DSM-5: TRAUMA AND STRESSOR RELATED DIAGNOSES

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TRAUMA TRAINING

Counselors should understand the “effects of...trauma-causing events on persons of all ages” (CACREP, 2009, p. 10)

Council for Accreditation of Counseling and Related Educational Programs (CACREP) emphasizes in both master’s and doctoral training levels the importance of understanding the implications of trauma theory, research and practice in counselor preparation and practice.

CACREP standards incorporate trauma training within all 8 core areas of knowledge and within each core counseling track.

TRAUMA IN THE DSM

In layman's terms, trauma typically refers to *both* the event that produces distress and the ensuing distress in an individual (Briere & Scott, 2006)

Trauma-and-stressor-related diagnoses presuppose exposure to traumatic event (APA, 2013)

What counts as a traumatic event?

- DSM-III—combat, violent assault, natural disasters (outside the range of usual human experience)
- DSM-III-R—expanded to include learning about or witnessing friend or family member exposure to life-threatening event

DSM-IV-TR

Defined a traumatic event as:

Involving actual or threatened death or serious injury or threat to one's physical integrity to self or other (Criterion A1)

Witnessing or learning about event

Subjective feeling of intense fear, horror or helplessness (Criterion A2)

Sudden and unpredictable

Shocking in nature (APA, 2000)

DSM-5

Traumatic event is described as exposure to actual or threatened death, serious injury, or sexual violence

Adds experiencing repeated or extreme exposure to aversive details of the traumatic event (collecting human remains; police officers repeatedly exposed to details of child abuse)

Specifies repeated exposure is not through electronic media, television, movies, or pictures– unless exposure is work related (APA, 2013)

Developmentally inappropriate sexual experiences without physical violence or injury (children)

TRAUMA & STRESSOR RELATED DIAGNOSES

Posttraumatic Stress Disorder

Acute Stress Disorder

Adjustment Disorders

Reactive Attachment Disorder

Disinhibited Social Engagement Disorder

Other Specified Trauma- and Stressor-Related Disorder

Unspecified Trauma- and Stressor-Related Disorder

PTSD IN *DSM-5*

No longer **Anxiety Disorder** – not all traumatizing events are fear based

Criterion A2 (response involves "fear, helplessness, or horror") *removed from DSM-5*

3 clusters are divided into 4 clusters in *DSM-5*

- Avoidance
- Intrusion / Re-experiencing
- *Persistent negative changes in mood and cognition*
- Arousal

3 new symptoms were added

Other symptoms revised to clarify symptom expression

All symptoms must have onset or significantly worsened after the traumatic event (*DSM-IV* only 7 symptoms explicitly tied to event)

Separate diagnostic criteria for "preschool" (children 6 years or younger)

New dissociative subtype for PTSD added

CHANGES TO CRITERION A

Criterion A was *expanded* to include ***sexual violence***

Indirect exposure (A3) was modified: learning about what happened – event must be accident or violent; added A4 – ***repeated extreme exposure to details*** (first responders, police, military mortuary workers, mental health / trauma clinicians – media exposure is excluded)

Eliminated sudden death of a loved one due to natural / medical causes (Friedman, 2013)

CHANGES TO CRITERION B

Criterion B: Intrusion

- Same 5 symptoms as *DSM-IV-TR*
- Endorse at least **1**
- "The memory of the trauma is at the heart of the diagnosis and the organizing core around which all of the other symptoms can be understood" (Friedman, 2013, p.550)

B1: Memories

- Applies only to distressing *involuntary* here and now recollection (sensory / emotional component)
  - Versus *DSM-IV-TR* ruminations / recollections (images, thoughts, perceptions)

B2: Nightmares

  - Includes trauma related dream content as well as instant replay of event

B3: Flashbacks

- Emphasis on dissociation and continuum of reactions (partial to total loss of awareness)

Note: In children look for repetitive play/ trauma specific reenactment

CHANGES TO CRITERION C

CRITERION C: Avoidance

- Numbing separated from avoidance (moved to Criterion D)
- From 7 symptoms to 2 symptoms; endorse at least 1
  - C1: Avoid internal reminders (memories, thoughts, feelings, talking about event)
  - C2: Avoid external reminders (activities, objects, situations, or people)

CHANGES TO CRITERION D

CRITERION D : Negative alterations in cognition and mood (APA, 2013**)**

- Changes in self or other appraisals and mood that began or worsened since event
- Numbing symptoms from *DSM-IV-TR* plus *two new symptoms*
- D1: Amnesia about aspects of event(not due to TBI or intoxication)
- D2:Negative beliefs (broader version of previous “foreshortened future”) – belief the self, world, future has been irrevocable altered because of the event
- *D3: Distorted cognitions and beliefs about blame (self / other) about causes or consequences of event*
- *D4: Negative emotions / mood state* (fear, horror, *anger*, guilt, shame)
- D5: Diminished interest
- D6: Detachment or estrangement
- D7: Inability to experience positive emotions

CHANGES TO CRITERION E

CHANGES TO CRITERION E: Arousal and Reactivity

- Formerly *hyperarousal* cluster (Criterion D)
  - Now encompasses behavioral reactivity to account for externalizing symptoms (aggression, recklessness, suicidality)
- Similar to *DSM-IV* but with *one new symptom:*
- E1: Irritable behavior and angry outbursts (distinguish between angry mood and angry behavior)
- *E2: Reckless or self-destructive behavior (new emphasis on behavior).* Ex: reckless driving, excessive alcohol use, suicidal behavior, risky sexual behavior
- E3: Hypervigilance
- E4: Exaggerated startle
- E5: Problems with concentration
- E6: Sleep disturbance

CHANGES TO CRITERIA F-H

CHANGES TO CRITERIA F-G: None

F. Duration is more than 1 month

G. Clinically significant distress or impairment

Added Criterion H:

H. Not attributed to the physiological effects of a substance or other medical condition.

Specify

- With dissociative symptoms
- With delayed expression – 6 months post event

IN SUMMARY…

In *DSM-5*, PTSD is now a trauma or stressor-related disorder initiated by exposure (direct / indirect) to a traumatic event that results in intrusive thoughts, avoidance, altered cognition or mood, and hyperarousal or reactive behavior that lasts more than a month, causes significant distress, and is not the result of substance abuse or a medical condition.

IMPLICATIONS FOR ASSESSMENT

- The expanded symptom set leads to extensive variations in possible trauma responses
- The increase in symptoms (from 17-20) results in over 600,000 possible symptom combinations for PTSD in *DSM-5* (Galatzer-Levy & Bryant, 2013)
  - Opposed to 70,000 possible combinations for PTSD in *DSM-IV-TR* (APA, 2000) -- This number was criticized for its *expansiveness*
  - Only 256 possible combinations for depression (Zoellner, Rothbaum, & Feeny, 2011)

IMPLICATIONS FOR ASSESSMENT

- Variation in behavioral presentation may lead to confusion for counselors and clients
  - Two clients present in dramatically different manner and receive same diagnosis
    - One may be distrustful, have violent nightmares and aggressive behavior
    - Another may be withdrawn, self-blaming, with internal negative emotions
  - Two clients could present with same symptomology but, due to *nature* of traumatic event, one is diagnosable and the other is not (ex: spouse leaving; being fired – PTSD vs Adjustment Disorder)
    - Complications in determining appropriate clinical interventions

CLINICAL ASSESSMENT

Informal Assessment

- Sensitivity in soliciting needed information early in counseling process
    - Some clients may be wary of sharing information while others recount detailed incidents
  - Foster therapeutic alliance to facilitate client disclosure
    - Remain aware of risk of re-traumatization and pace sessions accordingly
  - Practice acute observation skills – nonverbal clues of numbing, intrusion, arousal, dissociation
  - Behavioral responses – reckless and self destructive behavior
  - Cognitions – determine survivor's perception of event, self and world and how these may have changed post-trauma
  - Client safety – partner violence

(Jones & Cureton, 2014)

CLINICAL ASSESSMENT

Formal Assessment (Jones & Cureton, 2014)

- Provision of diagnostic assessments related to *DSM-5*
- Aid to capture the full range of symptoms as well as the severity of a particular diagnosis
- Online Assessment Measures www.psychiatry.org/psychiatrists/practice/dsm/dsm-5/online-assessment-measures
  - Level 1 Cross-Cutting Symptom Measures
  - Level 2 Cross-Cutting Symptom Measures
  - Disorder-Specific Severity Measures
  - Disability Measures
  - Personality Inventories
  - Early Development and Home Background

CROSS-CUTTING SYMPTOM MEASURES

Aid comprehensive mental status assessment by highlighting symptoms important across diagnoses

- Level 1
  - Brief assessment
  - Surveys include questions related to avoidance, sleep quality, repetitive unpleasant thoughts, and other symptoms in *DSM-5* PTSD criteria
  - Self-measure for adults, children 11-17; guardian-rated measure for children 6-17
- Level 2
  - More in-depth exploration of symptoms / certain domains

DISORDER-SPECIFIC SEVERITY MEASURES

Correspond closely to criteria that define disorder

- May be administered to individuals with diagnosis or with clinically significant syndrome that does not meet diagnostic criteria
- Self-completed and clinician completed
- Adults and children 11-17
  - National Stressful Events Survey PTSD Short Scale (NSESS)
  - Severity Measure for Depression, Adult
  - Severity Measure for Panic Disorder, Adult

NATIONAL CENTER FOR PTSD

- Updated measures to include *DSM-5* criteria
  - Clinician-Administered PTSD Scale for *DSM-5* (CAPS-5)
  - PTSD Checklist for *DSM-5*
  - Life Events Checklist for *DSM-5*

Website: www.ptsd.va.gov/

TREATMENT IMPLICATIONS

- Separation of avoidance and numbing (Asmundson, Stapleton, & Taylor, 2004)
  - Address each as unique symptom sets in client
  - Example:
    - Positive emotional numbing is neurologically based, unconscious, and out of control of survivor
    - Behavioral-based responses of purposeful avoidance to decrease arousal is conscious or conditioned
  - Degree of numbing vs avoidance suggest differential treatment approaches
    - Exposure beneficial for avoidance
    - Limited measures to assess response to treatment for numbing
  - Effective treatment multidimensional and multidisciplinary

TREATMENT IMPLICATIONS

Addition of symptoms in Criterion E

- *Reckless or self-destructive behavior* – encompasses suicidal behavior (Friedman, 2013)
  - Inclusion of self-destructive behavior as symptom of PTSD lends credence to strong correlations between PTSD and suicide risk
  - Counselors must be vigilant to warning signs of suicidality
  - Distress tolerance moderates PTSD symptom severity (Marshall-Berenz et al., 2010) and suicidal behavior (Anestis et al., 2013)

PRESCHOOL SUBTYPE: 6 YEARS OR YOUNGER

Diagnostic thresholds for children and adolescents lowered; preschool subtype added

Criterion A. In children (younger than 6 years), exposure to actual or threatened death, serious injury, or sexual violence, as follows:

- 1) Direct exposure
- 2) Witnessing, in person, (especially as the event occurred to primary caregivers) Note: Witnessing does not include viewing events in electronic media, television, movies, or pictures.
- 3) Indirect exposure, learning that a parent or caregiver was exposed

PRESCHOOL SUBTYPE: 6 YEARS OR YOUNGER

Criterion B –1 (or more) symptoms

- ***Intrusion symptoms*** may display as…
  - Play reenactment may not appear distressing
  - Dreams- content may not be related to trauma

Criterion C – 1 (or more) symptoms

- ***Avoidance symptoms***
- ***Alteration in cognitions or mood***
- Preschool does not include: amnesia; foreshortened future; persistent blame of self or others; reckless behavior

Criterion D – 2 (or more) symptoms

- ***Arousal symptoms***
- Extreme temper tantrums

PRESCHOOL SUBTYPE: 6 YEARS OR YOUNGER

Criterion E – Duration more than 1 month

Criterion F – Clinically significant distress /impairment

Criterion G – Not due to medical condition / medication

Specifiers:

- Dissociative symptoms
    - Depersonalization
    - Derealization
- Delayed onset
    - Criteria not met until 6 months after event

IMPLICATIONS FOR ASSESSMENT TREATMENT

Informal Assessment

- Even with developmentally appropriate criteria, informal assessment can be challenging
- Observations of behavior, interpersonal interactions, play, sleep patterns
- Recognition of trauma responses in children can help to identify survivors and lead to appropriate care
- Addition of preschool PTSD diagnosis points to importance of trauma therapy with children / families
    - CBT, TF-CBT, Play Therapy, Child-Parent Relational Psychotherapy

TRAUMA- AND STRESSOR-RELATED DISORDERS

Posttraumatic Stress Disorder

Acute Stress Disorder

Adjustment Disorders

Reactive Attachment Disorder

Disinhibited Social Engagement Disorder

Other Specified Trauma- and Stressor-Related Disorder

Unspecified Trauma- and Stressor-Related Disorder

ACUTE STRESS DISORDER

Acute stress disorder (ASD) “introduced in the *DSM-IV* as a new diagnosis to describe acute stress reactions (ASRs) that may precede posttraumatic stress disorder” (PTSD; Bryant et al., 2011, p. 802).

Transient disorder that may or may not develop into PTSD

Primary difference between ASD and PTSD is duration of symptoms and emphasis on dissociative reactions (*DSM-IV-TR*)

Two reasons for ASD diagnosis in *DSM-IV-TR*:

- Describe ASRs in initial month after trauma exposure (typically unrecognized or labeled adjustment disorder)
- Identify trauma survivors at high risk for development of PTSD

ACUTE STRESS DISORDER IN DSM-5

Criterion A changes same as PTSD updates – A1 is clarified; A2 is deleted.

Criterion B – Person now must meet **any 9 of the 14 symptoms** from 5 categories: intrusion (4), negative mood (1), dissociation (2), avoidance (2), and arousal (5)

- *DSM-IV-TR*'s ASD criteria was too heavily focused on dissociation; dissociation is no longer ***required*** for diagnosis
  - Dissociation is common under high stress and not necessarily associated with psychopathology
  - Requirement for dissociation precludes many high-risk patients from being identified – may play role in PTSD development in some individuals but not others (Bryant et al, 2011)

No one symptom of the 14 is required for a diagnosis.

ACUTE STRESS DISORDER IN DSM-5

- **Criterion C** – Duration **3** days to 1 month
  Criterion D – Clinically significant distress / impairment (social, occupational, other)
- **Criterion E** – Not due to substance or medical condition

IMPLICATIONS FOR ASSESSMENT AND TREATMENT

Time frame change (2 days to 3) reflects *International Classification of Diseases* (ICD-10) conceptualization of ASR as a transient reaction that is evident immediately after event and usually resolves in 2-3 days (Bryant et al., 2011)

Intended to reduce likelihood of false positives – people may no longer have the symptoms after 1-2 days

Also provides balance between diagnosing too early and making sure highly distressed individuals receive treatment as soon as necessary (Bryant et al., 2011)

IMPLICATIONS FOR ASSESSMENT AND TREATMENT

Elimination of requirement that individuals have symptoms from multiple symptom clusters

Requisite number of symptoms (9) ensures

- "(a) only the minority of trauma survivors are captured by the diagnosis, and
- (b) the symptoms are likely to describe marked stress responses that will be assisted by targeted intervention" (Bryant et al., 2011, p. 810)

In practice, this could mean that one client with ASD could have all four intrusion symptoms while another has none

(Barnhill, 2014)

CASE STUDY
(BARNHILL, 2014)

Traumatic Event:

- Premier of big-budget movie at local theater
- Man in ski mask appears in front of screen with assault rifle
- Fires directly into the audience
- People scream and mad rush for exit
- Becky (23) witnesses many people being shot, including woman sitting right next to her
- Terrified but able to fight toward exit and escape (uninjured) to parking lot
- Charles (25) also witnesses shootings
- Hides behind row of seats and is able to crawl to aisle and sprint to exit
- Covered in blood (of others) but escapes without physical injury

2 DAYS LATER:

Becky and Charles:

- Grateful to be alive but a “nervous wreck” – anxious and on edge
- Jump at slightest noise
- Watch tv for information on shooting
- Actual videotape footage of event results in panic attack, breaking out in sweat, being unable to calm down, and unable to stop thinking about the event
- Nightmares
- Intrusive memories of gunshots, screams and own personal terror during the day

TWO WEEKS LATER:

Becky:

- Traumatic reminders lead to brief panic or physiological reaction but do not dominate waking hours
- Thoughts, feelings, and behaviors return to pre-traumatic state / level
- Recognizes will never forget what happened but life is returning to normal
- Life back on same trajectory as before shootings

TWO WEEKS LATER:

Charles:

- Emotionally constricted; unable to experience pleasant or positive feelings
- Jumps at slightest sound
- Unable to focus on work
- Sleep fitful and marked by traumatic nightmares
- Avoidance of reminders of shooting
- Intrusion of memories of sounds of gunfire, screams, feel of blood pouring out of neighbor onto him
- Disconnected from self and surroundings
- Views life as changed by traumatic experience

Diagnoses???

Becky

- **No diagnosis; *normative stress reaction* (DSM-5; normal response to stress and not a psychiatric disorder)**
  - Emotional reactions (shock, grief, anger, numbing, etc)
  - Cognitive reactions (unwanted memories, difficulty concentrating, dissociation)
  - Physical reactions (tension, insomnia, startle reactions)
  - Interpersonal reactions (irritability, isolation, distrust, distant)

Charles

- **Acute Stress Disorder**
  - Intrusion (distressing memories, dreams, dissociative reliving [flashbacks] and intense psychological distress or physiological reactivity
  - Negative mood (inability to experience positive emotions)
  - Dissociative symptoms (amnesia, derealization, depersonalization)
  - Avoidance symptoms (internal and external)
  - Arousal symptoms (insomnia, irritability, hypervigilance, problems concentrating, exaggerated startle reaction)

SIX WEEKS LATER:

Charles:

- *Intrusion* of memories of sounds of gunfire, screams, feel of blood pouring out of neighbor onto him (B1)
- Sleep fitful and marked by traumatic nightmares (B2)
- *Avoidance* of reminders of shooting (C1 / C2)
- Views life as *changed* by traumatic experience (D2; neg alteration in cognition / mood)
- Disconnected from self and surroundings (D6)
- Emotionally constricted; unable to experience pleasant or positive feelings (D7)
- *Jumps* at slightest sound (E4; alteration in arousal and reactivity)
- Unable to focus on work (E5)

ADJUSTMENT DISORDER

1. HISTORY
2. DIAGNOSTIC CRITERIA
3. SPECIFIERS
4. STRESSORS
5. FUNCTIONAL CONSEQUENCES
6. DEVELOPMENT & COURSE
7. RISK, PREVALENCE, & COMORBIDITY
8. CULTURE-RELATED ISSUES
9. DIFFERENTIAL DIAGNOSIS
10. FORMAL ASSESSMENTS
11. TREATMENT

ADJUSTMENT DISORDER

Abnormal reaction to an identifiable stressor

- "out of proportion" reaction
- Significant impairment

Specifiers describe the type of reaction/impairment

Look out for:

- Depressive symptoms
- Anxiety symptoms
- Disturbance of conduct
  - Violating others' rights
  - Violation of laws, processes, or societal norms
- Any other abnormally severe or disproportionate maladaptive reactions

HISTORY

- **In the DSM**
  - Original DSM – similar diagnoses in the group of situational personality disorders
  - DSM-II "transient situational disturbance"
  - DSM-III
    - Shift to maladaptive response to everyday stressors
    - Included (now outdated) subtypes
  - Not changed much, except for new placement in the T&SRD
    - More exposure
    - Hopefully will spark more research
- **In the ICD**
  - ICD-9 "Adjustment Reaction"
  - ICD-10 "Adjustment Disorder" – subtypes reflect the DSM 5

(Casey, 2014)

DIAGNOSTIC CRITERIA

Adjustment Disorder

A-E

- Development of symptoms within 3 months of the onset of an identifiable stressor
- Clinically significant distress or impairment
- Is not another disorder
- Is not “normal bereavement”
- Symptoms do not last more than 6 months after the stressor or consequences have subsided

(APA, 2013)

DIAGNOSTIC SPECIFIERS

Diagnostic Criteria (cont.)

Specifiers:

- Depressed mood
- Anxiety
- Mixed depressed mood and anxiety
- Disturbance of Conduct
- Mixed disturbance of emotions and conduct
- Unspecified

(APA, 2013, pp. 286-287)

DESCRIPTION OF STRESSOR(S)

Stressor(s)

- Single or multiple events
- Recurrent or continuous
- Apply to individuals, families, or communities
- Can apply to typical developmental events

(APA, 2013)

EXAMPLE STRESSORS

Relationships

- The ending of a romantic relationship, partnership, or marriage
- Marital stress
- Unfulfilling sexual relationships

Illness that causes increasing disability or pain

Business difficulties

- Stress (seasonal or otherwise)
- Failure
- Job loss

Developmental events

- Starting college, leaving or reentering parental home, getting married, having children, Etc.

(APA, 2013)

GRIEF AS STRESSOR

Grief as a stressor:

- "may be diagnosed following the death of a loved one when the intensity, quality, or persistence of grief reactions exceeds what normally might be expected, when cultural, religious, or age-appropriate norms are taken into account" (p. 287)
- **Persistent Complex Bereavement Disorder (More Later)**

(APA, 2013)

FUNCTIONAL CONSEQUENCES

"Associated with an increased risk of suicide attempts and completed suicide" (APA, 2013, p. 287)

- **Similar rates of as those who are experiencing a depressive episode** (Casey, 2009)
- **Risk for suicide** (Casey, 2009)
  - Positively correlated with:
    - severity of depression (measured with BDI-II)
    - non-participation in organized religion
  - Negatively correlated with age

Decreased performance

  - Impairment in important areas of functioning
  - May severely impact professional or academic achievement

(APA, 2013)

FUNCTIONAL CONSEQUENCES (CONT.)

Temporary social changes

- Withdrawal from social supports

May complicate illnesses

- Decreased compliance
- Increased hospital stays

May be more difficult to overcome for younger age groups
(international data; Casey & Bailey, 2011)

- Characterized by more comorbidity
- Poorer treatment outcomes

DEVELOPMENT & COURSE

Acute Event

- Onset is typically immediate
- Duration is brief (a few months)
- Must not last longer than 6 months after stressor/consequences

Persistent Stressor or Consequences

- "If the stressor or its consequences persist, the adjustment disorder may also continue to be present and become the persistent form" (p. 287)
- Must not last longer than 6 months after stressor/consequences

(APA, 2013)

RISK, PREVALENCE, AND COMORBIDITY

Risk: “disadvantaged life circumstances” (APA, 2013, p. 288) due to higher rate of stressors

Prevalence: “Common” (APA, 2013, p. 287)

- Outpatient mental health: 5%-20% (APA, 2013, p. 287)
- Most common diagnosis in consultation/liaison psychiatry (Casey & Bailey, 2011)
- Most common diagnosis in Psychiatric Hospitals: 50% (APA, 2013, p. 287)

“Can accompany most psychological disorders and any medical disorder” (APA, 2013, p. 289)

CULTURE RELATED ISSUES

Diagnosis is reliant on client's context

- Maladaptive?
- In excess?
- "Nature, meaning, & experience of the stressors and the evaluation of the response to the stressors may vary across cultures" (p. 288)

(APA, 2013)

DIFFERENTIAL DIAGNOSIS

Major Depressive Disorder

- If criteria are met, then diagnose MDD
- Even if in response to stressor
- Personality may play a part –
  - Clients with MDD show higher comorbidity with personality disorders than those with AD (Doherty, Jabbar, Kelly, & Casey, 2014)

Post-Traumatic Stress Disorder (PTSD) or Acute Stress Disorder (ASD)

- AD - Stressor may not necessarily be traumatic
- ASD is time-limited from 3 days to 1 month; AD can be diagnosed immediately and for up to 6 months
- AD – diagnosed after a traumatic event, but PTSD or ASD criteria aren't met or are exceeded
- AD – diagnosed for individuals who meet PTSD or ASD but have not experienced a traumatic event

(APA, 2013)

DIFFERENTIAL DIAGNOSIS (CONT.)

Personality Disorders

- Vulnerability to situational distress may appear to be AD
  - Assess Lifetime history (Casey, 2009)
- Stressors can exacerbate personality disorder symptoms
- Can be co-occurring

Normative Stress Reactions

- Magnitude exceeds what would normally be expected (dependent on culture)
- Functional impairment

(APA, 2013)

FORMAL ASSESSMENT

- **Gold Standard – Clinical Assessment** (Casey, 2014)
- **Structured Clinical Interview for DSM-IV (SCID-I);** SCID-5-CV comes out in October 2015
- **Mini International Neuropsychiatric Interview (MINI)**
- **Adjustment Disorder New Module (ADNM;** Einsel, Kollner, & Maercker, 2010)
- **Diagnostic Interview Adjustment Disorder (DIAD)**
  - Compared the DIAD to the Kessler Psychological Distress & World Health Organization's Disability Assessment Schedule
  - "Moderate-to-good" feedback from experts
    (Cornelius, Brouwer, de Boer, Groothoff & ven der Kilk, 2014)

TREATMENT

- **Not a lot of high quality research as to what works** (Casey, 2014)
- **Brief interventions** (Casey, 2009)
- **Group Therapy** (Casey, 2014)
- **Alternative Interventions** (Casey, 2014)
  - Yoga
  - Meditation
  - Herbal Remedies
- **Pharmacotherapy**
  - Symptomatic management of anxiety (Casey, 2014)
  - Insomnia (Casey, 2009)
  - Depressive subtype – currently being examined. So far, only a little support (Casey, 2014)

TREATMENT PLANNING

Short term, achievable goals

Focus should be a reduction of the specific symptoms and improvement of functioning

- Coping skills
- Problem solving skills
- Social support
- Stress reduction
- Connection to resources

Brief treatment means frequent re-assessment

CONTINUED ISSUES

Subthreshold diagnosis

Loosely Described

Lack of Research on Subtypes

(Casey, 2014)

CASE EXAMPLES - HANNAH

Hannah – Hospital admittance for suicide attempt (pills)

- **16 year old, Caucasian female**
- **Presentation**
  - No History of psychiatric issues, drug/alcohol abuse, legal issues
  - No Family history of suicide
  - No Recent feelings of depression – friends & family reported she was upbeat earlier that day
  - No self-injury, mania, psychosis, suicidal ideation
  - No use of drugs, alcohol, or cigarettes
  - Recently observed boyfriend kissing another girl
- **Diagnosis: adjustment disorder with depressed mood**
- **Treatment: outpatient care w/o medication**
  - Weekly CBT for coping skills for anger
  - 6 months with understanding that therapy is always an option

(Barnhill, 2015)

CASE EXAMPLES - FRANKLIN

Franklin – sought treatment at community mental health center for stress

- **21 year old, African American male**
- **Presentation:**
  - "stressed about money"
  - "Depressed" for about 3 months
    - Anger & depressed feelings
    - Social withdrawal
    - Impaired functioning in college
  - Three months ago
    - 3 year romantic relationship ended
    - Unwanted/unexpected discovery of biological father
  - Did not meet criteria for any other disorder
- **Diagnosis: Adjustment disorder with depressed mood**

(Barnhill, 2015)

CONDITION FOR FURTHER STUDY:

PERSISTENT COMPLEX BEREAVEMENT DISORDER

PERSISTENT COMPLEX BEREAVEMENT DISORDER (PCBD)

- **Experienced death; “close relationship”**
- **4 categories of clinically significant symptoms that persist on most days for 12 months for adults and 6 months for children**
- **6 of 12 clinically significant symptoms – Reactive distress and social/identity disruption**
- **Reactions of Complicated Grief**
  - Intense and persistent longing
  - Intense anger or disbelief
  - Disturbing preoccupation
    - With the individual
    - Manner of death
- **Includes a traumatic specifier**

PCBD – ASSESSMENT

- **Criteria developed by consensus & available literature review**
- **Lack of empirical evidence (APA, 2013; Boelen & Prigerson, 2012)**
- **Preliminary assessments**
  - The Persistent Complex Bereavement Inventory (PCBI; Sherman, 2015)

ATTACHMENT

"lasting physiological connectedness between human beings"
(Bowlby, 1969, p. 194)

- Adaptive connection to caregivers who provide food, shelter, and safety.
- Children will reach for caregivers to alleviate distress
- Young children typically feel distressed when removed from trusted caregivers
  - 6-7 months – signs of selective attachments
  - 8-9 months – reticence with strangers

(Barnhill, 2014; Bowlby, 1969)

REACTIVE ATTACHMENT DISORDER

HISTORY

DIAGNOSTIC CRITERIA

PREVALENCE

DEVELOPMENT & COURSE

RISK FACTORS

CULTURE-RELATED ISSUES

DIFFERENTIAL DIAGNOSIS

COMORBIDITY

ASSESSMENT

TREATMENT

HISTORY OF REACTIVE ATTACHMENT DISORDER

First appeared in the DSM-III

- **2 Subtypes**
  - Inhibited Attachment Disorder
  - Disinhibited Attachment Disorder

In ICD-10 - 2 separate disorders

- Disinhibited attachment
- Reactive attachment

Not highly researched (APA, 2013; Kay & Green, 2012)

REACTIVE ATTACHMENT

- **Child does not have a connection with attachment figures**
  - May develop selective attachments
  - Does not express much positive affect
- **Experiences Emotional Upset**
  - Unexplained irritability, fear, and/or sadness
  - Does not typically seek comfort
- **Experienced extremes in care**
  - Neglect
  - Frequent changes
  - Insufficient attachments

Theory: Behaviors were at one point adaptive

DIAGNOSTIC CRITERIA

A. Behavior toward caregivers is emotionally withdrawn

- Rarely or minimally seeks or responds to comfort when in distress

B. Social/Emotional disturbance

- Rare/minimal emotional responsiveness
- Little positive affect
- Unexplained episodes of emotional reactivity even in non-threatening interactions
  - Irritability
  - Sadness
  - fearfulness

C. Pattern of extremes of insufficient care

- Neglect or deprivation
- Frequent changes in primary caregivers
- Settings that limit attachments

(APA, 2013)

DIAGNOSTIC CRITERIA (CONT.)

D. Pattern of extremes of insufficient care is seen as responsible for the behaviors in A & B

E. Not autism

F. Disturbance before 5 years old

G. At least 9 months old

Specifiers:

- **Persistent:** more than 12 months
- **Severe:** all symptoms at high levels

(APA, 2013)

FUNCTIONAL CONSEQUENCES, DEVELOPMENT, & COURSE

Starts with neglect in early life

- 9 months
- 5 years

May be expressed differently depending on age

- Social functioning – adults & peers
- Impairment is across "many domains" (p. 266)

Development beyond 5 is unknown

"Prognosis depends on the quality of caregiving environment following serious neglect" (p. 266)

(APA, 2013)

RISK, PREVALENCE, & COMORBIDITY

Risk:

- Severe neglect is only known risk factor
- Majority of severely neglected children do not develop RAD

Prevalence:

- Unknown
- Relatively rare
- Less than 10% among “severely neglected children” (p. 266)

Comorbidity:

- Delays in cognition and language
- Stereotypies
- Possibly malnutrition or other medical disorders due to neglect
- Depressive symptoms

(APA, 2013)

CULTURE

Take precaution "in cultures in which attachment has not been studied"(p. 267)

(APA, 2013)

DIFFERENTIAL DIAGNOSIS

Autism Spectrum Disorder

- Clinical presentation can be very similar
  - Lack of social engagement
  - Emotional expression
  - Stereotypic reactions
- Differences:
  - RA - History of Neglect
  - Autism - Restricted interests & ritualized behaviors
  - Autism - Social communication deficit in particular
    - "communication that is deliberate, goal-directed, and aimed at influencing the behavior of the recipient" (p. 268)
    - RA – will show communication functioning comparable to overall level of intellect
  - Autism – Show attachment behavior typical for level

(APA, 2013)

DIFFERENTIAL DIAGNOSIS(CONT.)

Intellectual Developmental Disorder

- Can accompany the disorder, however…
- Will not have reduction in positive affect or emotion regulation difficulties
- Will demonstrate selective attachments

Depressive Disorders

- Little evidence shows attachment impairments
- Look for seeking/responding to comfort

(APA, 2013)

ASSESSMENT

Serial observations of child with primary caregivers

- Patterns of attachment behavior (attachment styles are not disorders)
- Consider cooperative tasks for caregiver & child to perform
- Separation from caregiver
- Pattern with unknown adult

History of Early Caregiving Environment

- Multi-source

(Boris & Zeanah, 2005)

EXAMPLE OF STRUCTURED OBSERVATION

Episode 1	5 minutes	The clinician observes parent–child "free play." *Note especially familiarity, comfort, and warmth in the child as he/she interacts with attachment figure.*
Episode 2	3 minutes	The clinician talks with, then approaches, then attempts to engage the child in play. *Most young children exhibit some reticence, especially initially, about engaging with an unfamiliar adult.*
Episode 3	3 minutes	The clinician picks up child and shows him/her a picture on the wall or looks out window with the child. *This increases the stress for the child. Again, note the child's comfort and familiarity with this stranger.*
Episode 4	3 minutes	The caregiver picks up the child and shows him/her a picture on the wall or looks out window with the child. *In contrast to stranger pick up, the child should feel obviously more comfortable during this activity.*
Episode 4a[a]	1 minute	The child is placed between the caregiver and a stranger, and a novel (e.g., scary/exciting) remote control toy is introduced. *The child should seek comfort preferentially from parent. If interested rather than frightened, the child should share positive affect with parent.*
Episode 5	3 minutes	The clinician leaves the room. *This separation should not elicit much of a reaction in the child because the clinician is a stranger.*
Episode 6	1 minute	The clinician returns. *Similarly, the child should not be much affected by the stranger's return.*
Episode 7	3 minutes	The caregiver leaves the room. *The child should definitely take notice of caregiver's departure, although not necessarily exhibit obvious distress. If the child is distressed, then the clinician should be little comfort to the child.*
Episode 8	1 minute	The caregiver returns. *The child's reunion behavior with the caregiver should be congruent with separation behavior. That is, distressed children should seek comfort and nondistressed children should reengage positively with the caregiver by introducing them to a toy or activity or talking with them about what occurred during the separation.*

Note: Adapted from Boris et al. (2004).

[a] Optional episode.

(Boris & Zeanah, 2005)

FORMAL ASSESSMENTS

Relationship Problems Questionnaire (RPQ; Vervoort et al., 2013)

- Parents/caregivers or educators

Secure Base Safe Haven Observation list (SBSHO; De Schipper et al. 2009)

Disturbances of Attachment (DAI; Gleason et al. 2011)

TREATMENT CONSIDERATIONS

Potential need to report current maltreatment

Assessments for developmental delays including speech/language and physical delays

Advocate for child – need for emotionally available attachment figure

Involve the parent

- Caregivers can feel anxious or angry
- Assess attachment style

(Boris & Zeanah, 2005)

TREATMENT

“Little is known” (Zeanah & Gleason, 2015)

Boris & Zeanah (2005) – Practice Parameter for the Assessment & treatment of Children and Adolescents with RAD in Infancy and Early Childhood

- Focus is creating positive interactions with caregivers
  - Parenting training – sensitive responsiveness
  - Parent stress relief

- Dyadic work
  - Build trust/therapeutic alliance
  - Focus on parent’s strengths
  - Consider taping – reflection for parents
  - Suggested Approaches:
    - Infant-parent psychotherapy
    - Interaction guidance

TREATMENT (CONT.)

Family Therapy

- **Great as a second-stage after dyadic**

Individual Therapy

- **Can supplement dyadic therapy to remove barriers to caregiver attachment**
- **Should be in conjunction with attachment building with caregivers**

Physical restraint therapies (Holding, Rebirthing, Reattaching, Etc.) are ineffective & associated with serious harm.

Regressive caregiving has not been shown to be effective

(Boris & Zeanah, 2005)

CASE EXAMPLE:

DISINHIBITED SOCIAL ENGAGEMENT DISORDER

HISTORY

DIAGNOSTIC CRITERIA

PREVALENCE

DEVELOPMENT & COURSE

RISK FACTORS

CULTURE-RELATED ISSUES

DIFFERENTIAL DIAGNOSIS

COMORBIDITY

ASSESSMENT

TREATMENT

DSED

- **Child relates with adult caregivers with a high degree of familiarity**
  - Overly physical or verbal
  - Overly trusting of adults
- **Expresses emotions that are insincere**
  - May display distress
  - Show little regret or remorse
- **Experienced extremes in care**
  - Neglect
  - Frequent changes
  - Insufficient attachments

Theory: Behaviors were at one point adaptive

HISTORY OF DSED

Split from RAD for a few reasons (Gleason, 2011)

- **Vastly different behaviors with caregivers**
- **Different link to the quality of caregiving**
- **Prognosis looks different**

DIAGNOSTIC CRITERIA

A. Behavior toward adults is emotionally & physically unrestrained

- Little or no hesitancy with unfamiliar adults
- Overly familiar, physically & verbally
- Little or no checking back with caregivers
- Little or no hesitancy to leave with unfamiliar adults

B. Behavior is not just impulsivity (i.e. not ADHD)

C. Pattern of extremes of insufficient care

- Neglect or deprivation
- Frequent changes in primary caregivers
- Settings that limit attachments

(APA, 2013)

DIAGNOSTIC CRITERIA (CONT.)

D. Pattern of extremes of insufficient care is seen as responsible for the behaviors

E. At least 9 months old

Specifiers:

- **Persistent:** more than 12 months
- **Severe:** all symptoms at high levels

(APA, 2013)

NORMAL VS. ABNORMAL

Social approach with a Stranger

- **Verbal - typical development deems normal when meeting an adult in the presence of a caregiver in many settings**
  - May be especially normal for those raised in institutionalized settings
  - Should decrease after stable attachment opportunities and/or socialization

- **Physical contact with a stranger (in American culture) is inappropriate**
  - May be more normative for other cultures
  - May be more normative for those raised in institutionalized settings
  - Should decrease after stable attachment opportunities and/or socialization

DSED symptoms do not decrease

(Lawler et al., 2014)

FUNCTIONAL CONSEQUENCES, DEVELOPMENT, & COURSE

Starts with neglect before the age of 2 yrs.

Toddlerhood

- Lack of reticence
- Social behavior is indiscriminate

Preschool

- Attention seeking behaviors
- Verbal and physical intrusiveness

Middle Childhood

- Overfamiliarity
- “Inauthentic expression of emotion” (p. 269)

Adolescence

- Social behavior with peers becomes indiscriminate
- More relational conflict than non DSED adolescents
- Superficial relationships

(APA, 2013)

FUNCTIONAL CONSEQUENCES, DEVELOPMENT, & COURSE (CONT.)

"Prognosis is only modestly associated with quality of the caregiving environment following serious neglect. In many cases, the disorder persists, even in children whose caregiving environment becomes markedly improved" (APA, 2013, p. 270)

RISK, PREVALENCE, & COMORBIDITY

Risk:

- Severe neglect before age 2 is the only known risk factor
- Majority of severely neglected children do not develop DSED
- Neurobiology may play a role, but this is not confirmed by research

Prevalence:

- Unknown
- Relatively rare in clinic settings
- Less than 20% among “severely neglected children” (p. 269)

Comorbidity:

- Delays in cognition and language
- Stereotypies
- May be comorbid with ADHD diagnosis

(APA, 2013)

CULTURE

Take precaution "in cultures in which attachment has not been studied"(p. 267)

(APA, 2013)

DIFFERENTIAL DIAGNOSIS

ADHD

- May appear similar due to social impulsivity
- DSED – do not show difficulties with attention or hyperactivity

(APA, 2013)

ASSESSMENT

Child's History

- **Tie to length or degree of neglect is not understood** (Lawler et al., 2014)
- **Multi-source History** (Boris & Zeanah, 2005)

Parent Report

Observation of child (Boris & Zeanah, 2005; Lawler et al., 2014)

- **With caregivers & with unknown adults**
- **Stranger at the Door** (Gleason, 2011)

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Note: Adapted from Boris et al. (2004).

[a] Optional episode.

(Boris & Zeanah, 2005)

FORMAL ASSESSMENTS

Relationship Problems Questionnaire (RPQ; Vervoort et al., 2013)

Secure Base Safe Haven Observation list (SBSHO; De Schipper et al. 2009)

Disturbances of Attachment (DAI; Gleason et al. 2011)

TREATMENT

"Prognosis is only modestly associated with quality of the caregiving environment following serious neglect. In many cases, the disorder persists, even in children whose caregiving environment becomes markedly improved" (APA, 2013, p. 270)

Inhibitory control deficits (Lawler et al., 2014)

Theory of treatment is to support good attachment (Lawler et al., 2014)

- Building attachment with caregiver may diminish the seeking behaviors
- Increasing attachment to caregivers may improve wellbeing, but not diminish DSED symptoms

TREATMENT (CONT.)

Boris & Zeanah (2005) – Practice Parameter for the Assessment & treatment of Children and Adolescents with RAD in Infancy and Early Childhood

Play Therapy & Family Therapy (O'Connor, Spagnola, & Byrne, 2012)

Pharmacotherapy- no significant evidence (Sperry, Carlson, Sauerheber, & Sperry, 2015)

CASE EXAMPLE - ADRIANA

- **4 ½ years old**
- **Referred for "dangerous behaviors"**
  - Poor boundaries
  - Impulsive
  - Too quick to trust strangers
- **Adopted from Eastern European Orphanage at 2 ½ years old**
  - Spontaneous and happy
  - Growth was at 5th percentile
  - Gained weight after adoption, but still in 5th percentile for head circumference
- **Energetic**
  - Difficulty with taking turns,
  - sitting for a long time,
  - respecting peers' personal space.
- **Emotion Regulation**
  - Small triggers upset her for a long time,
  - but she is clamed by being held.
- **Developmental Delays**
  - Language
  - School readiness

(Barnhill, 2014)

CASE EXAMPLE - CLINICAL PRESENTATION

Quiet but engaged during interview.

Within a few minutes, she attempted to crawl into the interviewer's lap

Case Report:

- **Regulating proximity (risk for abduction or abuse)**
  - excess physical familiarity with strangers
  - Lack of checking back with caregivers
- **Clues to issues**
  - Original behavior at 29 months was desirable (welcoming/engaging)
  - Sign of attachment-related psychopathology
  - Exposure to environment happened before 2 years old

(Barnhill, 2014)

CASE EXAMPLE - ASSESSMENT

Caregivers

- **Serial observation**
- **History of attachment**

Observation with Strangers

History of Early Caregiving Environment

(Barnhill, 2014)

CASE EXAMPLE - CONCEPTUALIZATION

Behavior is thought to be caused by environment and biology during a critical period of social brain development

- Neglect
  - High child-to-caregiver ratio
  - Lack of early attachment figures
  - Possible malnutrition in early life
- Biological vulnerability
  - Lack of social inhibitory control could be due to abnormality in prefrontal and cingulate cortices
  - Prenatal malnutrition or toxicity
  - Genetic risk factors

(Barnhill, 2014)

TREATMENT

Already assessed by physician and learning experts

Parent Psychoeducation

Dyad therapy to strengthen attachment

Family Therapy to support growth

(Boris et al., 2005)

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