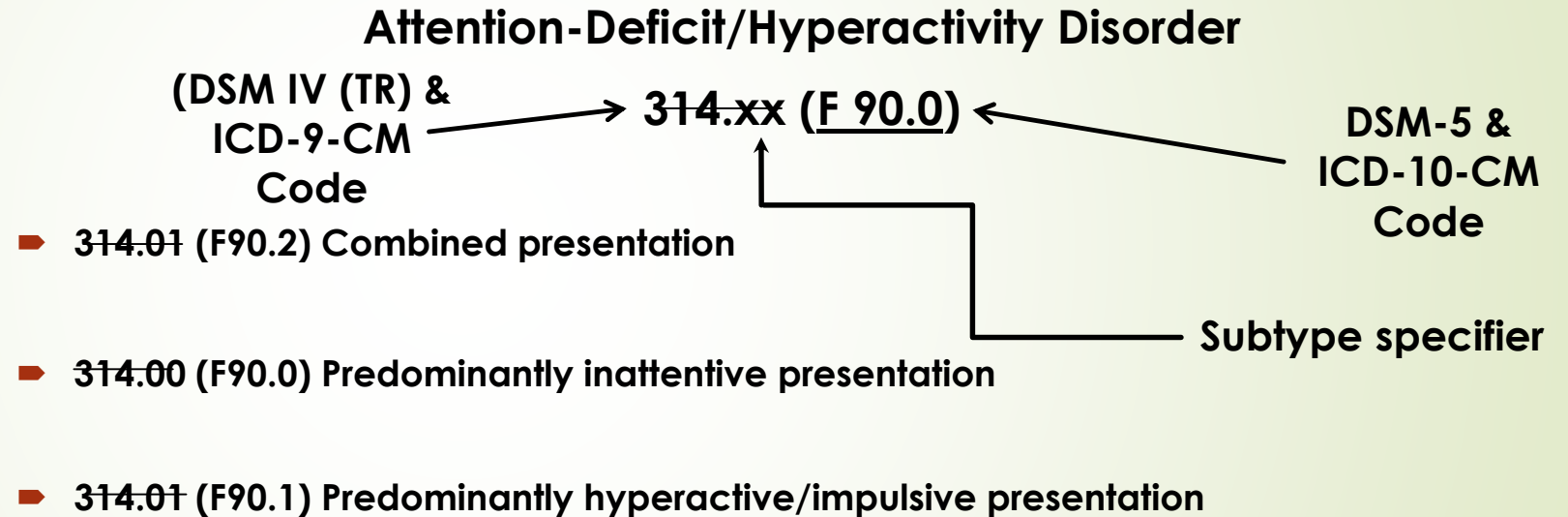
- International Classification of Diseases (ICD), 10th Revision, Clinical Modification
- The ICD is the global standard in diagnostic classification for health reporting and clinical applications for all medical diagnoses, including mental health and behavioral disorders

# How important are these ICD letters & numbers?

- ▶ **Very important for cross verification**
- ▶ **Since 2003, these ICD codes have been mandatory for 3<sup>rd</sup> party billing**
- ▶ **Who produces this medical coding system?**
  - ▶ **WHO (The World Health Organization)**
  - ▶ **A major purpose is to track the causes of diseases/disorders globally**
    - ▶ **(AKA, etiology - is the study of causation, or origination)**

## DSM Codes Defined

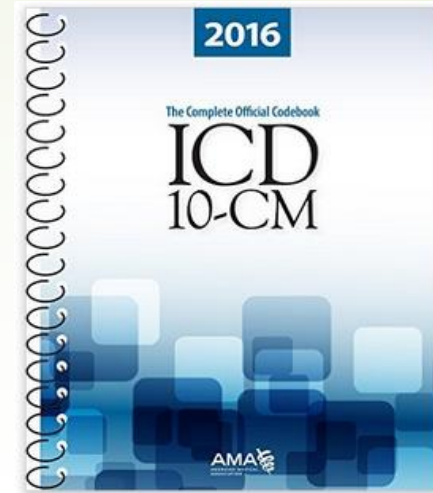
- The codes represent an actual diagnosis in a numerical expression
- The part after the decimal point typically indicates a specific subtype of a diagnosis and/or severity or other characteristics



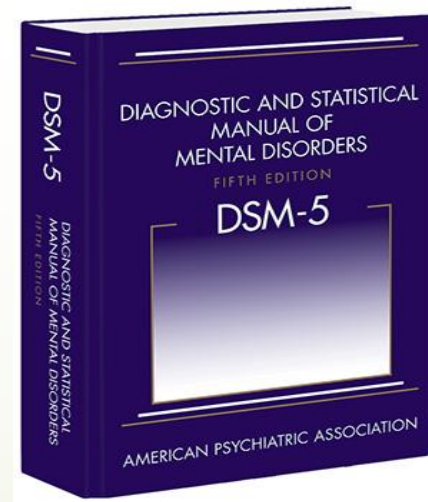


# Putting Things Into Perspective by Comparison

Excellent reference when struggling through ICD-10 implementation



**ICD-10-CM contains approximately 150,000 codes**  
(This offers greater specificity when diagnosing and providing clinical detail)



**DSM-5 contains approximately 724 mental health diagnosis codes taken directly from the ICD-10-CM code list**

# ICD-10-CM Code Structure

All 2016 ICD-10-CM codes can be found here: <http://www.icd10data.com/ICD10CM/Codes>



**T 7 4 . 0 2 X A**

Adult and child abuse, neglect and other maltreatment, confirmed

The majority of our DSM-5 (ICD-10-CM) codes will begin with the letter "F" followed by at least 2 numerical digits.

Child neglect or abandonment, confirmed

The dummy placeholder of "X" allows for future expansion (as research progresses). When a placeholder character applies, it must be used in order for the code to be considered valid.

Injuries and External Causes:  
"Initial Encounter"

(If the value "D" is listed here, this would be classified as a "subsequent encounter").

# DSM-5 Expanded List of “Z” codes in ICD-10

- **These codes pertain to all disorders**
  - Not just to Trauma- and Stressor- Related Disorders Chapter
  - These codes classify the many issues to assess and problems to manage
- **There was a general movement to improve quality care assessment**
  - Led to expanded list of Z-codes in DSM-5
  - Makes it easier for clinicians to note the circumstances that may have influenced clients
- **Now there are Z-codes for items like:**
  - Personal history (past history) of sexual abuse in childhood
  - Phase of life problem
  - Victim of crime
  - Victim of terrorism or torture
  - Problem related to current military deployment status
  - Religious or spiritual problem
  - And on and on...

# Understanding the Various Codes Used in DSM-5

- All 2016 ICD-10-CM codes can be found here: <http://www.icd10data.com/ICD10CM/Codes>
- “F” codes – (F01-F99) Mental, Behavioral, and Neurodevelopmental disorders
  - Full range of mental health related disorders
  - Includes disorders of psychological development (this is the breakdown we are used to in DSM 5)
    - (F01-F09) Mental disorders due to known physiological conditions
    - (F10-F19) Mental and behavioral disorders due to psychoactive substance use
    - (F20-F29) Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders
    - (F30-F39) Mood [affective] disorders
    - (F40-F48) Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders
    - (F50-F59) Behavioral syndromes associated with physiological disturbances and physical factors
    - (F60-F69) Disorders of adult personality and behavior
    - (F70-F79) Intellectual disabilities
    - (F80-F89) Pervasive and specific developmental disorders
    - (F90-F98) Behavioral and emotional disorders with onset usually occurring in childhood and adolescence
    - (F99-F99) Unspecified mental disorder

# Understanding the Various Codes Used in DSM-5

- **“R” codes – (R00-R99) Includes symptoms, signs, abnormal results of clinical or other investigative procedures, and ill-defined conditions regarding which no diagnosis classifiable elsewhere is recorded**
  - **(R10-R19) Symptoms and signs involving the digestive system and abdomen**
    - **(R15) Fecal incontinence**
      - **(R15.9) Full incontinence of feces**
        - **R15.9 – Other Specified Elimination Disorder (with fecal symptoms) (p. 359)**
- **“G” codes – (G30-G32) Other degenerative diseases of the nervous system**
  - **(G31) Other degenerative diseases of nervous system, not elsewhere classified**
    - **(G31.8) Other specified degenerative diseases of nervous system**
      - **(G31.84) is a specific ICD-10-CM diagnosis code representing “Mild cognitive impairment, so stated”**
        - **G31.84 – Mild Neurocognitive Disorder Due to Alzheimer’s Disease (p. 611)**
- **“Z” Codes – (Z00-Z99) Factors influencing health status and contact with health services**
  - **(Z55-Z65) Persons with potential health hazards related to socioeconomic and psychosocial circumstances**
    - **(Z62) Problems related to upbringing**
      - **(Z62.820) Parent-biological child conflict**
        - **Z62.820 - Problems Related to Family Upbringing (Parent-Child Relational Problem) (p. 715)**

# Understanding the Various Codes Used in DSM-5

- **“N” codes – (N00-N99) Diseases of the genitourinary system**
  - (N00-N99) Intraoperative and post procedural complications and disorders of genito-urinary system, not elsewhere classified
    - (N00-N99) Intraoperative and post procedural complications and disorders of genito-urinary system, not elsewhere classified
    - N94.3 – Premenstrual Dysphoric Disorder (p. 171)
- **“L” codes – (L00-L99) Diseases of the skin and subcutaneous tissue**
  - (L80-L99) Other disorders of the skin and subcutaneous tissue
    - (L98) Other disorders of skin and subcutaneous tissue, not elsewhere classified
      - (L98.1) Factitial dermatitis
        - (L98.1) Excoriation (traumatic) - (neurotic)
          - L98.1 – Excoriation (Skin-Picking) Disorder (p. 254)
- **“T” codes – (S00-T88) Injury, poisoning and certain other consequences of external causes**
  - (T66-T78) Other and unspecified effects of external causes
    - (T74) Adult and child abuse, neglect and other maltreatment, confirmed
      - (T74.02XA) Child Neglect or Abandonment, confirmed, initial encounter
        - T74.02XA – Child Neglect, Confirmed (Initial Encounter) (p. 718)
- **“E” codes – (E00-E89) Endocrine, nutritional and metabolic diseases**
  - (E65-E68) Overweight, obesity and other hyper alimentation
    - (E66) Overweight and obesity
      - (E66.9) Obesity, unspecified
        - E66.9 – Overweight or Obesity (p. 726)



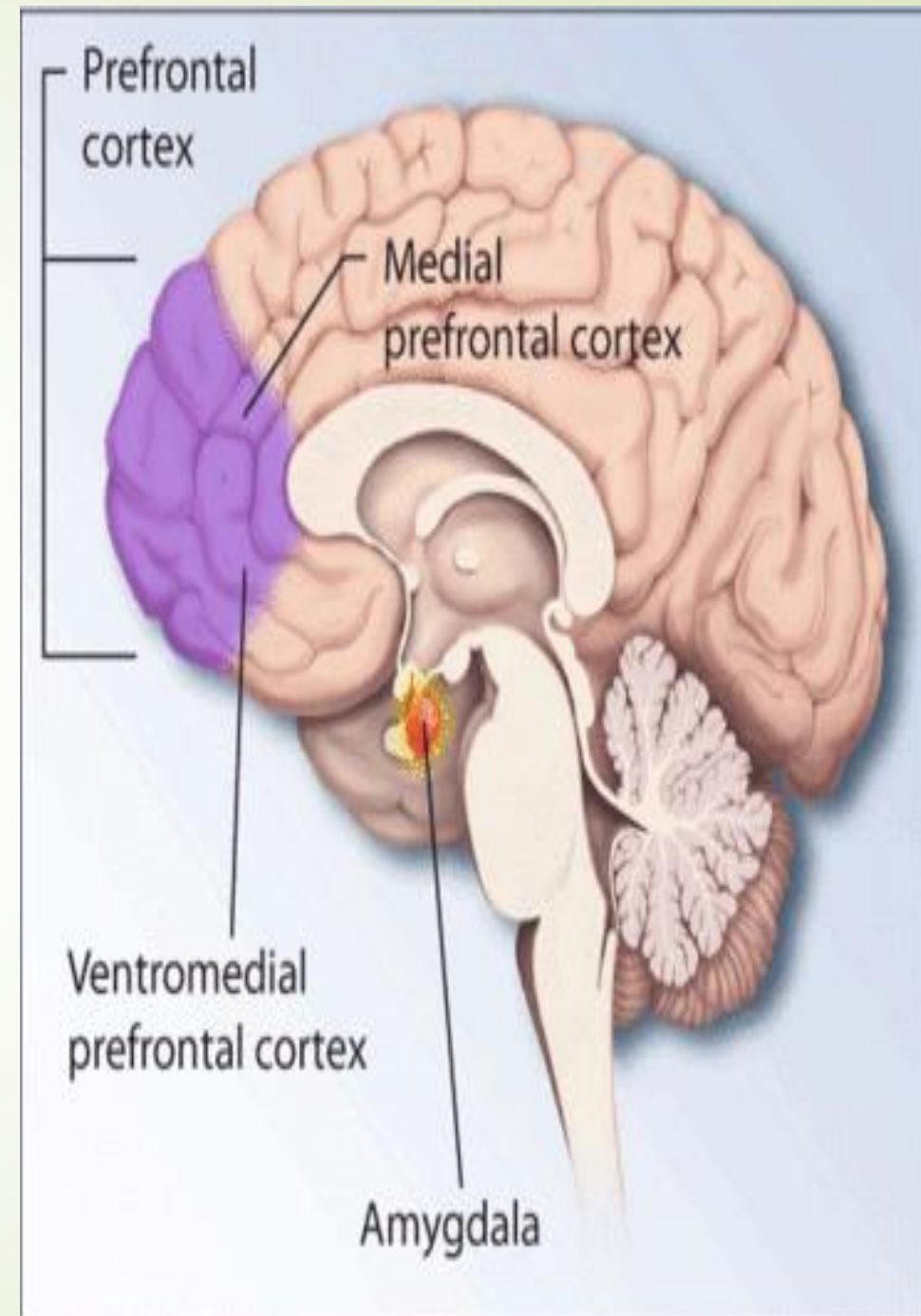
# Part 3

**Brief Overview of**

**Neurobiological Research Findings**

# Neurobiological Findings on PTSD

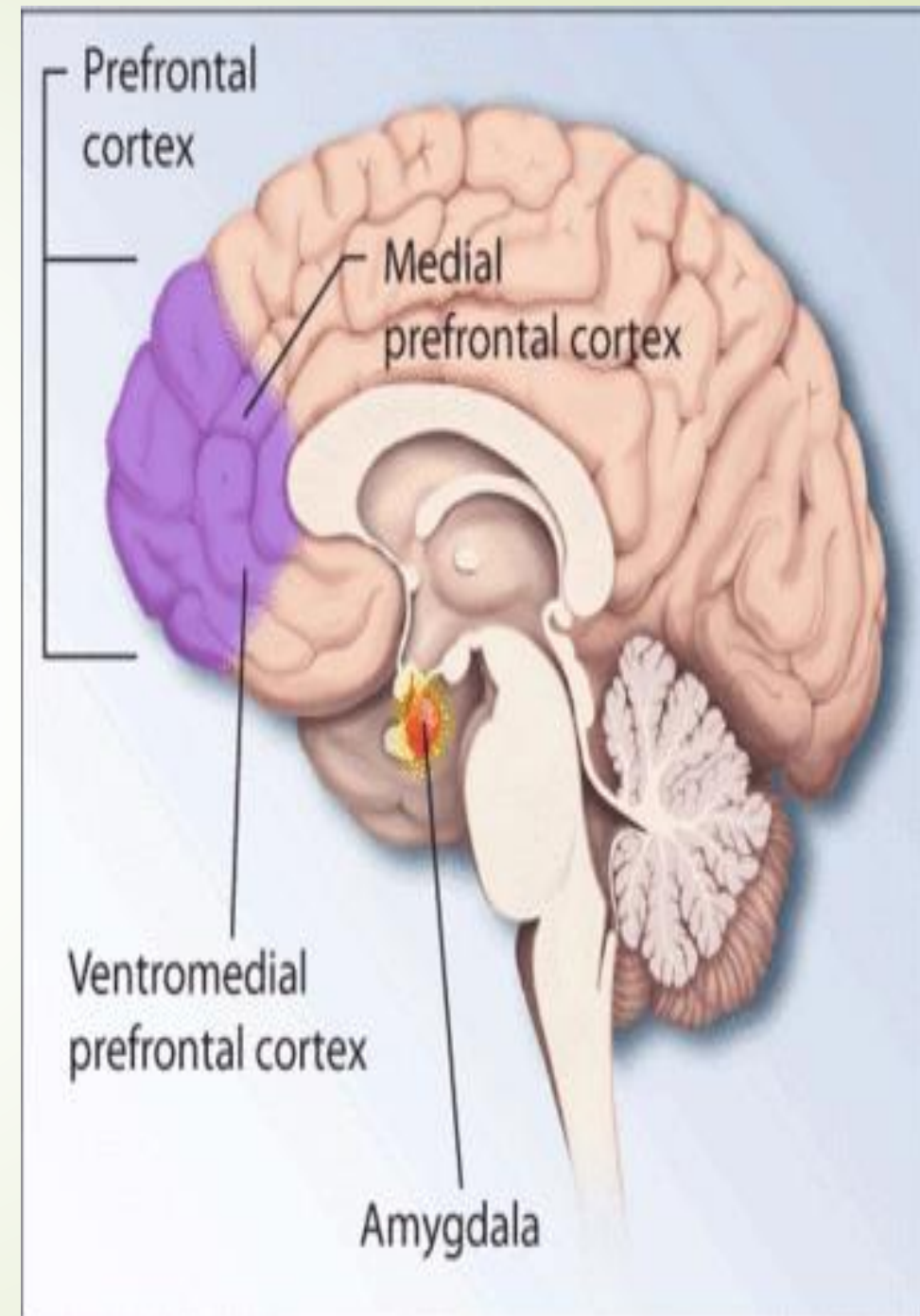
- Interestingly – the form and function of the brain changes due to long-term stress
  - Much research has been conducted since DSM IV (TR)
- Most consistent finding: There is a fear circuit involved
  - Amygdala is disinhibited, overreacts
  - Stress causes excessive activation of the Amygdala
    - 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:
  - Cortisol differences – lower baseline levels
  - Why is it not good to have lower levels of Cortisol?
    - Cortisol – is one of the principal chemicals necessary for fight or flight
    - Cortisol - narrows the arteries while the 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 is often difficult
  - Why? Because Posttraumatic Stress Disorder is quite varied according to expression





# Part 4

## Brief Overview of New Chapter Creation

### “Trauma- and Stressor- Related Disorders”

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

Exact  
same  
specifiers

- (F 94.1) Reactive Attachment Disorder (p. 265)
  - Specify if: Persistent
  - Specify current severity: Severe
- (F 94.2) Disinhibited Social Engagement Disorder (p. 268)
  - Specify if: Persistent
  - Specify current severity: Severe
- (F 43.10) Posttraumatic Stress Disorder (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 (p. 280) – was in Anxiety Disorders chapter in DSM-IV (TR)
- (\_\_\_) Adjustment Disorders (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 (p. 289) – which replaced “NOS” diagnoses throughout DSM-5
- (F 43.9) Unspecified Trauma- and Stressor-Related Disorder (p. 290) – which replaced “NOS” diagnoses throughout DSM-5

# General Notes: Trauma- and Stressor- Related Disorders Chapter

- **DSM-5's new chapter combines:**
  - **Three childhood-related diagnoses...**
    - **Reactive Attachment Disorder**
    - **Disinhibited Social Engagement Disorder**
    - **Posttraumatic Stress Disorder for Children 6 years and Younger**
  - **Post Traumatic Stress Disorder**
  - **Acute Stress Disorder**
  - **Adjustment Disorders**
    - **... into one classification of disorders in which stressful or traumatic life event has precipitated the onset of symptoms**
- **These disorders all require exposure to a traumatic or stressful event prior to symptom onset, but can be distinguished from each other in terms of timing and symptom severity**
- **Exposure to stress or trauma can result in a wide range of symptoms, depending on:**
  - **Age**
  - **Previous exposure to trauma**
  - **Genetics**
  - **Temperament**
  - **Environmental factors**
- **We know that trauma may occur:**
  - **After a single episode (i.e., rape, car accident)**  
or
  - **Over a period of time of continuous exposure (e.g., chronic child abuse, exposure to war)**

# General Notes: Trauma- and Stressor- Related Disorders Chapter

- Research tells us that approximately 50% of people will experience at least one traumatic event in their lifetime, but very few will develop a clinical disorder
- The following individuals are at an increased risk for developing a Trauma- and Stressor- Related Disorder
  - Children
  - Adolescents
  - Women
  - People with medical injuries or illnesses
  - Survivors of disasters, civil wars, or genocide
- As with other mental disorders, a genetic predisposition is thought to underlie the development of a stress-related disorder, which only develops after an environmental stressor has occurred
- Research further tells us that people are more likely to develop a clinical disorder:
  - If they were injured or hurt
  - If they are female
  - If the stress occurred after a series of stressful events
  - or
  - If they:
    - Felt in danger
    - Felt helpless
    - or
    - Believed a family member was threatened

# General Notes: Trauma- and Stressor- Related Disorders Chapter

- ▶ Long-term, stress is believed to alter the expression of a certain gene, which results in epigenesis
  - ▶ Combining Psychology and Biology we attempt at a definition of Epigenesis
    - ▶ Which examines the way a gene changes in the face of environmental influences
      - ▶ In other words, things in the environment can positively or negatively impact the way genetic material is expressed in the development of human beings
    - ▶ Our hybrid definition of Epigenesis
      - ▶ Epigenesis - The belief that the features of an organism alter due to the interaction between genetic and environmental influences
    - ▶ Epigenetic effects of trauma exposure may have lasting effects, altering the ability to cope with future stress
      - ▶ An example of this effect is child abuse or severe neglect
- ▶ Childhood trauma has a deleterious effect on the individual's ability to cope with future stressors and regulate affect
  - ▶ The individual is likely to develop other mental disorders later in life

## Effect of Childhood Trauma – How does the DSM-5 address these effects?

- ▶ **Reactive Attachment Disorder (RAD) & Disinhibited Social Engagement Disorder (DSED)**
  - ▶ Two related examples of the long-term effects of trauma on children
- ▶ **Reactive Attachment Disorder & Disinhibited Social Engagement Disorder are now included in this new chapter on Trauma- and Stressor- Related Disorders**
  - ▶ Both disorders are believed to be responses to trauma or chronic emotional neglect in the early formative years of development
- ▶ **These two disorders (RAD & DSED) have been uncoupled because they appear to have different progressions**
  - ▶ After children are placed in stable environments, research indicates that symptoms of Reactive Attachment Disorder disappear
  - ▶ While symptoms of Disinhibited Social Engagement Disorder take much longer to resolve and may become worse during adolescence
- ▶ **Several research studies have validated the criteria for Reactive Attachment Disorder and Disinhibited Social Engagement Disorder and found them to be distinct disorders that cause significant functional impairment**



# Part 5

## Review of Chapter

**“Trauma- and Stressor- Related Disorders”**



# 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
    - 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 5.1

(F 94.1)

Reactive Attachment Disorder (RAD)

(p. 265)

“Trauma- and Stressor- Related Disorders”

## (F 94.1) Reactive Attachment Disorder (RAD) (p. 265)

- **Appears first in the chapter since this disorder is generally diagnosed in childhood**
  - **Reflective of the within-chapter developmental reorganization**
- **In DSM-IV (TR), we were only working with “Reactive Attachment Disorder of Infancy or Early Childhood”**
  - **We had two subtypes for choices**
    - **Inhibited type**
    - **Disinhibited type**
- **Similar result, social neglect, as a result of developmentally inappropriate social behavior with adults/caregivers**
  - **Researchers believe it is useful to distinguish between these 2 distinct disorders**
    - **Reactive Attachment Disorder**
    - **Disinhibited Social Engagement Disorder**
  - **Distinguishing between these two disorders were believed to be necessary**
  - **Why?**
    - **Different presentations**
    - **Correlates to RAD – for example, comorbid depression, malnutrition**
    - **Responses to intervention – once again, after children are placed in stable environments, research indicates that symptoms of RAD disappear**
- **Child exhibits absent/very minimal attachment behavior toward adult caregivers**
- **Ongoing social-emotional disturbances**
  - **Limited positive affect**
  - **Limitability in social contexts**
- **Child has experienced extremely insufficient care**
  - **Which is presumed responsible for child’s behavior**
- **Frequent comorbidities**
  - **Cognitive and language delays**
  - **Depressive symptoms**

## (F 94.1) Reactive Attachment Disorder (RAD) (p. 265)

- Reactive Attachment Disorder is a rare disorder that affects fewer than 10% of children who have experienced severe neglect or abuse
- Symptoms first manifest between 9 months and 5 years of age
- It is unclear whether children over the age of 5 can develop symptoms of the disorder
- Serious neglect is the only known risk factor for Reactive Attachment Disorder, and is also a requirement for diagnosis
- A pattern of insufficient care is defined by at least one of the following:
  - Lack of having emotional needs met
  - Frequent changes in primary caregiver
  - Inability to form selective attachments due to being raised in an unusual environment that limited opportunities for developing attachments (e.g., institution)
- A child must rarely seek or respond to comfort when distressed and must exhibit at least two of the following emotional and social symptoms:
  - Minimal responsiveness to others
  - Limited positive affect
  - Unexplained episodes of irritability, sadness or fear
- Symptoms can develop before the first birthday and are specified as severe if all of the symptoms are met
- The disorder is specified as persistent if symptoms are present for more than 12 months

## **(F 94.1) Reactive Attachment Disorder (RAD) (p. 265)**

- **Comorbid conditions include those that are commonly associated with neglect:**
  - **Cognitive or language delays**
  - **Stereotypies – defined as persistent mechanical repetition of speech or movement, sometimes occurring as a symptom of schizophrenia, autism, or another mental disorder**
- **Medical conditions can also be present, especially malnutrition**
- **Depressive symptoms are also common and may result from the same conditions that cause Reactive Attachment Disorder**
  - **There is no indication however, that depression alone is responsible for causing Reactive Attachment Disorder**
- **In addition to detached and emotional nonresponsiveness, disruptive behavior disorders and developmental delays can also be present which can lead to some diagnostic confusion between:**
  - **Reactive Attachment Disorder**
  - **Bipolar Disorder**
  - **Post Traumatic Stress Disorder**
  - **Anxiety**
  - **Dissociative Disorders**
- **Prior to diagnosing Reactive Attachment Disorder, the following disorders must be ruled out:**
  - **Autism Spectrum Disorder**
  - **Intellectual Disability**
  - **Depressive Disorders**
  - **Attention Deficit Hyperactivity Disorder**



# Part 5.2

(F 94.2)

Disinhibited Social Engagement Disorder (DSED)

(p. 268)

“Trauma- and Stressor- Related Disorders”

## (F 94.2) Disinhibited Social Engagement Disorder (DSED) (p. 268)

- ▶ When interacting with unfamiliar adults, the child shows inappropriate, overly familiar behavior pattern
  - ▶ For example, the child:
    - ▶ Goes off with an unfamiliar adult
    - ▶ Does not check in with caregiver
    - ▶ Behavior violates social boundaries for the culture
- ▶ The child's impulsivity manifests with adults but not necessarily with other children
  - ▶ A child may have a noticeable lack of inhibition with strangers, and indiscriminate affection toward adults
  - ▶ Indiscriminate sociability w/unfamiliar adults is the main characteristic of Disinhibited Social Engagement Disorder
- ▶ Child's behavior is believed to be caused by extremely insufficient caregiving when the child was younger
  - ▶ As a reminder, children might not have disordered attachment because of the negative experiences from when they were younger

## (F 94.2) Disinhibited Social Engagement Disorder (DSED) (p. 268)

- Interestingly, the criteria for Disinhibited Social Engagement Disorder is the same as Reactive Attachment Disorder in that the child must be:
  - At least 9 months old
  - Symptoms must manifest before the age of 5
  - They must have a history of social and emotional neglect
  - Multiple changes in caregivers
  - Institutionalization

To the point that appropriate attachments with caregivers have not been formed
- The disorder is specified as persistent if it has been present for more than 12 months
- In addition, this new disorder requires the presence of indiscriminate sociability with unfamiliar adults manifested by the presence of at least two of the following:
  - 1. An overfamiliarity with strangers that is inconsistent with the child's developmental age or culture
  - 2. Lack of concern about or checking back with an adult caregiver (e.g., walking away from caregiver with out concern)
  - 3. Reduced hesitancy to approach and interact with unfamiliar adults
  - 4. Willingness to go off with an unfamiliar adult without any hesitation
- A major concern is the possibility of further trauma occurring to these children who may be susceptible to adults or older children who may prey on them
- Unfortunately, the child victims have often already been maltreated within closed systems (for example, within families and/or institutions) and are isolated



## **(F 94.2) Disinhibited Social Engagement Disorder (DSED) (p. 268)**

- **This failure to respond appropriately to social interactions impairs a child's ability to interact in a culturally appropriate manner that is consistent with age-appropriate social boundaries**
  - **In middle-childhood, children with Disinhibited Social Engagement Disorder may appear to be verbally and physically overly familiar or make inauthentic expressions of emotions, mainly to adults**
- **These symptoms often persist, even though the cause of the neglect no longer impacts the child's life**
- **In adolescence, peer relationships are likely to be affected as indiscriminate behavior with peers begin to cause problems**
  - **Conflicts with peers are likely to result that can lead to lifelong problems relating to adults and peers**
- **Disinhibited Social Engagement Disorder has a high degree of comorbidity:**
  - **ADHD**
  - **PTSD**
  - **ODD**
  - **Conduct disorder**
  - **At a greater risk of attachment difficulties**
  - **Most symptoms are evident in childhood and adolescence**
  - **It is unknown whether there are any adult manifestations of the disorder**
    - **Common comorbidities occur in nearly 80% of cases**
- **The manifestation of certain symptoms, attention-seeking behaviors and the development of superficial relationships, are particularly associated with psychopathology and functional impairment**

# Common Difficulties Diagnosing Reactive Attachment Disorder and Disinhibited Social Engagement Disorder – Why?

- 1. Diagnosis can be difficult with this population if maltreatment has not been documented
  - Reason: Children under the age of 5 cannot provide history, and if they have been removed from the home are not likely to be accurate reporters of what happened
- 2. Reactive Attachment Disorder has actually been recorded in children:
  - Who have secure attachments
  - Who have disorganized attachment
  - Those who have never developed an attachment to a primary caregiver

***Note: To date, no evidence-based practice has been deemed the only method to use when dealing with Reactive Attachment Disorder and Disinhibited Social Engagement Disorder.***

## But here is what we can do to

### Interventions should be tailored individually remembering:

- ▶ 1. Sensitive parenting reduces the effects of stress on children
- ▶ 2. Treatment for motor, language, and cognitive developments are likely to show improvement before social development
- ▶ 3. Interventions should provide caregivers with an understanding of age appropriate expectations based on the child's current level of functioning

### Prognosis

Early and effective intervention is needed to change the course of both RAD and DSED and to prevent the development of more serious behavior disorders later on

## One's Study's Findings – Disinhibited Social Engagement Disorder

- ▶ One study of children adopted out of institutions found that indiscriminate sociability is the most persistent social abnormality in this population and may persist for years even if the child subsequently becomes attached to new caregivers
- ▶ Additional symptoms of compulsive lying, stealing, and sexuality may occur as the child reaches adolescence
  - ▶ For DSED, adolescence appears to be the peak period for many reactions to manifest

# Client Characteristics

- ▶ **More than 500,000 children in the United States currently reside in some form of foster care or institutionalized setting**
  - ▶ Even more are adopted each year
  - ▶ The number of children in kinship care in which a relative provides foster care are unknown, but statistics indicate that more than 7.8 million children in the United States live in grandparent-headed household (Ellis & Simmons, 2014)
    - ▶ Most of these children are well cared for, loved, and securely attached to their primary caregivers
  - ▶ But for those who have experienced abuse, neglect, and multiple serial disruptions in caregivers prior to the age of 5, there may be some residual damage and functional impairment
- ▶ **Attachment - is the emotional bond that develops between an infant and parents/caregivers**
  - ▶ Early identification and treatment of these disorders can have a substantial impact on the child's future relationships
- ▶ **Despite its name, reactive attachment disorder can occur in:**
  - ▶ Children who have secure attachment
  - ▶ Children who have disorganized attachment
  - ▶ Children who have never developed an attachment to primary caregivers
- ▶ **In addition, data on maltreated noninstitutionalized adolescents found that Reactive Attachment Disorder was associated with numerous incidents of maltreatment, increased rates of psychopathology and earlier entry into treatment (Kocovska et al., 2012)**

# Client Characteristics

- ▶ Limited research is available on children raised in institutions who were later adopted
- ▶ One study of children, ages 10-17, found more dysfunction between children and peers or other siblings in the new household than problems between the child and the adoptive caregiver (usually the mother)
  - ▶ The study was limited to self-reports from families in which a child had been adopted from a Russian orphanage and brought to the United States (Hawk & McCall, 2014)
  - ▶ More research of this type would be beneficial to help determine the actual number of cases, symptoms to be addressed and to conserve aspects of families that could ameliorate the effect of early childhood disruptions in caregiving
- ▶ Maltreatment and suffering takes a toll on emotional, social, language, and cognitive development
  - ▶ These effects are individual and vary based on the child's level of development and the length, severity, and type of deprivation (Knudsen, 2003; Nelson, Thomas & de Haan, 2006)
- ▶ A complete discussion of the effects of early maltreatment and stress on brain development can be found in a study by Nelson, Zeanah, and Fox (2007)
- ▶ More research in this area is necessary:
  - ▶ To understand how children process these experiences in attention, memory, the development of cognitive biases, and their effects on metacognition (Zilberstein, 2014)
  - ▶ To determine how early childhood social and emotional deprivation interferes with the attachment process and those that information can be used to inform the development of evidence-based practice for children diagnosed with Reactive Attachment Disorder
- ▶ Clearly, children raised in orphanages in which maltreatment was the norm would likely have the most severe problems, but research shows that even poor parenting or stress at home can impact a child's developing brain (Romer & Walker, 2007)

# Assessment

- For a diagnosis of either RAD or DSED, a history of conditions that resulted in social neglect and are known to cause the symptoms of RAD, must be present before the age of 5, and include:
  - History of prolonged separation from primary caregivers
  - Repeated changes of primary caregivers
  - Severe neglect or abuse
  - Documented living in an institutional setting from an early age
- Clinical evaluation & confirmation of symptoms of RAD can be made by observing of the:
  - Child
  - Parent or caregivers
  - Other concerned and knowledgeable adults
- Observing the relational quality between children and their caregivers can be importance part of a complete assessment (Clark, Tluczek & Gallagher, 2004)
- Mares and Torres (2014) outline how to conduct a semi-structured observation as part of a clinical assessment for children in foster care
- Additionally, the child's current living situation may need to be assessed regularly to make sure the child is receiving attentive and appropriate care

# Preferred Therapist Characteristics

- Therapists who work with children with RAD & DSED should understand the dynamics of the attachment process
  - Building a relationship between the child and the parents or primary caregivers will most likely be the goal of treatment
- The therapist must remain supportive and empathic while also establishing boundaries and modeling appropriate behavior in their work with caregivers and children
- The therapist must become comfortable being part of a collaborative team that may involve:
  - Medical professionals
  - Teachers
  - School counselors
  - Do not forget about the other professionals who are legally responsible for ensuring the best interest of the child, such as:
    - Grandparents
    - Foster parents
    - Social workers
    - CASA workers



# Intervention Strategies

- Enough data is available in the research literature, however, to determine what children need to form the basis of a secure and stable home life so that they can flourish
  - The most important prerequisite is to ensure that the child has a caregiver who is sensitive, emotionally available & responsive so that the child can development a secure attachment
- Treatment must be individualized to the needs of the child (Shreeve, 2012)
- Some considerations:
  - DSED is associated with multiple maltreatment, earlier entry into care, and increased rates of psychopathology (Kay & Green, 2013)
  - Individualized, consistent human contact has a profoundly therapeutic role for an infant (Spitz, 1945)
  - Sensitive parenting reduced the effects of stress on children (Dozier et al., 2009)
  - Treatment for motor, language, and cognitive developments are likely to show improvement before social development (Rutter & O'Connor, & English and Romanian Adoptees [ERE] Study Team, 2004)
  - Parents or caregivers should be involved in treatment, assuming the caregivers are emotionally healthy enough to participate in treatment (Boris & Zeanah, 2005)
  - Basically interventions should help the parents see the child as a distinct person and not just as a “little adult” or even an extension of themselves
    - Therefore, interventions should provide caregivers with an understanding of age appropriate expectations based on the child’s current level of functioning (Bernier & Dozier, 2003)
  - Emotional neglect is not just the result of institutionalization or multiple foster care placement
    - It can result from parental psychiatric conditions such as substance abuse, major depressive disorder, and PTSD (Schechter & Wilhiem, 2009)
  - Variations in the mother's ability to cope with stress has implications for parenting practices with very young children (Martorall & Bugental, 2006)

# Intervention Strategies

- Based on our growing knowledge of attachment, some interventions are being tested
- What follows is a brief look at some early interventions for children:
  - Attachment and Biobehavioral Catchup (ABC) is an intervention based on attachment theory and stress neurobiology that was designed to facilitate relationship formation for infants and toddlers who have experienced disrupted attachment
    - The manualized intervention involved 10 in-home sessions with both foster parent and child
    - The goal of treatment is to improve the foster parent's ability to provide unconditional support and nurture, which, in turn, results in changes in the child's behavior
    - Interventions include: learning to nurture a child regardless of the child's behavior, eventually focusing on problematic behavior, learning how to reduce frightening or intrusive behaviors and, in the final sessions, incorporating the importance of motion and touch
    - Feedback is provided in the moment, and videotaping of each session provides review as well
    - Evidence indicated that ABC has a therapeutic effect on the child's ability to regulate stress and increases attachments security of infants and toddlers in foster care (Dozier et al., 2009)
    - Random controlled trials (RCTS) compared results of the ABC group with a control group in which Developmental Education for Families (DEF) was provided
    - The short-term effects were positive in terms of reducing avoidant behavior
    - More research is needed on long-term effects and the effect of the intention on attachment security (Dozier et al., 2008)
  - The ABC Intervention has been adapted for use with:
    - Children younger than 10 months old
    - Children 24 to 36 months
    - Children adopted by foreign parents

# Intervention Strategies

- ▶ **The Bucharest Early Intervention Project** studied abandoned, institutionalized children and discovered that the younger they were when removed from the institution and placed in foster care, the fewer the cognitive problems experienced at 42 and 54 months (Nelson et al., 2007)
  - ▶ The results of the project points to the sensitive period of childhood development and the importance of attachment with a caregiver in the early, formative years of human life
- ▶ Other interventions, NOT specific to RAD, have been shown to improve the caregiver-child relationship and, therefore, improve emotional regulation and reduce behavior problems of children include:
  - ▶ **The Incredible Years** (Webster-Stratton & Reid, 2010) - a multifaceted treatment approach for conduct disordered youths
  - ▶ **Behavior Management Training (BMT)**, a parent training program that shows promise for the treatment of Reactive Attachment Disorder
    - ▶ One case study outlined successful treatment as applied to Reactive Attachment Disorder (Buckner, Lopez, Dunkel, & Joiner, 2008)
  - ▶ **Mindful parenting training** teaches parents how to decrease harsh parenting techniques and improve positive bonding. Parenting satisfaction, compassion, and overall family functioning improve (Duncan, Coatsworth, & Greenberg, 2009)
    - ▶ Dimensions of mindful parenting include listening with full attention, self-regulation on the part of parents, compassionate and nonjudgmental acceptance of the child, and listening with complete attention

## Intervention Strategies: Vigilance Needed

- It is important to note that unproven treatments for RAD, especially coercive techniques that may be dangerous, should be avoided (AACAP, APA, APSAC)
- These techniques include any kind of forced interventions, so-called “rebirthing” techniques of “holding” strategies in which the child is forcefully held until calm, and any type of therapy that attempts to break down “resistance” to attachment
- The American Association of Child and Adolescent Psychiatry and the American Psychiatry Association have spoken out against such unsupported practices as:
  - Controversial
  - Having the potential for being psychologically and physically damaging
  - And even resulting - in some cases - in accidental deaths

### Prognosis

- Early, effective interventions are needed, if possible, to...
  - Change the course of both Reactive Attachment Disorder and Disinhibited Social Engagement Disorder
  - Prevent the development of more serious behavior disorders later on
- No outcomes studies are available for these disorders
- It seems likely that children who experience severe emotional deprivation early in life are likely to have more serious outcomes later in life



# Part 5.3

**(F 43.10)**

**Posttraumatic Stress Disorder**

**(includes Posttraumatic Stress Disorder for  
Children 6 years and Younger)**

**(p. 271)**

**“Trauma- and Stressor- Related Disorders”**



## (F 43.10) Posttraumatic Stress Disorder (includes Posttraumatic Stress Disorder for Children 6 years and Younger) (p. 271)

- ▶ Time frame same as it was in DSM-IV (TR)
  - ▶ 1 month duration of the manifestation of symptoms
- ▶ Client must have experienced a traumatic event
  - ▶ Revised definition
- ▶ Post Traumatic Stress Disorder
  - ▶ 4 symptoms clusters, not 3
  - ▶ Post Traumatic Stress Disorder and Post Traumatic Stress Disorder for children 6 and younger – revised criteria set for children
  - ▶ Addition of a dissociative subtype

# Diagnosing PTSD in Young Children

- ▶ **A little different in DSM-5**
- ▶ **One PTSD criteria set for children 6 years and younger**
  - ▶ Because children often express these reactions differently
- ▶ **Six and under criteria set**
  - ▶ Fewer symptoms required
  - ▶ Avoidance OR negative alteration in mood, no both
- ▶ **For children 7 years and older use regular PTSD criteria**
  - ▶ But it is noted that symptoms may be expressed differently
  - ▶ E.g., intrusive memories may emerge in play re-enactment
- ▶ **Specifiers**
  - ▶ Both “dissociative” subtype and “delayed expression” specifier may be used with children

# Post Traumatic Stress Disorder

- The expanding research and evidence base for Post Traumatic Stress Disorder has resulted in multiple changes to the disorder in the DSM-5
  - First, PTSD is no longer considered to be an anxiety disorder as it was in DSM-IV (TR), but is now one of the trauma- and stressor-related disorders, and, by definition, exposure to a traumatic or stressful event is a requirement for diagnosis
  - Not all symptoms of PTSD can be understood in the context of anxiety or fear
  - Intrusive memories or dissociative reactions may be present, along with symptoms of:
    - Physiological arousal after the traumatic event
    - Aversion to or avoidance of stimuli related to the trauma
    - Negative changes in thinking or mood
    - Other emotional reactions are also part of the PTSD sequelae
- PTSD can occur at any age, beginning with the first year of life (APA, 2013)



# PTSD Symptomology

- Following are symptoms of PTSD that related to adults, adolescents, & children over the age of 6
- The characteristic feature of PTSD is exposure to a traumatic event, which is defined in the DSM-5 as exposure to, or actually experiencing, threatened death, serious injury, or sexual violence
- The exposure can occur in any of the following ways:
  - Direct experience
  - Witnessing the event as it occurred to others (in real life-not via electronic media or pictures)
  - Learning of a traumatic event that happened to a loved one (the event must have been violent or accidental)
  - Experiencing repeated or extreme exposure to aversive detailed of the even as might be experienced by first responders or police officers

## Definition of Disorder

- **The presence of one or more of the following intrusive symptoms must have occurred and been associated with the traumatic event**
  - Intrusive memories of the event (In children, memories may be acted out through play)
  - Recurrent frightening dreams about the traumatic events (In children, such dreams may lack details specific to the traumatic event)
  - Dissociate reactions in which it seems that the event is actually recurring
  - Intense psychological distress
  - Physiological reactions to internal or external cues that cause distress
  - Negative changes in thoughts or mood, including two or more of the following:
    - Inability to remember important aspects of the traumatic event
    - Persistent negative beliefs about oneself
    - Distorted cognition about the cause or consequence of the trauma
    - Persistent negative emotional state (e.g. shame, anger, guilt, horror, fear)
    - Lack of interest in activities
    - Feeling detached from other
    - Unable to experience pleasure or positive emotional
  - Alterations in arousal responses after the traumatic event as noted by two or more of the following symptoms:
    - Irritability and angry outburst
    - Self-destructive behavior
    - Hypervigilance
    - Exaggerated startle response
    - Problems concentrating
    - Sleep disturbances
- **Symptoms of the disorder must be present for least 1 month and cause distress or functional impairment in one or more areas of functioning**

## Definition of Disorder

- ▶ **The following specifiers can be used for PTSD:**
  - ▶ **With dissociative symptoms - depersonalization (i.e., feeling detached, as if outside one's body)**
  - ▶ **With dissociative symptoms - derealization (i.e., feeling of unreality of surroundings that appear dreamlike or surreal)**
  - ▶ **With delayed expression - if the full criteria for PTSD are not met until 6 months after exposure to the trauma or event**
- ▶ **At least one other disorder co-occurs in 80% of individuals who meet the criteria for PTSD**
- ▶ **The most common are depressive, anxiety, bipolar, and substance use disorders**
- ▶ **Among returning combat veterans who were deployed to Afghanistan and Iraq, mild traumatic brain injury (TBI) co-occurs in 48% of those with PTSD**
- ▶ **The relationship between PTSD and suicide has been the focus of increasing research as the suicide rate continues to increase as the suicide rate continues to increase for male veterans returning from combat**
  - ▶ **In 2009, the suicide rate among male veteran VA users was 38.3 per 100,000, nearly double the rate of 19.4 per 100,000 for males in the general U.S. population**
  - ▶ **During the same period, the suicide rate for females was 12.8% and 4.9%, respectively**
- ▶ **Research on combat trauma indicates that those who were wounded multiple times or hospitalized for an injury experienced the highest suicide risk (Bullman & Kang, 1995)**
- ▶ **If suicidality is present, it must be addressed before proceeding with treatment for PTSD**

# DSM-5 Changes to PTSD Diagnosis: Dissociative Subtype Specifier

- **New dissociative subtype**
- **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**
    - **Also more common in women (most studies)**
    - **Dissociative symptoms in PTSD found across 16-nation study (i.e., not just a Western phenomenon)**
- **A 2013 study indicated some interesting neurobiological findings**
  - **Dissociative symptoms were the most frequently reported reactions to sexual trauma**
  - **The neuro research indicated that the findings are reversed from non-dissociative PTSD**
  - **So the imbalance between the Amygdala and the prefrontal cortex kind of goes the other way**
  - **So the Prefrontal Cortex is almost too strong and the Amygdala is inhibited which kind of slows down instinctive, emotional responses to situations**
- **DSM-5 language refers only to depersonalization and derealization**
  - **Also, dissociative symptoms must be “persistent or recurrent”**
- **Different neurobiological findings –**
  - **Often amygdala is under- reactive**

# PTSD In Children 6 Years and Younger

- ▶ This diagnosis uses a set of criteria that are developmentally sensitive and takes into account symptoms and experiences relevant to the preschool population (Scheeringa, Zeanah & Cohen, 2011)
  - ▶ Types of traumas include exposure to actual or threatened death, serious injury, or sexual violence
  - ▶ This may include abuse, motor vehicle accidents, natural disasters, being bitten by a dog, invasive medical procedures, witnessing interpersonal violence, or inappropriate sexual experiences without violence or injury (APA, 2013)
  - ▶ This child may experience the trauma directly, witness it happening to others (especially primary caregivers), or learn that the traumatic event occurred to a parent or caregiving figure
  - ▶ Note: Witnessing a traumatic event does not include seeing it on electronic media, television, or in pictures
- ▶ For a diagnosis of childhood PTSD, the presence of one or more of the following intrusive symptoms is required:
  - ▶ Recurrent memories
  - ▶ Upsetting dreams
  - ▶ Dissociative reactions (i.e., flashbacks)
  - ▶ Psychological distress
  - ▶ Physiological reactions to reminders of the trauma

# PTSD In Children 6 Years and Younger

- ▶ The presence of one or more of the following avoidance symptoms or negative cognitions is also required:
  - ▶ Attempts to avoid activities or physical reminders of the event
  - ▶ Attempts to avoid people or interpersonal reminders of the event
  - ▶ Increased frequency of negative emotions
  - ▶ Reduced interest in activities
  - ▶ Social withdrawal
  - ▶ Reduction in positive emotions
- ▶ Developmentally appropriate reactions to traumatic events criteria for childhood PTSD are more behaviorally orientated than for adults
- ▶ Children often do not talk about the trauma but may exhibit behaviors such as excitement or arousal symptoms
- ▶ The presence of two or more arousal symptoms is required, including:
  - ▶ Irritability
  - ▶ Outbursts of anger
  - ▶ Temper tantrums

# PTSD In Children 6 Years and Younger

- ▶ Also required is the presence of two or more physiological symptoms of:
  - ▶ Hypervigilance
  - ▶ Exaggerated startle response
  - ▶ Problems concentrating
  - ▶ Sleep disturbances
- ▶ As with adult PTSD, the duration of childhood symptoms must persist longer than 1 month and cause significant distress at school, with parents or other caregivers or with peers and cannot be the result of another medical condition, medication, or intellectual disability
- ▶ Specifiers for childhood PTSD include the following
  - ▶ With dissociative symptoms: Depersonalization or Derealization
  - ▶ With delayed expression - if full symptoms are not experienced until at least 6 months after the traumatic events

# Client Characteristics

- ▶ PTSD is more prevalent among females than males and is estimated to affect about 8.7% of people across their lifetime
  - ▶ Rates of PTSD are lower in European and most Asian, African, and Latin American countries
- ▶ Rates of PTSD increase according to types of employment, with veterans, emergency medical personnel, police, and firefighters having rates as high as 30% of those exposed to traumatic events
  - ▶ The highest rates of PTSD are found in people who have survived rape, military combat, and being held captive (APA, 2013)
- ▶ Symptoms of PTSD in children and adolescents will differ from adults
  - ▶ In young children, symptoms often resemble the hyperactivity seen in ADHD (e.g., distractibility, increased impulsivity)
  - ▶ Comorbidity with separation anxiety and oppositional defiant disorder are likely
  - ▶ Symptoms may include school refusal, anger, irritability, and increased thoughts concerning safety and death
  - ▶ Problems with sleeping, eating, and attention are also common, as are nightmares and other bad dreams
  - ▶ Repetitive themes may emerge during play, or become the subject of repeated nightmares
  - ▶ Other symptoms may include agitation, confusion, or dissociative symptoms
    - ▶ These behaviors may negatively impact academic achievement and disrupt relationships with family and peers
- ▶ Trauma in adolescents has been associated with high-risk behaviors, including sexual behaviors, substance abuse, reckless and aggressive actions
- ▶ Children who have been sexually abused may have dissociative symptoms and lack any memory of event
- ▶ When a family member is the perpetrator of the abuse, family loyalty may elicit less support from the family than if the perpetrator had been a stranger



# Client Characteristics

- ▶ **Developmental regression may occur in children (e.g., bedwetting, loss of language)**
  - ▶ Subthreshold levels of PTSD may present in later life
  - ▶ Some believe this may occur in the early years as well, as a result of chronic abuse, neglect, or sexual abuse that is not remembered, or other traumas that affects the brain's arousal system but that currently fall below the threshold for childhood PTSD (van der Kolk, 2014)
- ▶ **Adult trauma symptoms can often mimic other disorders**
  - ▶ It is the self-protective defensive nature of arousal states that differentiates them from other disorders (e.g., bipolar disorders, ADHD)
  - ▶ Therapy for mood instability plays an important role in helping people to recognize the fear and anxiety behind their extreme emotional responses (Courtois & Ford, 2013)
- ▶ **Interestingly, when hyperarousal, irritability, concentration problems, hypervigilance, or sleep disturbances are viewed as being based on threat reactivity, that is when therapy is believed to be most effective**
- ▶ **Briere and Scott (2006) discuss the importance of recognizing when the client is approaching the “therapeutic window” and has developed the capacity to tolerate emotional arousal**
- ▶ **At this point, the client is encouraged to feel the emotion, with increasing tolerance for it, rather than shutting down**
  - ▶ Different types and lengths of exposure-based approaches are available to gradually expand the client's “window of tolerance”

# Assessment

- ▶ People who experience a traumatic life event are often hesitant to talk about it
  - ▶ Therefore, assessment will need to probe deeper than the surface
  - ▶ Clients should be asked to explain or say more about any symptoms of PTSD they have endorsed
- ▶ A variety of instruments, including questionnaires, self-report instruments, scales and checklist are available for assessing trauma in children and adolescents
- ▶ Both of the following structured psychiatric interviews for children include modules on PTSD
  - ▶ Both include child and parent self-reports
    - ▶ The Diagnostic Interview Schedule for Children-Version IV (DISC-IV)
    - ▶ The Kiddie Schedule of Affective Disorders and Schizophrenia for School-Age Children
- ▶ A comprehensive clinical interview is often the best source of information of PTSD in children, and should include assessment of:
  - ▶ Type of trauma
  - ▶ Severity
  - ▶ The presence of co-occurring disorders (e.g., somatic disturbances, oppositional defiant disorder, conduct disorder)

# Assessment

- Severity of PTSD symptoms in children ages 6 to 17 can be assessed with the Child PTSD Reaction Index (CPTSD-RI) and a shorter, 17 – item version (Ohan, Myers & Collett, 2002)
- The assessment scale has the most psychometric research to back it up, and has shown good reliability and validity (Foa, Keane, Friedman & Cohen, 2009)
- There scales and assessments for children include:
  - Child and Adolescent Trauma Survey
  - Trauma Symptoms Checklist for Young Children [TSCYC] (Briere, 2001) - a caregiver self-report for children
  - Clinician - Administered PTSD scale - Child and Adolescent Version, the Child PTSD Checklist
  - Child PTSD Symptom Scale (CPSS); assesses frequency of symptoms of PTSD as well as daily functioning, for children ages 8 to 18
- Standardized screening tests for childhood PTSD include caregiver self-reports, and self-administered checklists
- Semi-structured diagnostic interviews are also helpful
- A complete discussion of assessment instruments for children is beyond the scope of this presentation
  - Interested readers are referred to Balaban (2009) for a more detailed discussion

# Preferred Therapist Characteristics

- **All evidence-based treatments for PTSD are active and directive, with the therapist playing an active role**
  - Sessions are goal-oriented, skills based, and usually time limited
- **Therapists must be able to establish the Rogerian conditions of warmth, positive regard, empathy, and consistency in building the client's trust**
  - They must also provide the client with a safe environment in which the person can resign to a sense of control and empowerment
  - Clients should NOT be forced to discuss a traumatic event until they feel comfortable enough in the therapeutic environment to do so
- **Validating the client's experience is an important part of therapy, and clinicians must carefully balance acknowledge of the client's fear and vulnerability with comments on their resilience and strength**
- **Reluctance to engage productively in treatment is common in people with PTSD or Acute Stress Disorder and may manifest as missed appointments or noncompliance with treatment recommendations**
  - A collaborative relationship in which the client's input into goals and pacing of the treatment can help to improve the client's sense of control and empowerment, and improve the likelihood of treatment success (Rubin, 2009)
  - For example, women who have been the subject of domestic violence may voice a strong preference for working with a female therapist
    - Similarly, returning war veterans may prefer a therapist who has experienced active duty
- **Therapists who work with trauma are particularly prone to developing secondary or vicarious traumatization**
  - Awareness of reactions (e.g., feeling vulnerable or less safe, a changing view of the world) and actively seeking supervision, balancing of caseload, and peer consultation can help the clinician handle any secondary trauma that arises

# Intervention Strategies

- ▶ **Early intervention and treatment of symptoms is important and may help prevent the transition of acute stress disorder into full-blown PTSD**
- ▶ **Trauma-focused Cognitive Behavior Therapy (CBT) has the most evidence-based support in the treatment of PTSD**
  - ▶ **Within the broad umbrella of CBT, the following approaches have shown good results across all forms of trauma, including sexual assault and combat:**
    - ▶ **Stress inoculation training**
    - ▶ **Emotional processing of the trauma**
    - ▶ **Prolonged exposure (PE; Foa et al., 2009)**
    - ▶ **Cognitive processing therapy (Resick, Monson & Rizvi, 2008)**
- ▶ **A combination of treatment approaches that meet the client's specific circumstances seems to be the most useful**
  - ▶ **For those with severe symptoms or clients who are emotionally distraught or functionally impaired, interventions should first rebuild a sense of safety and control before exposure to the trauma**

# Intervention Strategies

- In general, effective cognitive and behavioral treatment approaches are designed to :
  - Promote accessing the trauma
  - Increase expression of feelings
  - Increase coping skills
  - Improve control over traumatic memories
  - Reduce cognitive distortions and self-blame
  - Restore the client to previous levels of functioning
  
- Evidence-based treatments for PTSD include the following:
  - Exposure therapy
  - Cognitive processing therapy
  - Anxiety management therapy
  - and possibly*
  - Eye Movement Desensitization and Reprocessing (EMDR)
    - Although this latter approach remains controversial to some, I believe it is a very effective intervention
  
- We will take a very brief look at each evidence-based treatment now

# Evidence-Based Treatments for PTSD: Prolonged Exposure

- ▶ The best treatment for PTSD appears to be prolonged exposure to the trauma memory
- ▶ Exposure therapy is a well-validated treatment for PTSD (Foa, Keane, Friedman & Cohen, 2009; Ponniah & Hollon, 2009)
- ▶ The goal of exposure therapy is to activate the fear memory while providing new information that is incompatible with the fear so that new learning is the result
- ▶ Clients establish a fear hierarchy and then focus on feared cues for 45 minutes daily, beginning with a moderately feared stimulus and progressing through the list until fear is extinguished
- ▶ Length of sessions, number of treatments, and type of exposure will vary depending on the client's needs
- ▶ Exposure based CBT can be adapted to early interventions, for different populations and specific traumas
  - ▶ Some models use longer (3-hours) sessions with less frequency
  - ▶ Exposure may involve in vivo, guided imagery, or virtual reality
    - ▶ One study of veterans of Operation Iraqi Freedom, involved the creation of virtual Iraq to facilitate prolonged exposure (Zoellner, et al. 2008)

# Evidence-Based Treatments for PTSD: Cognitive Processing Therapy (CPT)

- Resick and Schnicke (1992) developed Cognitive Processing Therapy specifically for the treatment of sexual assault survivors
- Perceptions of danger, guilt and anger were found to separate PTSD from an anxiety disorder, and these cognitions along with the role of control (avoidance) serve to keep the trauma memory alive
- In cognitive processing therapy exposure is combined with anxiety management training and cognitive restructuring to help clients alter disrupted cognitions
  - Clients are asked to write about the traumatic event and then read the recollections to the therapist, who facilitates understanding, exploration of responses, and emotional expression
  - Clients are then instructed to read their accounts to themselves daily to habituate themselves to the experience and increase their understanding of the traumatic events and their reactions
- When paired with training in coping skills, clients become sensitized to repeated exposure to trauma
  - Since the original study, numerous Random Controlled Trials (RCT) have found Cognitive Processing Therapy (CPT) to be effective for a variety of situations and populations including female victims of physical or sexual assault, male and female combat veterans, and war refugees from Afghanistan and Bosnia- Herzegovina
  - A 12-session structured model of CPT was found to be as effective as exposure therapy alone in the treatment of rape-related PTSD (Keane & Barlow, 2002)



# Evidence-Based Treatments for PTSD: Anxiety Management Therapy (AMT)

- ▶ The goal of Anxiety Management Therapy (also called Stress Inoculation Training [SIT]) is to modify memories associated with fear
  - ▶ To do this, Anxiety Management Therapy combines the activation of traumatic memories with skills known to reduce anxiety such as:
    - ▶ Relaxation techniques
    - ▶ Breathe retraining
    - ▶ Cognitive restructuring to help clients alter maladaptive thoughts and beliefs
- ▶ One study of Vietnam combat veterans with PTSD found Anxiety Management Therapy to be as effective as exposure-based treatments in decreasing the frequency and intensity of intrusive war memories and avoidance of stimuli that reminded veterans of their war experiences (Patalon & Motto, 1998)
- ▶ Anxiety Management Therapy can be used with or without exposure in the treatment of Post Traumatic Stress Disorder

# Evidence-Based Treatments for PTSD: Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro, 1989)

- ▶ EMDR is recommended as a first-line treatment for PTSD in clinical guidelines put out by the Department of Veterans Affairs (2010)
- ▶ There is some scientific literature that indicates EMDR is an efficacious treatment for PTSD (NICE, 2005; Spates & Rubin, 2013)
- ▶ EMDR may be less effective, however, for combat veterans than for civilians (Bisson & Andrew, 2007)
- ▶ EMDR does not appear to be more effective than the other evidence-base treatments for PTSD, and it is still unclear exactly how EMDR works, leaving some to conclude that more research is needed (Lilienfeld, Lynn & Lohr, 2015; Lohr et al. 2015)
- ▶ For more information, go to [www.emdria.org](http://www.emdria.org)
  - ▶ EMDR International Association
    - ▶ This website allows you to locate a trained therapist, find information related to the annual conference, sign-up for local EMDR training, locate EMDR-related resources, and more

## Other Treatments

- The following are other treatment options often incorporated into working with people diagnosed with PTSD:
  - Group therapy
  - Family therapy
  - Mindfulness and acceptance therapies
- Each of these treatments show promise but have not been empirically validated for the treatment of PTSD, although they might still be beneficial

# Medication

- ▶ **Medication management for PTSD includes:**
  - ▶ Selective Serotonin Reuptake Inhibitors (SSRI)
  - ▶ Beta-blockers
  - ▶ Antipsychotic medication
  - ▶ Anticonvulsants (APA, 2004/2009)
- ▶ The FDA has approved the SSRIs paroxetine (Paxil) & sertraline (Zoloft) for treatment of PTSD
- ▶ Other SSRIs may also be effective as noted in successful open trials and case reports
- ▶ A comprehensive review of medication for the treatment of PTSD can be found at Friedman and Davidson (2007)
  - ▶ Atypical antipsychotic benzodiazepines, and beta blockers have also been used to treat symptoms of PTSD, but to date, no one medication has been found to address the complex variety of PTSD symptoms (i.e., re-experiencing, avoidance/numbing, and hyper-arousal)
- ▶ Even so, many medication have been used effectively in the treatment of PTSD
- ▶ Caution should be used with benzodiazepines due to the potential for addiction and the lack of efficacy studies
  - ▶ Worsening of symptoms when benzodiazepines are discontinued is also cause for concern (APA, 2002/2009)

# Group and Family Therapy

- ▶ Family therapy is often warranted for treatment of childhoods trauma
- ▶ People who were abused as children have higher-than-average likelihood of experiencing abuse as adults (Messen & Long, 1996)
  - ▶ Often the initial abuse was at the hands of a family member, and it contributed to family difficulties
- ▶ Group therapy can also help people with PTSD, including veterans, do the following:
  - ▶ Establish a support network
  - ▶ Normalize their experiences
  - ▶ Reduce stigmatization
  - ▶ Avoid the feeling of being alone
- ▶ Although group therapy can foster interdependence and sharing, it can also contribute to the exacerbation of the trauma
  - ▶ Therefore, group therapists must screen potential group members for readiness for the group experience and closely monitor disclosure of an exposure to graphic descriptions of traumatic experiences

## Military Population

- **Choice of occupation can increase a person's risk of developing Posttraumatic Stress Disorder (PTSD)**
- **Specifically, combat veterans and police officers have a rate of PTSD that ranged between 17% and 19% (Cailier, Lamberts, & Gersons, 1997; Richardson, Frueh & Acierno, 2010)**
- **Acceptance-based treatments for PTSD have been found to be effective and well-tolerated in military veterans**
- **Mindfulness, with its focus on the present moment, reduces anxiety about the future and rumination about the past (Mantzios, 2014; Vujanovic, Niles, Pietrefesa, Schmertz, & Potter, 2011)**

# Treatment for Children with PTSD

- ▶ Treatment should begin by establishing the physical safety of the children, especially if there is a history of abuse
- ▶ The first-line of treatment will include some form of psychotherapy
- ▶ Trauma-Focused CBT (TF-CBT) most likely has more evidence of its effectiveness for children than other treatments
  - ▶ In one multisite study, TF-CBT was found to be more effective than child-centered therapy for the treatment of children who had been sexually abused (Cohen, Deblinger, Mannarino, & Steer, 2004)
- ▶ A randomized controlled trial of Skills Training in Affect and Interpersonal Regulation (STAIR) followed by exposure found the STAIR/exposure condition to be more effective than a control group of supportive counseling followed by exposure or a control group of skills training followed by supportive counseling (Cloitre et al., 2010)
- ▶ No empirical research has yet determined that psychotherapy is more effective than medication, but the side effects and risks associated with SSRIs and other psychotropic medications on children generally precludes their usage except in the more serious case of ASD or PTSD
  - ▶ Nor are there any studies on the effectiveness of antipsychotics for children with PTSD
  - ▶ Although many medications can reduce arousal and anxiety, the side effect profile of the medication must be considered when deciding whether to administer powerful neuroleptic medications to young children

## Prognosis

- Although PTSD can be a debilitating illness for many people, it is important to remember that fully 2/3 of people who are exposed to natural disasters, rape, violence, and other interpersonal trauma will not develop symptoms of PTSD
- Many others will have minor symptoms that remit spontaneously
- Of those who develop PTSD, 50% will have a complete recovery within 3 months, and many will have symptoms that last for more than 12 months (Blanco, 2011)
- Factors that significantly increase the chances of a positive outcome include:
  - Good premorbid functioning
  - Having good coping skills
  - A supportive family
  - Seeking treatment soon after the trauma occurs
- Prognosis is not as good for those who have late onset or who have co-occurring disorders




# 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 Criterion B or C symptoms
      - ▶ Furthermore, not does it include a number of symptoms from PTSD Criterion 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

# Complex – Posttraumatic Stress Disorder

- There are several definitions of C-PTSD which is problematic
- Has not officially been added to the DSM-5 as a diagnosis
- Complex – Posttraumatic Stress Disorder is often the result of chronic, interpersonal trauma
  - Might present with symptoms of Posttraumatic Stress Disorder, in addition to problems such as:
    - Somatization symptoms
    - Affect dysregulation
    - Memory and attention problems
    - Distorted perception of self and/or others (perpetrators)
    - Relations with Others
- DSM-5 has broadened its perception of Posttraumatic Stress Disorder to include some, but not all, of what is included in Complex – Post Traumatic Stress Disorder
- Dissociative disorders, while often preceded by trauma, do not require traumatic event for a diagnosis to be rendered
  - There is an acknowledge in the DSM-5 that dissociative symptoms are an indicator of severity

# Complex – Posttraumatic Stress Disorder

- **Reasons provided against adding Complex – Posttraumatic Stress Disorder to the DSM-5**
  - It would be rare for someone to have Complex-Posttraumatic Stress Disorder and not qualify for a Posttraumatic Stress Disorder diagnosis
  - A new diagnosis does not add enough to justify the addition
  - Difficulties in assessing this construct
    - Therefore, contains an insufficient research base to include in DSM-5
  
- **Reasons provided for adding Complex – Posttraumatic Stress Disorder to the DSM-5:**
  - Would be a valid entry as a diagnosis
  - Could have important treatment implications
  - One “catch-all” diagnosis
    - We would be able to account for symptom presentation from several disorders with PCBD
    - Some examples of this include, but are not limited to, the following:
      - Attention Deficit Hyperactivity Disorder
      - Borderline Personality Disorder (common)
      - Dissociative Disorders
      - Posttraumatic Stress Disorder

# Criteria Set: Persistent Complex Bereavement Disorder (PCBD)

- Has been previously referred to as “prolonged grief disorder” or “complicated grief”
- Persistent Complex Bereavement Disorder’s Criteria Set would include:
  - Adult - death of someone close (at least 12 months ago)
  - Children - death of a loved one (at least 6 months ago)
  - Constant yearning/intense sorrow/preoccupation with deceased
  - Symptoms of reactive distress to the death and social/identity disruption
  - Distress or impairment
  - Reaction inconsistent with cultural, religious norms
  - “Normal” acute symptoms of grief last longer than expected
- There was much controversy regarding the removal of “bereavement exclusion” in the diagnosis of Major Depressive Disorder
  - Note that criteria for PCBD are quite different from MDD criteria
    - Grief not equal to depression
    - Grief – person is more focused on emptiness and loss; focus on loss of person; symptomology might spike when reminded of the person
    - Depression – not really linked to a particular person; focus is on worthlessness of the self
- Prevalence of Persistent Complex Bereavement Disorder – 2-5% – fairly high
- Risk factors include being of female gender, experiencing death of a child, and for children, having a caregiver die, experiencing a collapse in caregiver support – higher risk of PCBD
- Common morbidities - Posttraumatic Stress Disorder, Major Depressive Disorder, Substance Use Disorders



# Part 5.4

(F 43.0)

Acute Stress Disorder

(p. 280)

“Trauma- and Stressor- Related Disorders”

# Acute Stress Disorder (ASD)

- Symptoms of acute stress disorder usually begin during or immediately after exposure to a traumatic event (e.g., war, threatened - or actual - physical assault) and include re-experiencing the event arousal symptoms, avoidance symptoms
- Dissociative symptoms may be included, but are no longer required
- Major differences between Acute Stress Disorder & Posttraumatic Stress Disorder include:
  - The time of onset
  - The duration criterion
- Acute Stress Disorder persists for at least 3 days to 1 month during this time
  - A minimum of 9 out of 14 symptoms from any of the five categories must be present
- Most people who have been exposed to a traumatic life event do not develop Acute Stress Disorder
  - Acute Stress Disorder is diagnosed in 20% to 50% of interpersonal traumatic events (e.g., assault, rape, witnessing a mass shooting) and fewer than 20% of cases that do not involve interpersonal assault (such as motor vehicle accidents or industrial accidents)
  - Females are at increased risk of the development of Acute Stress Disorder, possibly due to a greater risk of exposure to interpersonal assault (APA, 2013)
  - A review of 22 studies indicates that at least half of trauma survivors who initially develop acute stress disorder will subsequently meet the criteria for Posttraumatic Stress Disorder (Bryant, 2011)
- The 3-day window allows for people to have a normal reaction to a stressful life event, without being considered to have a disorder
- The majority of people who experience trauma will not develop Acute Stress Disorder, or eventual Posttraumatic Stress Disorder





# Part 5.5

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## Adjustment Disorders

(p. 286)

“Trauma- and Stressor- Related Disorders”

# Adjustment Disorders

- ▶ Adjustment disorders are some of the most frequently diagnosed disorders in clinical practice
- ▶ Any stressful life event...
  - ▶ Bullying
  - ▶ Divorce
  - ▶ Receiving a medical diagnosis
  - ▶ Being fired from a job
    - ▶ ... can be a precipitating factor that triggers disturbing thoughts, anxiety, depression or unusual behavioral changes that affect relationships or cause problems at home, work, or school
- ▶ As many as 30% of people experiencing a recurrence of cancer will develop symptoms of an adjustment disorder (Okamura et al., 2002)

## Description of the Disorder

- Adjustment disorders are one of the few disorders in DSM-5 that is time-limited
- Specifically, the symptoms occur within 3 months of a precipitating event, are out of proportion to what would be expected, and remit within 6 months of the end of the stressor
- In some cases, the symptoms of an adjustment disorder may persist beyond the 6-month cut-off because the precipitant (such as a disabling medical condition or a prolonged child-custody battle) is chronic and enduring
  - In this case, the diagnosis may be maintained for many months or even years
  - However, an adjustment disorder that persists for more than 6 months without a prolonged continuation of the stressor would be diagnosed as other specified trauma-and stressor-related disorder
- Six types of adjustment disorders are identified in the DSM-5 and should be specified:
  - With depressed mood
  - With anxiety
  - With mixed anxiety and depressed mood
  - With disturbance of conduct
  - With mixed disturbance of emotions and conduct
  - Unspecified
- Adjustment disorder with depressed mood is the most commonly occurring, followed by adjustment disorder with anxiety (Pelkonen, Marttunen, Henriksson & Lonnqvist, 2005)
- Adjustment disorders are also associated with an increased risk of suicide
- One study found that as many as 1 / 3 of adolescents who died by suicide had a diagnosis of adjustment disorder (Casey & Bailey, 2011)

## Description of the Disorder

- Prevalence rates vary widely for adjustment disorders, depending on the population being studied
  - Between 7% and 28% of people seeking out-patient mental health treatment and 50% of those in hospital psychiatric settings meet the criteria for an adjustment disorder (APA, 2013; Casey, 2009; Mitchell et al., 2011; Pelkonen et al., 2005)
- Positive events can be stressors, too
- Many people experience adjustment disorders:
  - After leaving home for the first time
  - Getting married
  - Having their first child
  - Retiring from work
- Sometimes it can be difficult to determine whether a person is experiencing a normal reaction to a stressful life situation or whether it is an adjustment disorder
  - If the reaction is out of proportion to what would be expected for the situation, or the alteration in mood, anxiety, or conduct result in functional impairment, an adjustment disorder should be considered
- Cultural considerations should be taken into account when diagnosing an adjustment disorder
  - In some cultures, strong emotional reactions to specific life event, such as bereavement, are expected
    - Whether the reaction is considered maladaptive or stronger than what would be normative for the culture should be taken into consideration

## Children and Adolescents

- ▶ Children who experience adjustment disorders are likely to exhibit changes in behavior and even disturbances in conduct
- ▶ The presence of a childhood adjustment disorder is generally predictive of a more serious disturbance later in life (Andreasen & Hoenck, 1982)
- ▶ Normal bereavement would be considered to be an adjustment disorder, but if the grief persists or is of the intensity beyond what might be expected when cultural, religious, or age appropriate consideration are made, then the diagnosis may be appropriate
- ▶ If the symptoms are severe, persistent complex bereavement disorder, which is listed in the DSM-5 Section III “conditions for Further Study,” may be diagnosed

# Client Characteristics

- ▶ **People with adjustment disorders tend to present with extreme anxiety and feelings of being unable to cope with a stressful life situation**
  - ▶ Depressed mood and acting out behavior (e.g. drinking, irritability) may also be present
  - ▶ Environmental change can sometimes help to reduce symptoms
- ▶ **Life can sometimes be stressful, and people who have a history of coping well with stressful life circumstances are generally those who have:**
  - ▶ A strong support systems in place
  - ▶ A positive attitude about life
  - ▶ Meaningful relationships
- ▶ **Individuals are more likely to adapt to life's problems:**
  - ▶ If their overall functioning is good prior to the event
  - ▶ If they have advanced education
  - ▶ If they are in a stable relationship
  - ▶ If they are financially stable situation
- ▶ **Healthy coping is also more likely to occur if there is only one stressor**
- ▶ **In such cases spontaneous remission of symptoms may occur, and the individual may never seek treatment**
- ▶ **It is not uncommon for people who seek treatment for an adjustment disorder to have subclinical symptoms of anxiety or depressed mood**
  - ▶ Often, ineffective coping styles prevent them from resolving the problem or accepting the intuition in which they find themselves
  - ▶ Multiple stressors, also known as “stressor pile-up”, may also result if several stressful life events occur are once, such as being firing from a job after a diagnosis of cancer, or living through a natural disaster

# Adjustment Disorder and Suicide

- ▶ **Common factors that tend to precede the development of an adjustment disorder include family conflict, poorly controlled physical pain, alcohol or other substance-related disorders, financial difficulties, and a history of mood or anxiety disorders**
  - ▶ **In one study, depression was found to co-occur with adjustment disorders 46% of the time**
  - ▶ **Substance abuse is also common, as people use alcohol and other drugs to reduce stress and attempt to cope with the problem**
    - ▶ **In one study, 59% of individuals first diagnosed with an adjustment disorder were later re-diagnosed with a substance use disorder (Greenberg, Rosenfeld & Ortega, 1995)**
- ▶ **Other co-occurring disorders include anxiety disorder, panic disorder, conduct and behavioral disorders in children**
- ▶ **Adjustment disorders are associated with higher rates of suicide, therefore adolescents and adults who present with adjustment-related disorders should be carefully assessed and a safety plan developed, if it is determined to be necessary (Strain, Klipstein & Newcorn, 2011)**
  - ▶ **Recent demographic information predicts that as the baby boom generation ages, the suicide rate will go up, especially for males and those with a high school diploma or less (Phillips, 2010; Phillips, Robin, Nugent & Idler, 2013)**
  - ▶ **Additional stressors commonly associated with aging (e.g. economic strain, chronic illness, depression and anxiety) can also contribute and increase the risk of suicide**
  - ▶ **One study found that women in midlife who are single, widowed, or divorced also have a higher rate of depressive symptoms and an increased risk of suicide (Bernal et al., 2007)**

# Adjustment Disorder and Suicide

- Adjustment disorders seem to occur more frequently in adolescents and children who have more serious losses and possess developmentally less mature coping strategies
- Common precipitants include:
  - The loss of a caregiver
  - Parental divorce
  - Moving
  - Changing schools
  - Abuse
- Difficult social interactions bullying, anxiety over poor grades, teen pregnancy, and other adolescent stressors can also result in a diagnosis of adjustment disorder, depending on factors such as the child's age, level of family support, and temperament
- Disappointment in relationships was the most often cited precursor to the development of an adjustment disorder in adolescents (Benton & Lynch, 2006)
  - Adolescent suicide attempts are also related to interpersonal difficulties with parents, teachers, or others
- It may be the result of severe stress, as in an adjustment disorder, and may be exacerbated by alcohol and substance abuse, which are taken as a way of self-medicating the emotional pain
  - Their effects are additive with adjustment disorders
- The biggest predictor of suicide is a history of prior suicide attempts
  - As many as 40% of people who complete suicide have attempted before
  - In adolescents, such attempts are often related to family history of suicide, depression, or having been abused
  - Although suicide attempts occur 3 Xs more often in adolescent girls than in boys, adolescent boys are 5 times more likely to die by suicide
- Males tend to use more lethal mean (e.g., firearms, jumping from a high place, asphyxiation) than girls, and girls are more likely to take an over dose of prescription medications or other drugs (e.g., self-poisoning)



## Preferred Therapist Characteristics

- Treatment for adjustment disorders is usually short, often urgent, and mainly focused on helping people cope more effectively with changing life circumstances
- Therapists who are supportive, empathic, and affirming are the most likely to help clients mobilize the personal resources and resilience needed to get through the current crisis
  - A collaborative attitude and the ability to provide some direction and guidance in decision-making can be helpful
  - Psychoeducation, brief and structured interventions and referrals to outside sources of support can be helpful
- Most people will respond well to treatment and move on with time
- Therapists should be prepared, however, to help people in distress who do not have adequate social support or other reserves to see them through the current crisis, as well as those feeling emotionally overwhelmed, hopeless, or even suicidal
- Because of the frequent overlap in symptoms between adjustment disorder and a broad range of other disorders, therapists must also be adept at recognizing when the following disorders are interfering with the person's ability to cope:
  - Major depressive disorder
  - Generalized anxiety disorder
  - Personality disorder

# Assessment

- ▶ **Despite being one of the most diagnosed disorders in clinical practice, no assessment tool has yet to be developed specifically for adjustment disorders (Casey & Bailey, 2011)**
  - ▶ **Of the clinical interviews, only the Structured Clinical Interview (SCID; First, Spitzer, Gibbon & Williams, 2002) includes a section on adjustment disorders**
- ▶ **Even without such tools, therapists must be able to differentiate between normal reactions to stressful life events (e.g., sadness and anger after a job loss) from reactions that are pathological (suicide or homicidal ideation after a job loss)**
  - ▶ **Nothing can take place of a good clinical assessment and history taking that considers context, course, prior to level of functioning and treatment history**
- ▶ **Clinicians can gain a better understanding of intensity and severity of symptoms by using certain instruments designed to assess levels of stress, depression and anxiety**
- ▶ **Validated inventories such as the Beck Depression Inventory and the Beck Anxiety Inventory (Beck & Steer, 1990; Beck, Steer & Brown, 1996) will help determine whether symptoms are severe enough to constitute a separate diagnosis of those disorders**

# Assessment

- ▶ **The cross-cutting symptoms measure for depression and anxiety DSM-5 can be used to determine whether symptoms are mild, moderate or severe**
  - ▶ **Assessment measure are availed for adults, children (ages 11-17) and parents of young children**
  - ▶ **If symptoms warrant the diagnosis of depression or anxiety, then adjustment disorder is ruled out the cross-cutting measures are available online**  
at [www.psychiatry.org/practice/dsm/dsm5.online-assessment-measures](http://www.psychiatry.org/practice/dsm/dsm5.online-assessment-measures)
- ▶ **In general, adjustment disorder can be characterized as falling in between “no diagnosis” and a diagnosis of an affective disorder (depression, anxiety, or PTSD) (Fernandez et al., 2012)**
  - ▶ **Often, people with adjustment disorders are treated for depression (with antidepressant medication) for symptoms of anxiety (with benzodiazepines)**
  - ▶ **In one study, researchers found that 45% of those diagnosed with adjustment disorder were prescribed an antidepressant, despite the lack of any evidence-based research to support the usage for adjustment disorders**
  - ▶ **The use of brief psychological therapy is the recommended treatment for adjustment disorders (Fernandez et al., 2012)**

# Intervention Strategies

- Adjustment disorders are likely to remit spontaneously when stressors are removed, accepted, or resolved
- Therapy can help to facilitate recovery by providing a supportive environment in which maladaptive thought processes and behavior patterns can be addressed before poor choices and self-destructive behaviors have adverse consequences
- The goal of therapy should be the following:
  - Helping clients develop problem-solving techniques to reduce or remove the stressors
  - Strengthening coping skills
  - Altering the person's response to the stressor when it cannot be removed, through the use of acceptance, relaxation and mindfulness-based technique
- A short term crisis-intervention model can be helpful in treating individuals with adjustment disorders
  - The therapist's understanding of the nature of the crisis that led to the development of an adjustment disorder can guide the selection of appropriate treatment intervention
  - But, much like treating the common cold, treatment for adjustment disorders tends to focus on reducing specific symptoms
  - The client's current recourses and coping mechanisms will provide the foundation for treatment, and the therapist should work to increase client's awareness of their existing strengths, to build those strengths, and to help them develop new coping skills if necessary
- Very little research has been focused on the treatment of adjustment disorders
  - Interventions used for other trauma and stressor-related disorders could also be appropriate for people with adjustment disorders, and should focus on anxiety, depression or other presenting symptoms (Strain & Friedman, 2011)
  - Brief, focused individuals therapy specific to the situation or stressor has been the norm, with the continuation of long-term supportive therapy for ongoing stressors (Casey & Bailey, 2011)

# Intervention Strategies

- ▶ Although not specific to adjustment disorder, and not all-inclusive, some research has been found the following therapist to be helpful for specific symptoms of adjustment disorder
  - ▶ Anxiety: Relaxation training, deep breathing exercises, Mindfulness-Based Stress Reduction (MBSR), Mindfulness-Based Cognitive Therapy (MBCT)
  - ▶ Sleep Problems: Mindfulness meditation; Yoganidra
    - ▶ Yoganidra – one of the deepest forms of meditations, leading awareness through many levels of mental processes to a state of profound stillness and insight
    - ▶ In Yoganidra, one leaves the Waking state, goes beyond the Dreaming state, and enters into Dreamless Sleep while remaining awake
  - ▶ Excessive Rumination: Rational Emotive Behavior Therapy (REBT), acceptance based cognitive therapist (Dialectical Behavior Therapy [DBT], Acceptance and Commitment Therapy [ACT])
  - ▶ Poor Self Care: Encourage healthy diet, exercise, regular medical examination
  - ▶ Work Related Stress: Cognitive therapy; Career counseling
  - ▶ Partner Relation Problems: Couples therapy to improve communication skills
  - ▶ Grief and Loss: Interpersonal therapy to focus on the loss; eventually participation in a support group specific to grief and loss
  - ▶ Disease or Medical-Related Anxiety or Depressed Mood: Supportive individual therapy, mindfulness-based stress reeducation, support groups specific to illness (cancer, pain management)
  - ▶ Affect dysregulation: Dialectical Behavior Therapy (DBT), Mindfulness-Based Stress Reduction (MBSR)
  - ▶ Behavioral problems: Psychoeducation about alcohol and substance use; Reality Therapy
  - ▶ Suicidal Ideation: Suicide assessment, prevention, and intervention

# Psychosocial Interventions

- ▶ Mindfulness-based practices that help people to recognize, tolerate and accept emotions related to life stressors can be a valuable coping skill for people who have difficulty regulating emotions and are going through life transitions or crisis (Dimidjian & Linehan, 2008)
- ▶ One recent Relational Cultural Therapy (RCT) compared mindfulness-based group therapy with Cognitive Behavioral Therapy (CBT) in primary care patients with depressive, anxiety, and/or adjustment disorders
  - ▶ Both groups improved equally on scales of anxiety and depression, leading the researchers to conclude that individual therapy, include Cognitive Behavioral Therapy (CBT), had no benefit over Mindfulness-Based Group Therapy [MBGT] (Sundqvist et al., 2014)
- ▶ Other studies in the United States, Norway and Denmark have found reductions in anxiety and depression, and improvement in subjective well-being (Jazalleri, Goldin, Werner, Ziv, & Gross, 2012; Wurtsen et al., 2013)
- ▶ A 28-week controlled study of yoga meditation for adjustment disorder found incremental change on measures of depression, anxiety, and overall functioning (Srivastava, Talukdar, & Lahan, 2011)
- ▶ A qualitative study of the self-perceived benefits of Mindfulness-Based Stress Reduction (MBSR) for cancer patients found reduced pain and anxiety associated with medical treatment (Mackenzie, Carlson, Munoz & Speca, 2007)
- ▶ Others have found improved relaxation, reduced symptoms of anxiety, and improved sleep (Ferguson & Sgambato; Kabat-Zinn, 1990)

# Psychosocial Interventions

- **It seems reasonable then, to recommend an 8-week program of Mindfulness-Based Stress Reduction (MBSR) for clients who are experiencing subclinical symptoms of anxiety or depression**
  - **If improvement does not start to occur, clients can be referred for medication management**
  - **Alternatively, the 30% to 40% of individuals who fail to achieve symptom relief after a course of antidepressants or benzodiazepines, should be referred for a course in mindfulness-based Cognitive Behavior Therapy (CBT) or Mindfulness-Based Stress Reduction (MBSR)**
- **There is some reason to believe that the group nature of the treatment can have a beneficial effect for some people**
  - **Of course for those who are not suited to group sessions, Mindfulness-Based Stress Reduction (MBSR) would be best suited**
- **A Randomized Controlled Trial (RCT) of breast cancer survivors found that participation in mindfulness based stress reduction classes reduced depression and anxiety, and improved quality of life compared to a control group who did not participate (Lengacher et al., 2009)**
- **Problem-solving therapy has been recognized as an evidence-based application for behavior disorders, marriage and relationship issues, suicidal ideation, and people with medical conditions (Nezu, Nezu & McMurrin, 2008)**

# Psychosocial Interventions

- Cognitive therapy has been shown to help people who have problems at work, as does career counseling, and psychoeducation about career-related stressors
  - In one study, subjects receiving Dialectical Behavior Therapy (DBT) were half as likely as those who did not receive Dialectical Behavior Therapy (DBT) to make a suicide attempt (Lineham et al., 2006)
- Dialectical behavioral therapy is more likely to help clients with adjustment disorders not only learn how to regulate emotional distress, but learn to reduce such distress to a manageable level
- Intervention strategies will be unique to the person's specific stressor, resilience factors, and the presence of any co-occurring disorders
  - Clinical judgement, combined with effective treatment strategies for type of adjustment disorder (e.g. anxiety, depression, disturbances of conduct) seems best
- One study of 70 men and women diagnosed with adjustment disorders, randomly assigned the subjects to four commonly used treatments...
  - Supportive psychotherapy
  - Placebo
  - Antidepressants
  - Benzodiazepines
    - The author found that all four methodologies were associated with significant improvement in symptoms (de Leo, 1989)
- Clearly, additional research is indicated to determine the best course of treatment for this disorder



## Medication

- **Counseling should be recommended before medication, even though few controlled studies have been conducted specifically on the treatment of adjustment disorders**
- **If the psychological interventions do not significantly reduce the client's distress or if the symptoms of depression or anxiety become severe enough, it may be beneficial to refer the client for medication management**
- **Although, if symptoms are severe, one must consider whether a diagnosis of depressive disorder or an anxiety disorder might be more appropriate**
- **Recent research indicates that more people with adjustment disorders are treated with anti-anxiety medications than those who seek psychotherapy**
  - **Although such medication may reduce the initial anxiety, it does not help to promote coping skills, resilience, or provide the support that talking with a therapist offers**
  - **The possibility also exists that people who are experiencing normal stress will be medicated for what is really a normal grief reaction (Doka, 2013)**
- **Any use of medication should be symptom-focused, time-limited, and as an adjunct to psychotherapy**
- **Because of the increased risk of suicide associated with adjustment disorders, clinicians should also conduct a careful assessment of suicidal risk, including current suicidal ideation, and any history of suicide attempts**

# Medication

- ▶ **Positive coping strategies may also be disrupted, leading to the development of an adjustment disorder**
  - ▶ **Assessing positive coping skills, resilience, and support can be helpful in developing treatment strategies (Carl, Soskin, Kerns, & Barlow [2013])**
- ▶ **The Coping Inventory for Stressor Situations (Endler & Parker, 1990) is a 48-item self-report designed to measure three types of coping styles (active, passive, and avoidant)**
  - ▶ **Each style can be adaptive depending on the situation**
  - ▶ **In one study, for example, people with chronic pain who used more passive coping strategies tended to have more pain than those who used emotion-focused types of pain coping (Smith, Lumley, & Longo, 2002)**

# Family Therapy

- ▶ Depending on the age, circumstance, and incident, stress-reactions are likely to affect the entire family
  - ▶ At least a few sessions of family therapy may be warranted and can help to solidify the support the person is receiving, and ensure their efforts to cope are not being undermined
  - ▶ Especially when the stressor is life-changing (e.g., divorce, terminal illness, job transfer, new baby) involving the entire family can help everyone to gain perspective and pull together as a unit
- ▶ Treatment for children and adolescents will differ from adult treatment and should include a preventive component since there is some, albeit dated, evidence (Andresen & Hoenck, 1982), that indicates:
  - ▶ Adolescents who are diagnosed with adjustment disorders tend to eventually develop another mental disorder
  - ▶ Adolescents are at increased risk of suicide, at least partially due to their impulsivity (Portzky, Audenaert, van Heeringen, 2005)

# Bibliotherapy

- **Bibliotherapy (movie therapy) can also help to normalize the feelings that the client is experiencing**
- **Many excellent books are available to help children cope with the loss of a loved one including:**
  - *Tear Soup: A Recipe for Healing After Loss* (Schwiebert & DeKlyen, 2005)
  - *The Invisible String* (Kart & Stevenson, 2000)
- **Bibliotherapy can also be helpful for normalizing other types of life changes, such as:**
  - Divorce (Trafford, 2009, 2014)
  - Loss of love (Viorst, 2002)
  - Career change (Bolles, 2015; Coelho, 2005)
  - Retirement (Nelson & Bolles, 2010)
  - Cancer (Seligman, 1996)

# Prognosis

- ▶ **The prognosis for adults, particularly women, with adjustment disorders is excellent**
  - ▶ **Therapy for adjustment disorders can be a growth-promoting experience for many people**
    - ▶ **Most return to their previous level of functioning, and many seem to function even better because of the self-confidence they have gained, improved coping skills, and reinforcement of social support that results from reaching out to family, friends, and support groups**
- ▶ **The prognosis for men, adolescents, and those with behavioral symptoms or comorbid disorders is not as good**
  - ▶ **Adolescents with adjustment disorders frequently go on to develop a more severe disorder (Benton & Lynch, 2006)**
  - ▶ **Adolescent males, in particular, have been found to have increased suicidal ideation after the occurrence of a severe stressor (Portsky et al., 2005)**
  - ▶ **People who have experienced repeated stressors, or who have co-occurring personality disorders, depression, or anxiety disorders may also have a more difficult time adapting**
- ▶ **Some research indicates that people who receive treatment for adjustment disorders tend to seek therapy for other problems later in life**
  - ▶ **Perhaps they benefited from treatment and look to therapy as a positive opportunity for additional personal growth**
  - ▶ **Perhaps it is merely an indication of incomplete recovery**
    - ▶ **Either way, it points to the need for more research on the topic**

# Differential Diagnosis: Posttraumatic Stress Disorder/Acute Stress Disorder or Adjustment Disorder

- ▶ **How do you determine a diagnosis of Posttraumatic Stress Disorder over a diagnosis of Adjustment Disorder?**
  - ▶ **Posttraumatic Stress Disorder/Acute Stress Disorder require a certain type of event AND has specific symptom requirements?**
  - ▶ **With Adjustment Disorders, the stressor can be of any severity or type rather than that required by Posttraumatic Stress Disorder's Criterion "A"**
    - ▶ **The diagnosis of an Adjustment Disorder is used when the response to a stressor that meets Posttraumatic Stress Disorder's Criterion "A" does not meet all other Posttraumatic Stress Disorder criteria (or criteria for another mental disorder)**
  - ▶ **An Adjustment Disorder is also diagnosed when the symptom pattern of Posttraumatic Stress Disorder occurs in response to a stressor that does not meet Posttraumatic Stress Disorder Criterion "A" (e.g., spouse leaving, being fired)**



# Part 5.6

(F 43.8)

Other Trauma- and Stressor-Related Disorder  
(p. 289)

“Trauma- and Stressor- Related Disorders”

# General Notes About Other Specified & Unspecified Trauma- and Stressor-Related Disorders

- ▶ No more “Not Otherwise Specified” (NOS) diagnoses
  - ▶ Replaced with an attempt at greater detail
    - ▶ “Other specified...”
    - ▶ “Unspecified...”
- ▶ The creators of the DSM-5 has replaced the previous “NOS” diagnoses
  - ▶ Throughout DSM-5, not just this chapter



## (F 43.8) Other Specified Trauma and Stressor-Related Disorder (p. 289)

- Other Trauma and stressor-related disorder would be the appropriate diagnosis for symptoms that do not meet the full criteria of any of the disorders in this category
- The reason the full criteria have not been met should be listed
- Examples:
  - Adjustment-like disorders with delayed onset of symptoms that occur more than 3 months after the stressor
  - Adjustment-like disorders with prolonged duration of more than 6 months, without prolonged duration of the stressor
  - *Ataque de nervios*: See “Glossary of Cultural Concepts of Distress” (DSM-5 Appendix, p. 833)
    - Translated as “Attack of Nerves” – is a syndrome among individuals of Latino descent, characterized by symptoms of intense emotional upset, including acute anxiety, anger, or grief; screaming and shouting uncontrollably; attacks of crying; trembling; heat in the chest rising into the head; and becoming verbally and physically aggressive
    - A general feature of an *ataque de nervios* is a sense of being out-of-control
    - Many report their losing control stems from the accumulated experience of suffering
  - Other cultural syndromes: See “Glossary of Cultural Concepts of Distress” (DSM-5 Appendix, p. 833)
  - Persistent Complex Bereavement Disorder (PCBD) - this disorder is characterized by severe and persistent grief and mourning reactions (see the chapter “Conditions for Further Study)



# Part 5.7

(F 43.9)

Unspecified Trauma- and Stressor-Related Disorder  
(p. 290)

“Trauma- and Stressor- Related Disorders”

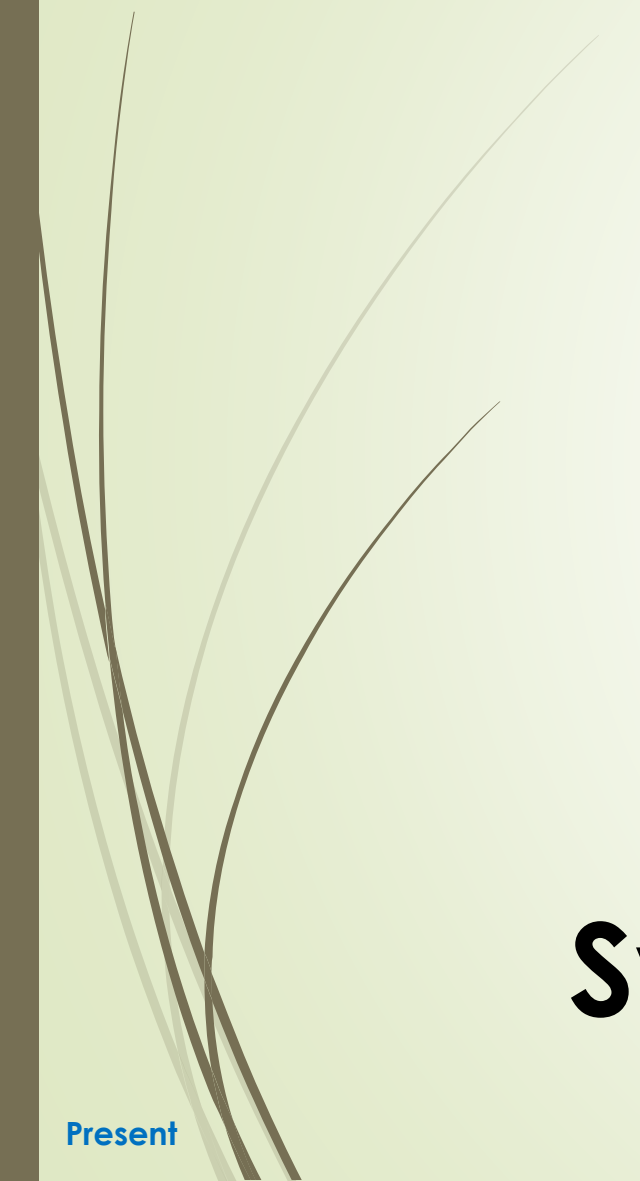

## (F 43.9) Unspecified Trauma- and Stressor-Related Disorder (p. 290)

- ▶ This category is appropriate when symptoms are similar to one of the disorders in the Trauma- and Stressor- Related Disorder category, but the clinician does not have enough information to make a valid diagnosis
- ▶ Clinician does not state why criteria are not meant for another disorder in this section
- ▶ Likely to arise through convenience, e.g., an emergency room situation
- ▶ With “Unspecified...”, the clinician does not have enough information



# Part 6

**Brief overview of the new  
DSM-5 assessment measures**



**For**

**Initial Assessment**

**and**

**Symptom / Disability Tracking**

# Using New Assessment Tools for Clients with Trauma- and Stress- Related Disorder Diagnoses

- Psychiatry.org (all measures are Free of Charge) for public consumption
  - Available here:
    - <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Recommended, not required, for a DSM-5 diagnosis
- Why does DSM-5 contain these measures?
  - Global Assessment of Functioning [GAF; Axis V in DSM-IV (TR)] deemed insufficient
  - It was determined that we should assess symptom severity and disability separately
  - “Cross-Cutting” Symptoms – we are able to assess and monitor symptoms that are common throughout many disorders
- Why might you want to use these?
  - Good practice to monitor client symptomatology and disability over time
    - For empirical support, Lambert & Hawkins, 2004 – main recommendation is to “assess” early on
  - Increase chances of reimbursement for particular tests and/or treatments
  - Third-party payers might eventually require some or all of these
- Historically, payers approved the nature and extent of services based upon:
  - GAF scores
  - Diagnosis
  - Severity of symptoms
  - Danger to self or others
  - Disability across life contexts

# Basic DSM-5 Assessment Procedure

- With the elimination of the Multiaxial system, counselors will no longer note a GAF score, and will NOT have an assessment of functioning built into the documentation process
- **Symptomology 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
  - With additional *disorder-specific* symptomatology measures
- **Disability (impairment)**
  - WHODAS 2.0
- **Other types of measures**
  - Personality
  - Cultural formulation
  - Early development
  - Home background

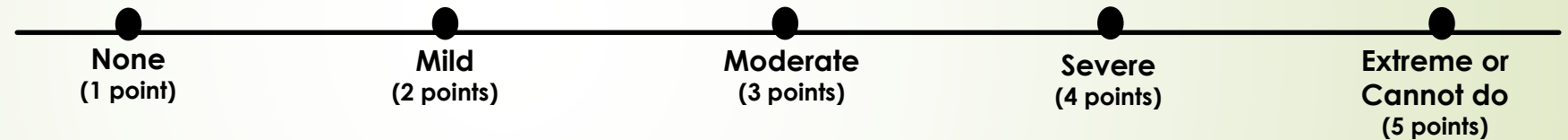
## Understanding WHODAS 2.0

- The APA (2013) recommended the WHODAS 2.0 as a preferred measure for use in assessing clients' functioning
  - The WHODAS 2.0 can be used with clients who have a mental or physical condition/disorder
  - The WHODAS 2.0 is a free assessment instrument that is provided in the DSM-5, included on the World Health Organization's website and available through the DSM-5 online assessment measures website ([www.psychiatry.org/dsm5](http://www.psychiatry.org/dsm5))
- A great WHODAS 2.0 manual is available free of
  - Ustün, Kostanjsek, Chatteriji, & Rehm (2010) concluded that the instrument is robust and easy to use after repeated practice and use
  - Detailed explanation and breakdown of the WHODAS 2.0 is available here:
    - [http://apps.who.int/iris/bitstream/10665/43974/1/9789241547598\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/43974/1/9789241547598_eng.pdf)



# Understanding WHODAS 2.0

- The WHODAS 2.0 is a 36-item measure that assesses disability in people 18 years and older
  - It assesses for disability across 6 different domains:
    - Self-care
    - Getting around
    - Understanding and communicating
    - Getting along with people
    - Life activities (e.g., work and/or school activities)
    - Participation in one's community/society
  - When completing the form, clients rate the six areas based on their functioning over the past 30 days
  - Respondents are asked to respond as follows:



- Scoring of the assessment measure involves either:
  - Simple scoring (i.e., the scores are added up based on the items endorsed with a maximum possible score suggesting extreme disability as 180)
  - or
  - Complex scoring (i.e., certain items are weighted differently)
    - The computer program that provides complex scoring can be found on the World Health Organization's website
- The WHODAS 2.0 can be used to track changes in the client's level of disability over time
- Convenient, it can be administered at specified intervals that are most relevant to the clients' & counselors' needs

# DSM 5 “Cross-Cutting” Measures of Assessment

- **The DSM-5 Task Force and Work Groups developed and proposed the incorporation of dimensional measures, i.e., self (i.e., adult and child/adolescent), and informant-report (i.e., parent/guardian) versions of the DSM-5 Cross-Cutting (CC) Symptom measures - to help address the issue of co-occurring symptoms across mental disorders**
- **The self- and informant- reported versions of the DSM-5 Cross-Cutting Symptom measures were developed to serve as a “review of mental systems” in each patient who presents for mental health evaluation and treatment**
- **The measures assess the presence and severity of psychiatric symptom domains that cut across diagnostic boundaries**
  - **These include:**
    - **Depression**
    - **Anger**
    - **Mania**
    - **Anxiety**
    - **Somatic symptoms**
    - **Sleep disturbance**
    - **Psychosis**
    - **Obsessive thoughts and behaviors**
    - **Suicidal thoughts and behaviors**
    - **Substance use (e.g., alcohol, nicotine, prescription medication, and illicit substance use)**
    - **Personality functioning**
    - **Dissociation**
    - **Cognition/memory problems in adults**
  - **Many of the same domains, except for personality functioning, dissociation, and cognition/memory problems, are also assessed in children/adolescents, along with inattention and irritability**
  - **The co-occurrence and severity of these symptoms have been shown to significantly affect the prognosis and treatment of many mental disorders**

# DSM 5 Cross Cutting Measures of Assessment

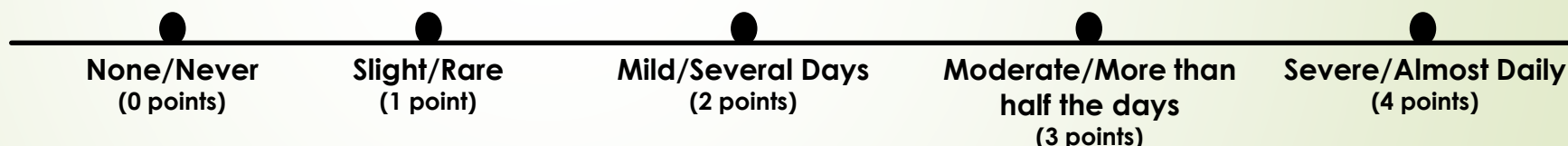
- ▶ **The intent is for all patients, regardless of the DSM diagnosis, to complete the DSM-5...**
  - ▶ **Level 1 symptom measure**
  - ▶ **Level 2 CC symptom measures**
    - ▶ **... routinely either at each clinic visit or at clinically-indicated intervals but prior to meeting with their clinicians**
- ▶ **This would enable clinicians to track the:**
  - ▶ **Presence**
  - ▶ **Frequency of occurrence**
  - ▶ **Severity**
    - ▶ **... of overall psychiatric symptomatology in their patients over time across diagnoses**
    - ▶ **... even in those areas not directly related to the patient's primary diagnosis**
- ▶ **This will also allow for the identification of heterogeneity (defined as diverse; different) within diagnoses, which is important for future research and understanding of mental disorders**

# Example of how one case assessment might progress: Adult PTSD Client

- **Symptomology assessment**
  - Client completes “Level 1” cross-cutting symptom measure
    - (Parent or Informant could complete)
  - Clinician reviews for areas of concern
    - Due to the score, the clinician has some 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**
  - Personality
  - Cultural formulation
  - Early development
  - Home background

# DSM 5 Cross Cutting Measures of Assessment

- ▶ The items on the DSM-5 CC Symptom measures do not relate to any specific disorder and as such are not intended to be diagnostic or to serve as screening measures for any disorder
  - ▶ Instead, the measures were developed to be used as adjunct tools to give clinicians quantitative ratings that characterize patients in a way that is simple, useful, and clinically meaningful
  - ▶ It is hoped that the information from these measures will inform clinical decision-making & treatment
  - ▶ For instance, the ability to characterize patients has the potential to lead to customizable treatment plans and improvement in treatment outcomes
- ▶ The DSM-5 Cross-Cutting Symptom measures are operationalized at 2 levels
  - ▶ Level 1 - consists of a 23-item (adults) or a 25-item (children/adolescents) measure of the presence and severity of symptoms over the past 2 weeks
    - ▶ The items, with the exception of suicide ideation, suicide attempts, and substance use in children/adolescents, are rated on a 5-point scale



- ▶ Higher scores indicate greater frequency of occurrence or greater degree of severity
- ▶ The suicide ideation, suicide attempts, and substance use items on the child/adolescent version of the scale are scored on a yes/no basis
- ▶ Items scored as 2 or greater (i.e., mild/several days) or with a “yes” trigger the completion of a more detailed assessment of that symptom domain using the associated self- or informant-reported DSM-5 Level 2 CC Symptom measure
- ▶ Level 2 Cross-Cutting measures - inquires about the presence and severity of symptoms within pure psychiatric domains during the past 7 days (e.g., the Altman Mania Scale for a more detailed assessment of mania, given the respondent endorsed the Level 1 mania item at a score of 2 or greater)



# Part 7

**Read the practice case studies  
in Microsoft Word.**

(As a reminder, you will not be tested on the practice case studies).



# Part 8

## References

# References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5<sup>th</sup> ed.)* Washington, DC: American Psychiatric Publishing.
- Bernier, A., & Dozier, M. (2003). Bridging the attachment transmission gap : The role of maternal mind-mindedness. *International Journal of Behavioral Development, 27*, 355-365.
- Boris, N. W., & Zeanah, C. H. (2005). Practice parameter for the assessment and treatment of children and adolescents with reactive attachment disorder in infancy and early childhood. *Child and Adolescent Psychiatry, 44*, 1206-1219.
- Briere, J. (2005). *Trauma symptom checklist for young children: Professional manual*. Lutz, FL. Psychological Assessment Resources.
- Briere, J. & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluation and treatment*. Thousand Oaks, CA: Sage.
- Bryant, R. A. (2011). Acute stress disorder as a predictor of posttraumatic stress disorder: A systematic review. *Journal of Clinical Psychiatry, 72*, 233-239.
- Bucknew, J. D., Lopez, C., Dunkel, S., & Joiner, T. E. (2008). Behavior management training for the treatment of reactive attachment disorder. *Child Maltreatment, 13*, 289-297.
- Carl, J. R., Soskin, D. P., Kerns, C., & Baarlo, D. H. (2013). Positive emotion regulation in emotional disorders: A theoretical review. *Clinical Psychology Review, 44*, 343-360.
- Carlier, I. V., Lamberts, R. D., Gersons, B. P. (1997). Risk factors for posttraumatic stress symptomatology in policy officers: A prospective analysis. *Journal of Nervous and Mental Disorders, 185*, 498-506.
- Casey, P. (2009). Adjustment disorder: Epidemiology, diagnosis and treatment. *CNS Drugs, 23*, 927-938.
- Coelho, P. (2005). *The Alchemist*. Scranton, PA: Thorndike Press.



# References

- Cohen, J. A., Deblinger, E., Mannarino, A. P. & Steer, R. A. (2004). A multisite, randomized, controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43, 393-402.
- Courtois, C. A., & Ford, J. D. (2013). *Treatment of complex trauma: A sequenced, relationship based approach*. New York, NY: Guilford Press.
- de Leo, D. (1989). Treatment of adjustment disorders: A comparative evaluation, *Psychological Rep*, 64, 51-54.
- Department of Veterans Affairs (2010). *VA/DoD clinical practice guidelines for the management of post-traumatic stress*. Washington, DC: Department of Veterans Affairs and Department of Defense.
- Dozier, M., Lindhiem, O., Lewis, E., Bick, J., Bernard, K., & Peloso, E. (2009). Effects of a foster parent training program on young children's attachment behaviors: Preliminary evidence from a randomized clinical trial. *Child and Adolescent Social Work Journal*, 26, 321-332.
- Dozier, M., Peloso, E., Lewis, E., Laurenceau, J., & Levin, S. (2008). Effects of an attachment-based intervention on the cortisol production of infants and toddlers in foster care. *Development and Psychopathology*, 20, 845-859.
- Duncan, L. G., Coatsworth, J. D., & Greenberg, M. T. (2009). A model of mindful parenting: Implication for parent-child relationships and prevention research. *Clinical Child and Family Psychology Review*, 12, 255-270.
- Foa, E. B., Keane, T. M., Friedman, J. & Cohen, J. A. (2009). *Effective treatments for PTSD*. New York, NY: Guilford Press.
- Friedman, M.J., Resick, P.A., Bryant, R.A., & Brewin, C.R. (2011). Considering PTSD for DSM-5. *Depression and Anxiety*, 28, 750-769.
- Friedman, M.J., Resick, P.A., Bryant, R.A., Strain, J., Horowitz, M., & Spiegel, D. (2011). Classification of trauma and stressor-related disorders in DSM-5. *Depression and Anxiety*, 28, 737-749.

# References

- Glowinski, A. (2011). Reactive attachment disorder: An evolving entity, *Journal of the American Academy of Child and Adolescent Psychiatry*, 50, 210-212.
- Greenberg, W. M., Rosenfeld, D. N., & Ortega, E. A. (1995). Adjustment disorder as an admission diagnosis. *American Journal of Psychiatry*, 152, 459-461.
- Hall, S. E. K., & Geher, G. (2003). Behavioral and personality characteristics of children with reactive attachment disorder. *Journal of Psychology*, 137, 145-162.
- Herman, J. (2012). CPTSD is a distinct entity: Comment on Resick et al. (2012). *Journal of Traumatic Stress*, 25, 256-257.
- Hetzel-Riggin, M.D. (2012). Emerging directions in traumatic stress disorders and treatment. *Journal of Traumatic Stress Disorders & Treatment*, 1, 1-2.
- Jazaleri, H., Goldin, P. R., Werner, K., Ziv, M., Gross, J. J. (2012). A randomized trial of MBSR versus aerobics exercise for social anxiety disorder. *Journal of Clinical Psychology*, 68, 715-731.
- Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness*. New York, NY: Dell Publishing.
- Kay, C., & Green, J. (2013). Reactive attachment disorder following early maltreatment: Systematic evidence beyond the institution. *Journal of Abnormal Child Psychology*, 41, 571-581.
- Lambert, M.J., & Hawkins, E.J. (2004). Measuring outcome in professional practice: Considerations in selecting and using outcome instruments. *Professional Psychology: Research and Practice*, 35, 492-498.
- Lilienfeld, S. O., Lynn, S. J., & Lohr, J. M. (Eds.). (2015). *Science and pseudoscience in clinical psychology* (2<sup>nd</sup> ed.), New York, NY: Guilford Press.
- Mantzios, M, (2014). Exploring the relationship between worry and impulsivity in military recruits: The role of mindfulness and self-compassion as potential mediators. *Stress and Health*, 30, 397-404.

# References

- Mares, S., & Torres, M. (2014). Young foster children and their careers: An approach to assessing relationships. *Clinical and Child Psychology and Psychiatry*, 19, 367-383.
- Martorell, G. A. & Bugental, D. B. (2006). Maternal variations in stress reactivity: Implications for harsh parenting practices with very young children. *Journal of Family Psychology*, 20, 641-647.
- Messman, T. L., & Long, P. J. (1996). Child sexual abuse and its relationship to revictimization in adult women: A review. *Clinical Psychology Review*, 16, 397-420.
- Morrison, J. (2014). *DSM-5 Made Easy: The clinician's guide to diagnosis*. New York, NY: The Guilford Press.
- National Institute for Clinical Excellence (NICE). (2005). Post-traumatic stress disorder (PTSD). The management of PTSD in adults and children in primary and secondary care. *Clinical Guideline*, 26. London, UK: NICE.
- Nelson, J. E., & Bolles, R. N. (2010). *What color is your parachute? For retirement (2<sup>nd</sup> ed.)*. Berkeley, CA: Ten Speed Press.
- Ohan, J., Myers, K., & Collett, B. (2002). Ten year review of rating scales: IV. Scales assessing trauma and its effects. *Journal of the American Academy of Child and Adolescent Psychiatry*, 41, 1401-1422.
- Okamura, H., Watanabe, T., Narabayashi, M., Katsumata, N., Ando, M., & Adachi, I. (2002). Psychological distress following first recurrence of disease in patients with breast cancer: Prevalence and risk factors. *Breast Cancer Research and Treatment*, 61, 131-137.
- Pantalon, M., & Motta, R. W. (1998). Effectiveness of anxiety management training in the treatment of posttraumatic stress disorder: A preliminary report. *Journal of Behavioral therapy and Experiential Psychiatry*, 29, 21-29.
- Pelkonen, M., Marttunen, M., Henrikson, M., & Lonnqvist, J. (2005). Suicidality in adjustment disorder, clinical characteristics of adolescent outpatients. *European Child and Adolescent Psychiatry*, 14, 174-180.

# References

- Phillips, J. A. (2013). Factors associated with temporal and spatial patterns in suicide rates across U.S. states, 1976-2000, *Demography*, 50, 591-614.
- Phillips, J. A., Robin, A. V., Nugent, C. N., & Idler, E. L. (2010). Understanding recent changes in suicide rates among middle-ages: Period or cohort effects? *Public Health Reports*, 125, 680-688.
- Pitman, R.K. (2013). A brief nosological history of PTSD. *Journal of Traumatic Stress Disorders & Treatment*, 2, 1-4.
- Ponniah, K., & Hollon, S. D. (2009). Empirically supported psychological treatments for adult acute stress disorder and posttraumatic stress disorder: A review. *Depression and Anxiety*, 26, 1086-1090.
- Portzky, G., Audenaert, K. & van Heeringen, K. (2005). Adjustment disorder and the course of the suicidal process in adolescents. *Journal of Affective Disorder*, 87, 265-270.
- Reichenberg, L. W., & Seligman, L. (2016). *Selecting Effective Treatments: A comprehensive, systematic guide to treating mental disorders* (5<sup>th</sup> ed.) Hoboken, NJ: Wiley.
- Resick, P.A., Bovin, M.J., Calloway, A.L., Dick, A.M., King, M.W., Mitchell, K.S., Suvak, M.K., Wells, S.Y., Stirman, S.W., & Wolf, E.J. (2012). A critical evaluation of the complex PTSD literature: Implications for DSM-5. *Journal of Traumatic Stress*, 25, 241-251.
- Resick, P. A. & Schnicke, M. K (1992). Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology*, 60, 748-756.
- Romer, D., & Walker, E. (Eds.). (2007). *Adolescent psychopathology and the developing brain: Integrating brain and prevention science*. New York, NY: Oxford University Press.
- Rutter, M., O'Connor, T. G., & English and Romanian Adoptees (ERE) Study Team. (2004). Are there biological programming effects for psychological development? Findings from a new study of Romanian adoptees. *Developmental Psychology*, 40, 81-94.

# References

- Schechter, D. S. (2012). The developmental neuroscience of emotional neglect, its consequences, and the psychosocial interventions that can reverse them. *American Journal of Psychiatry*, 169, 452-453.
- Schechter, D. S., & Wilhelm, E. (2009). When parenting becomes unthinkable: Intervening with traumatized parents and their toddlers. *Journal of the American Academy of Child and Adolescents Psychiatry*, 48, 249-253.
- Scheeringa, M. S., Zeanah, C. H., & Cohen, J. A. (2011). PTSD in children and adolescents: Toward an empirically based algorithm. *Depression and Anxiety*, 38, 770-782.
- Schwiebert, P., & DeKlyen, C. (2005). *Tear soup: A recipe for healing after loss*. Portland, OR: Grief Watch.
- Seligman, L. (1996). *Promoting a fighting spirit: Psychotherapy for cancer patients, survivors, and their families*. San Francisco, CA: Jossey-Bass.
- Shapiro, F. (1989). Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. *Journal of Traumatic Stress*, 2, 199-223.
- Shreeve, D. F. (2012). *Reactive attachment disorder: A case-based approach*. New York, NY: Springer.
- Smith, J. A., Lumley, M. A., & Longo, D. J. (2002). Contrasting emotional approach coping with passive coping for chronic myofascial pain. *Annals of Behavioral Medicine*, 24, 326-335.
- Stein, D.J., Koenen, K.C., Friedman, M.J., Hill, E., McLaughlin, K.A., Petukhova, M., Ruscio, A.M., Shahly, V., Spiegel, D., Borges, G., Bunting, B., Caldas-de-Almeida, J.M., de Girolamo, G., Demyttenaere, K., Florescu, S., Haro, J.M., Karam, E.G., Kovess-Masfety, K., Lee, S., Matschinger, H., Mladenova, M., Posada-Villa, J., Tachimori, H., Viana, M.C., & Kessler, R.C. (2013). Dissociation in posttraumatic stress disorder: Evidence from the World Mental Health Surveys. *Biological Psychiatry*, 73, 302-312.
- Steuwe, C., Lanius, R.A., & Frewen, P.A. (2012). Evidence for a dissociative subtype of PTSD by latent profile and confirmatory factor analyses in a civilian sample. *Depression and Anxiety*, 29, 689-700.
- Strain, J.J., & Friedman, M.J. (2011). Considering adjustment disorders as stress response syndromes for DSM-5. *Depression and Anxiety*, 28, 818-823.
- Srivastava, M., Talukdar, U., & Lahan, V. (2011). Meditation for the management of adjustment disorder, anxiety and depression. *Complementary Therapies in Clinical Proactive*, 17, 241-245.

# References

- Suvak, M.K., & Barrett, L.F. (2011). Considering PTSD from the perspective of brain processes: A psychological construction approach. *Journal of Traumatic Stress, 24*, 3-24.
- Van der Kolk, B.A. (2014). *The body keeps score: Brain, mind, and body in the healing of trauma*. New York, NY: Viking.
- van der Kolk, B.A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress, 18*, 389-399.
- Van Dijk, S. (2011). *Don't let emotions run your life: Dialectical behavior therapy skills for helping teens manage mood swings, control angry outbursts, and get along with others*. Oakland, CA: New Harbinger.
- Van Dijk, S. (2011). *Don't let your emotions run your life for teens Dialectical behavior therapy skills for helping teens manage mood swings, control angry outburst, and get along with others*. Oakland, CA: New Harbinger.
- van Dijk, A., Ford, J.D., van der Hart, O., van Son, M., van der Heijden, P., & Buhning, M. (2012). Complex posttraumatic stress disorder in patients with borderline disorder and somatoform disorders. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*, 162-168.
- Viorst, J. (2002). *Necessary losses*. New York, NY: Fireside Books.
- Wolf, E.J., Lunney, C.A., Miller, M.W., Resick, P.A., Friedman, M.J., & Schnurr, P.P. (2012). The dissociative subtype of PTSD: A replication and extension. *Depression and Anxiety, 29*, 679-688.
- Zilberstein, K. (2014). Neurocognitive considerations in the treatment of attachment and complex trauma in children. *Clinical and Child Psychology and Psychiatry, 19*, 336-354.
- Zoellner, L.A., Rothbaum, B.O., & Feeny, N.C. (2011). PTSD not an anxiety disorder? DSM committee proposal turns back the hands of time. *Depression and Anxiety, 28*, 853-856.
- Zoladz, P.R., & Diamond, D.M. (2013). Current status on behavioral and biological markers of PTSD: A search for clarity in a conflicting literature. *Neuroscience and Biobehavioral Reviews, 37*, 880-895.



# Part 9

## Take Quiz

**(Can be found in Microsoft Word Document)**

## Reminder: Info about the Q U I Z

You will be quizzed  
on material from  
red areas

- Part 1 – Using the DSM-5
- Part 2 - Understanding DSM-5's (ICD-10-CM) codes and how they relate to mental health
- Part 3 - Brief overview of neurobiological research findings
- Part 4 - Brief overview of new chapter creation (Trauma- and Stressor- Related Disorders)
- Part 5 - Review of chapter (Trauma- and Stressor- Related Disorders)
  - Definition of the disorder
  - Client characteristics
  - Assessment
  - Preferred Therapist Characteristics
  - Intervention Strategies
  - Differential Diagnosis
  - Prognosis
- Part 6 - Brief overview of the new DSM-5 assessment measures
- Part 7 - Five practice case studies (with criterion-based explanations on comment field)
  - (Located in separate Microsoft Word Document)
- Part 8 - References
- Part 9 - Take Quiz
  - (Located in separate Microsoft Word Document)
  - (Entire presentation – including practice case studies – worth 3 CEUs)