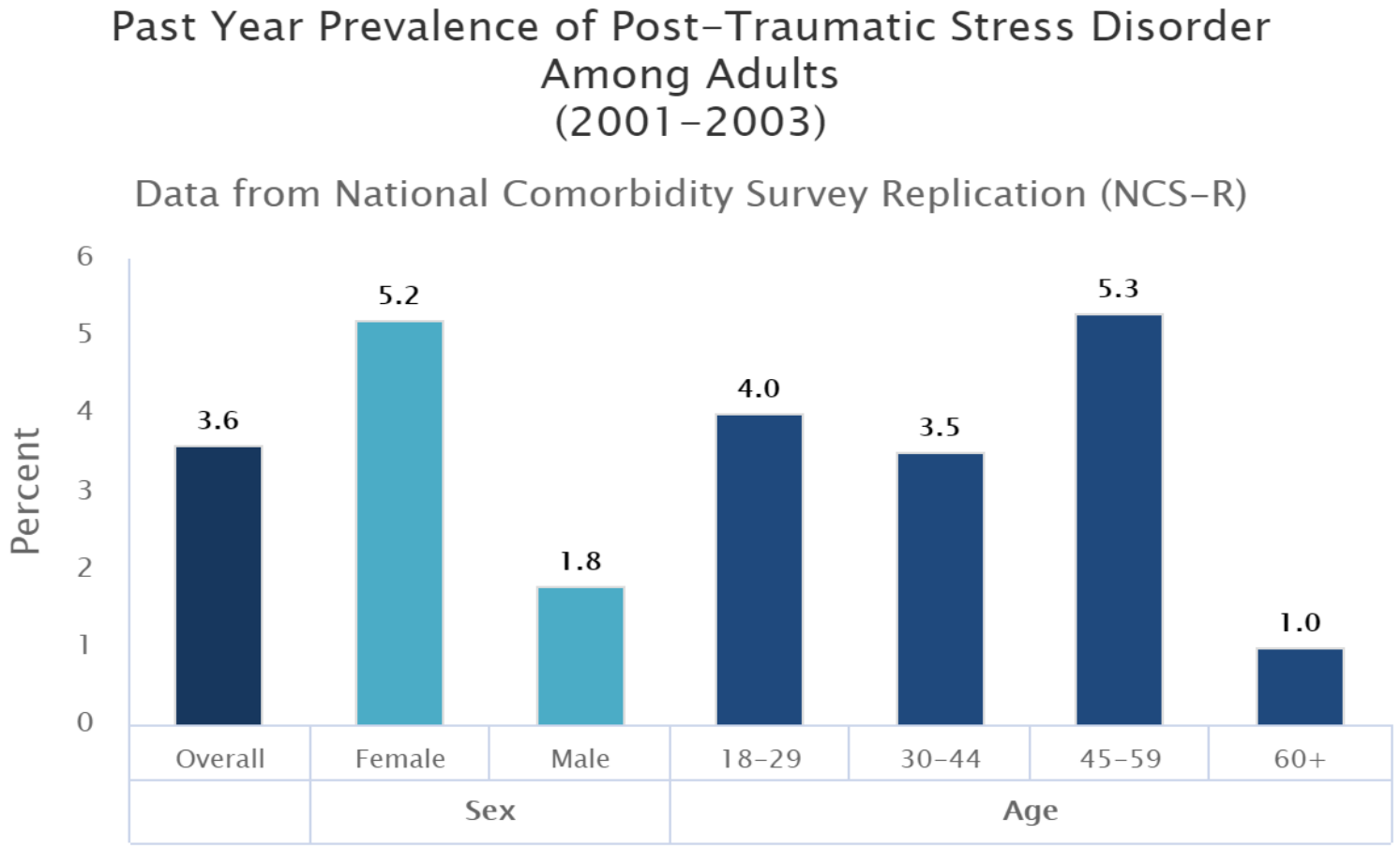
Advanced Clinicial Assessment and Diagnosis

5th week
Trauma and Stress-Related Disorders

Trauma and Stress-Related Disorders in DSM-5

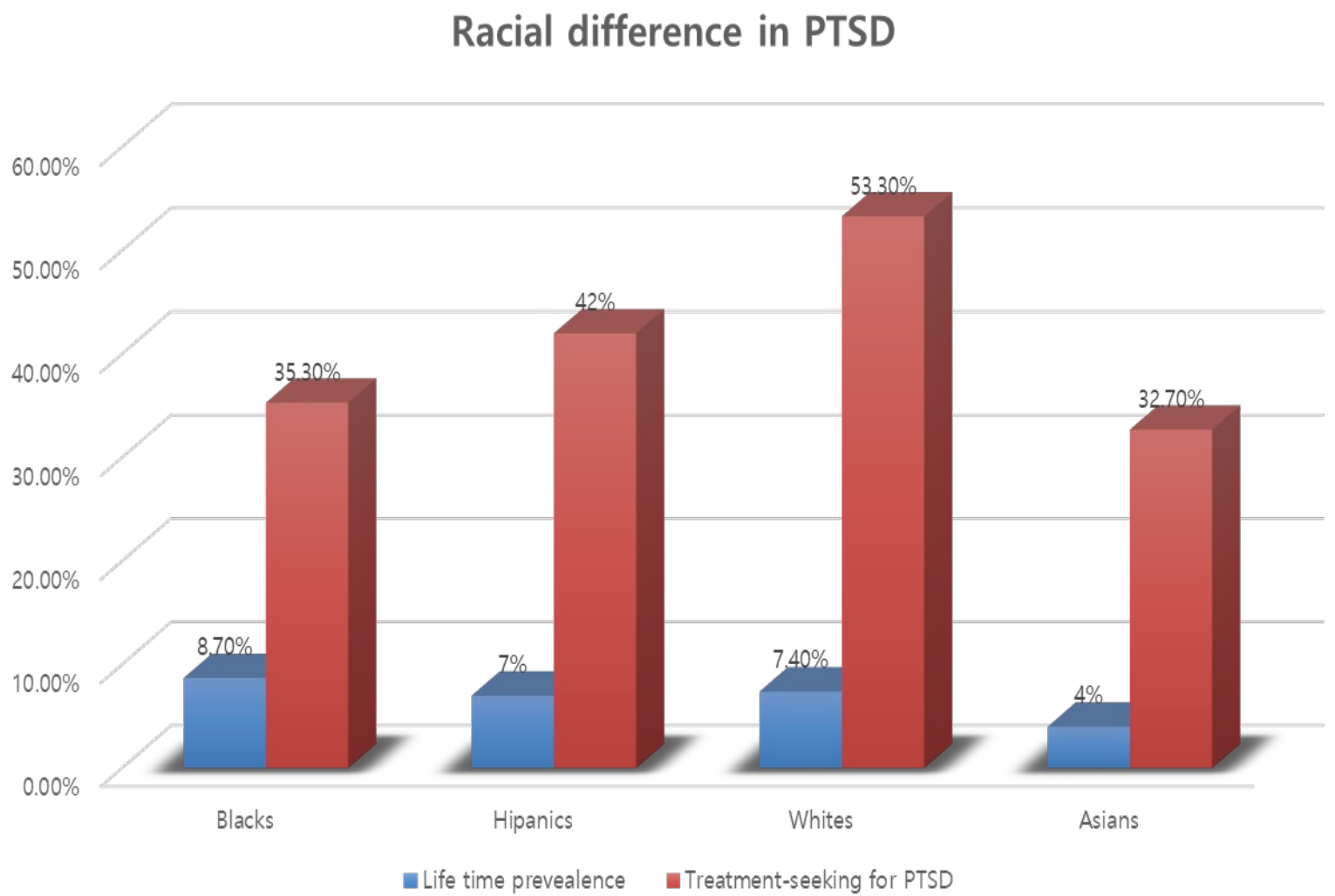
1) Posttraumatic Stress Disorder (PTSD)
2) Acute Stress Disorder
3) Adjustment Disorders
4) Reactive Attachment Disorder
5) Disinhibited Social Engagement Disorder
6) Other specified Trauma-and-Stress-Related Disorder
7) Unspecified Trauma-and Stress-Related Disorder

Prevalence of PTSD

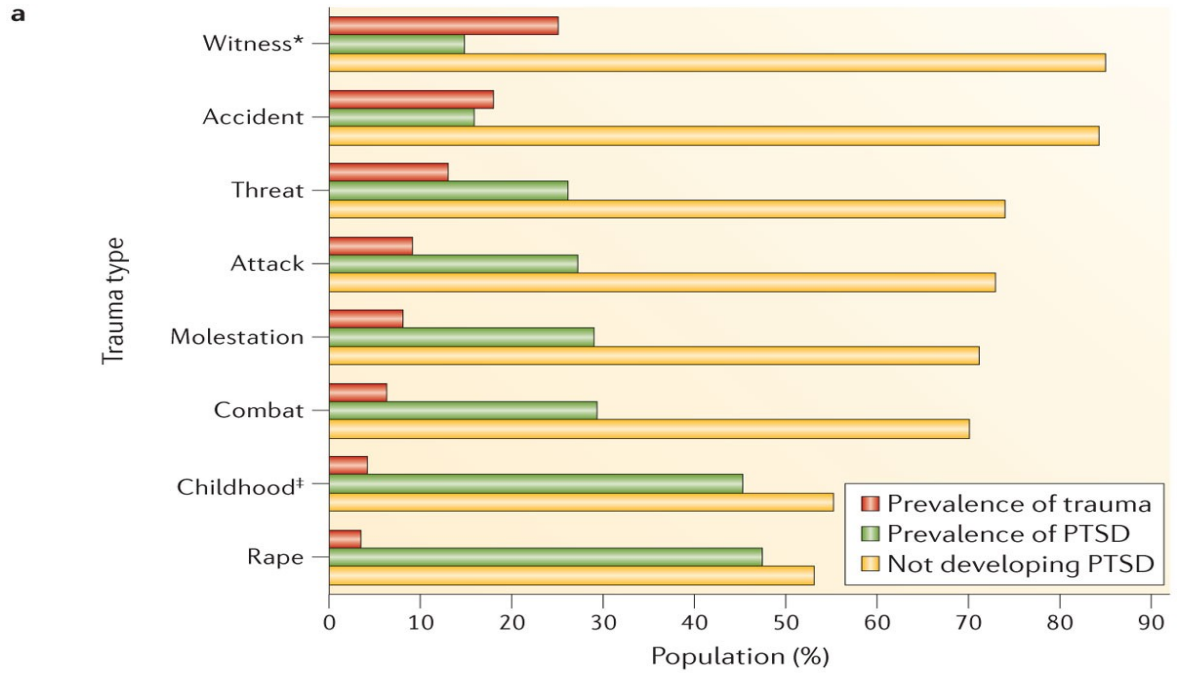


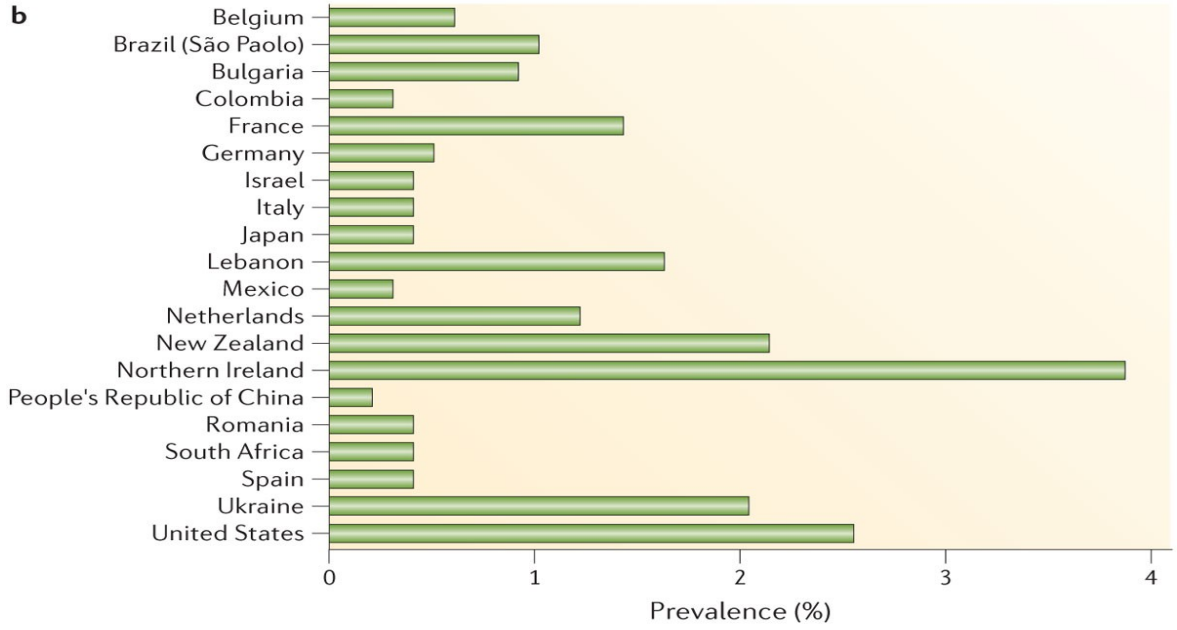
NIMH (n.d.)

Prevalence of PTSD



Pomeroy (2014)





Nature Reviews | Disease Primers

Yehuda, R. *et al*. (2015) Post-traumatic stress disorder *Nat. Rev. Dis. Primers* doi:10.1038/nrdp.2015.57

1)PTSD

A. Exposure to actual or threatened death, serious insure, or sexual violence in at least one of the following way

1. Direct experience 2. Witnessing 3. Learning
4. experiencing repeated or extreme exposure

B. Presence of at least one of the following intrusion symptoms

1. Recurrent, involuntary, and intrusive distressing memories
2. Recurrent distressing dreams
3. Dissociative reactions (e.g., flashbacks)
4. Intense or prolonged psychological distress at exposure to internal or external cues
5. Marked physiological reactions to internal or external cues

1)PTSD

C. Persistent avoidance of stimuli, as evidenced by one or both of the following

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings
2. Avoidance of or efforts to avoid external reminders

D. Negative alterations in cognitions and mood associated with traumatic event, as evidenced by two or more

1. Inability to remember an important aspect of the traumatic event
2. Persistent and exaggerated negative beliefs or expectations
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event
4. Persistent negative emotional state
5. Markedly diminished interest or participation in significant activites
6. Feelings of detachment or estrangement
7. Inability to experience positive emotions.

1)PTSD

E. Marked alterations in arousal and reactivity associated with the traumatic event

1. Irritable behavior and angry outburst
2. Reckless or self-destructive behavior
3. Hypervigilance
4. Exaggerated startle response
5. Problems with concentration
6. Sleep disturbance

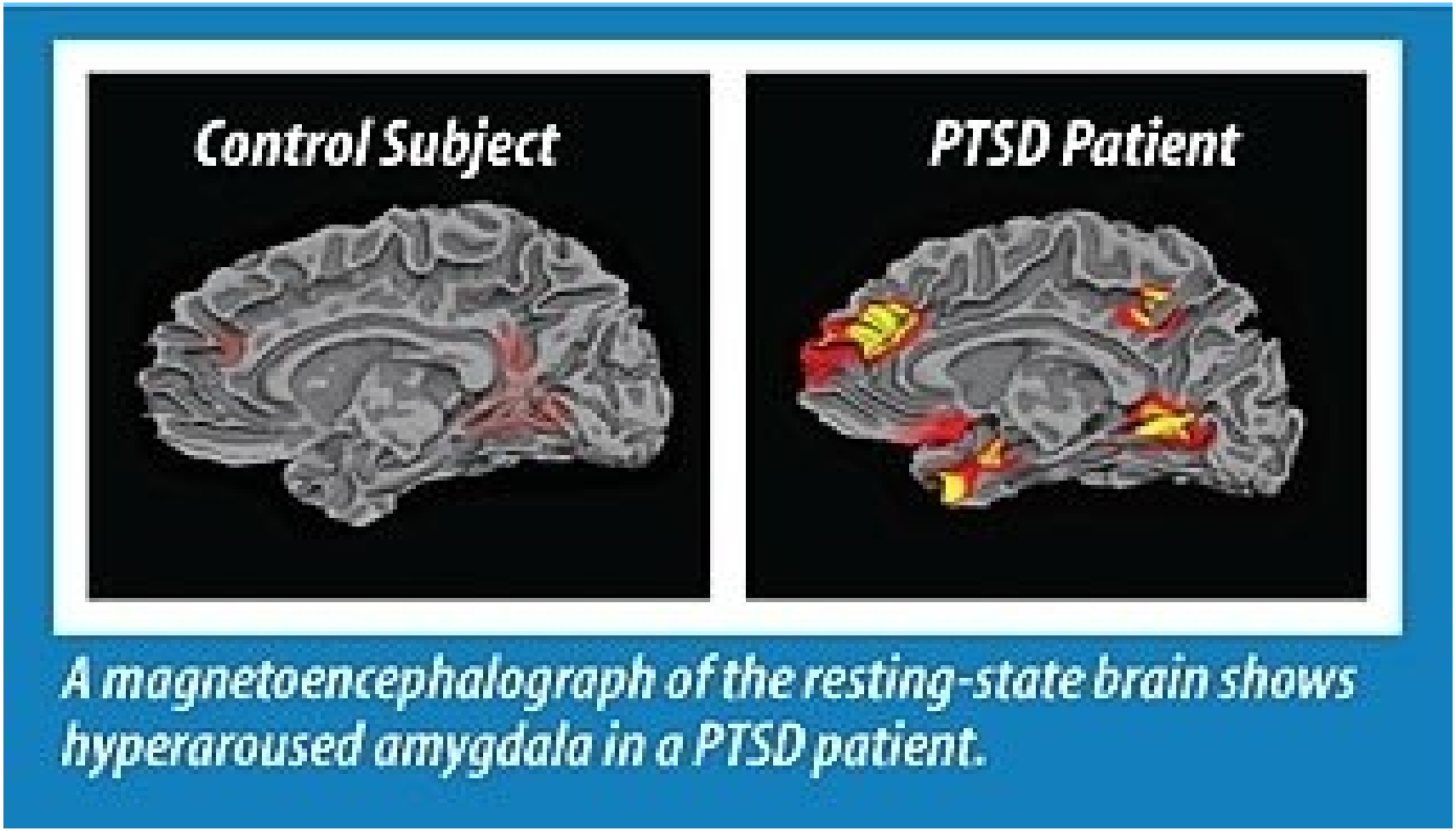
F. Duration of the disturbance is more than 1 month

Specify whether: with dissociative symptoms (depersonalization, Derealization) ; with delayed expression

PTSD for children 6 years and younger

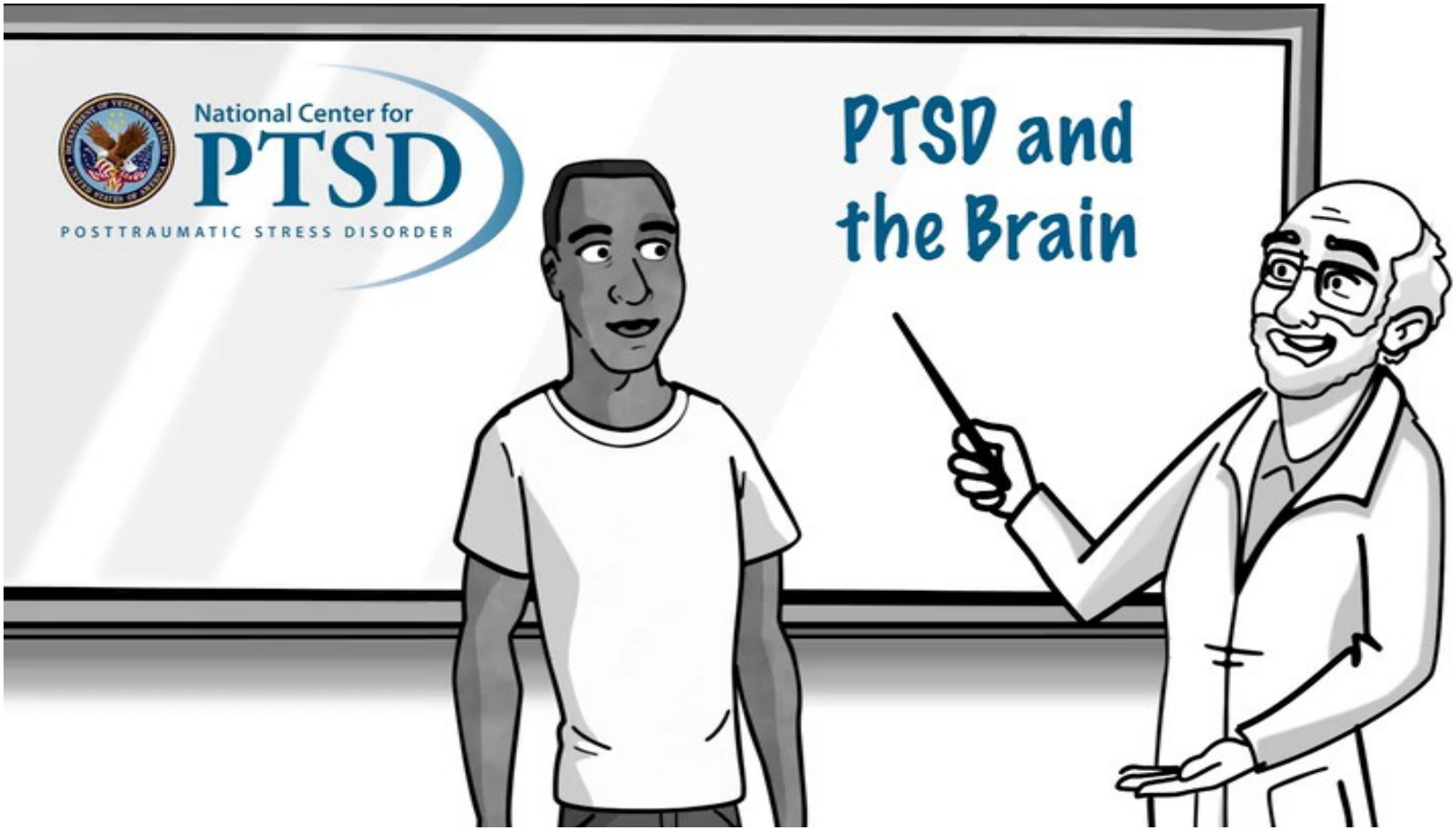
Criteria are the same as adult version; Criterion C and D are combined and require at least one symptom for both criteria.

PTSD and the Brain



Source: https://www.quora.com/What-is-complex-PTSD-and-how-does-it-affect-the-growth-and-functionality-in-an-individual

PTSD and the Brain



Source: https://www.ptsd.va.gov/appvid/video/index.asp

2) Acute Stress Disorder

- Starts within 1 month of trauma and lasts from 3 days to 1 month; PTSD may follow
- Distress and/or functioning impaired
- Presence of 9 or more symptoms including
    1. Intrusive distressing memories
    2. Recurrent distressing dreams
    3. Dissociative reactions (e.g., flashbacks)
    4. Intense or prolonged psychological distress or marked physiological reactions
    5. Negative moode
    6. Dissociation- an altered sense of the reality of one’s surroundings or oneself
    7. Inability to remember the traumatic event
    8. Efforts to avoid distressing memories, thoughts
    9. Efforts to avoid external reminders
    10. Sleep disturbance
    11. Irritable behavior and angry outbursts
    12. Hypervigilance
    13. Problems with concentration
    14. Exaggerated startle response

3) Adjustment Disorder

- Starts within 3 month of the onset of the stressor and lasts up to 6 months after stressor has terminated.
- The symptoms do not represent normal bereavement
  - –Distress that's out of proportion with the expected reactions to the stressor.
  - –Symptoms must be clinically significant. They cause severe distress and impairment in functioning.
- Specify whether
  - –With depressed mood
  - –With anxiety
  - –With mixed anxiety and depressed mood
  - –With disturbance of conduct
  - –With mixed disturbance of emotions and conduct
  - –Unspeified

Acute Stress Disorder VS. Adjustment Disorder

Acute Stress Disorder	Adjustment Disorder
Severe event	Any severity
Typical courses: Motor vehicle accident, war, child abuse, assault, natural disaster, violent death of loved one, witnessing a mass shooting, sever burns, etc.	Typical courses: Job loss, divorce, life changes, living in unsafe neighborhood
PTSD may follow	Resolves within 6 months at the end of stress

TABLE 6.1. Comparison of PTSD in Preschool Children, PTSD in Adults, and Acute Stress Disorder

Child PTSD	Adult PTSD	Acute Stress Disorder
	Trauma	
Direct experience Witness (not just TV) Learn of	Direct experience Witness Learn of Repeat exposure (not just TV)	Direct experience Witness Learn of Repeat exposure (not just TV)
Intrusion symptoms (1/5)[a] • Memories • Dreams • Dissociative reactions • Psychological distress • Physiological reactions	*Intrusion symptoms (1/5)* • Memories • Dreams • Dissociative reactions • Psychological distress • Physiological reactions	*All symptoms (9/14)* • Memories • Dreams • Dissociative reactions • Psychological distress *or* physiological reactions
Avoid/Neg. emotions (1/6) • Avoids memories • Avoids external reminders	*Avoidance (1/2)* • Avoids memories • Avoids external reminders	• Avoids memories • Avoids external reminders
	Negative emotions (2/7)	• Altered sense of reality of self or surroundings • Amnesia
• Negative emotional state • Decreased interest • Social withdrawal • Decreased positive emotions	• Amnesia • Negative beliefs • Distortion → self-blame • Negative emotional state • Decreased interest • Detached from others • No positive emotions	• No positive emotions
Physiological (2/5) • Irritable, angry • Hypervigilance • Startle • Poor concentration • Sleep disturbance	*Physiological (2/6)* • Irritable, angry • Reckless, self-destructive • Hypervigilance • Startle • Poor concentration • Sleep disturbance	• Irritable, angry • Hypervigilance • Startle • Poor concentration • Sleep disturbance
	Duration	
>1 month	>1 month	3 days–1 month

[a]Fractions indicate the number of symptoms required of the number possible in the following list.

Morrison (2017)

Assessment

- PTSD is not only disorder that might be a consequence of trauma; depression is more common than PTSD
- Hyperounsal and other symptoms of trauma can look like hyperactivity and poor impulse control; intrusive thoughts can interfere with attention and concentration- should be mindful, could be confused with ADHD
- Presence of dissociative symptoms and flashbacks may be mistaken for psychotic symptoms
- Irritability and agitation upon exposure to trauma reminders may look similar to ODD symptoms
- Anxiety disorders and depressive disorders have overleaping symptoms with those of PTSD
- Differences among Acute stress disorder, Adjustment disorder and PTSD
- Bereavement involves the anticipated death of a loved one
- Other diagnoses should be considered if the trauma did not precede the PTSD symptoms or if full criteria met

Risk factors for PTSD

1) Biological

- Introversion or behavioral inhibition
- Female gender
- Chronic illness or handicapping condition
- Genetic risk- abnormal levels of hormone that respond to stress
- Lower cortisol levles; higher levels of norepinephrine and epinephrine
- High levels of opiate even when not in danger
- Smaller hicampus

2) Psychological

- Behavioral or psychiatric disorder
- Dissociation after trauma

Risk factors

3) Social

- Family history of psychiatric illness
- Adverse life events and prior child trauma exposure
- Lack of social support
- Poverty
- Immigration to the IS because armed conflict or political repression

4) Features of the traumatic experience

- Degree of exposure to trauma
- Subjective sense of danger

5) Stressors After the Traumatic experience

- Secondary stressors
- Continued experience of adverse events

Interventions

☺☺☺ Very good evidence ☺☺ Good evidence ☺ Promising treatment

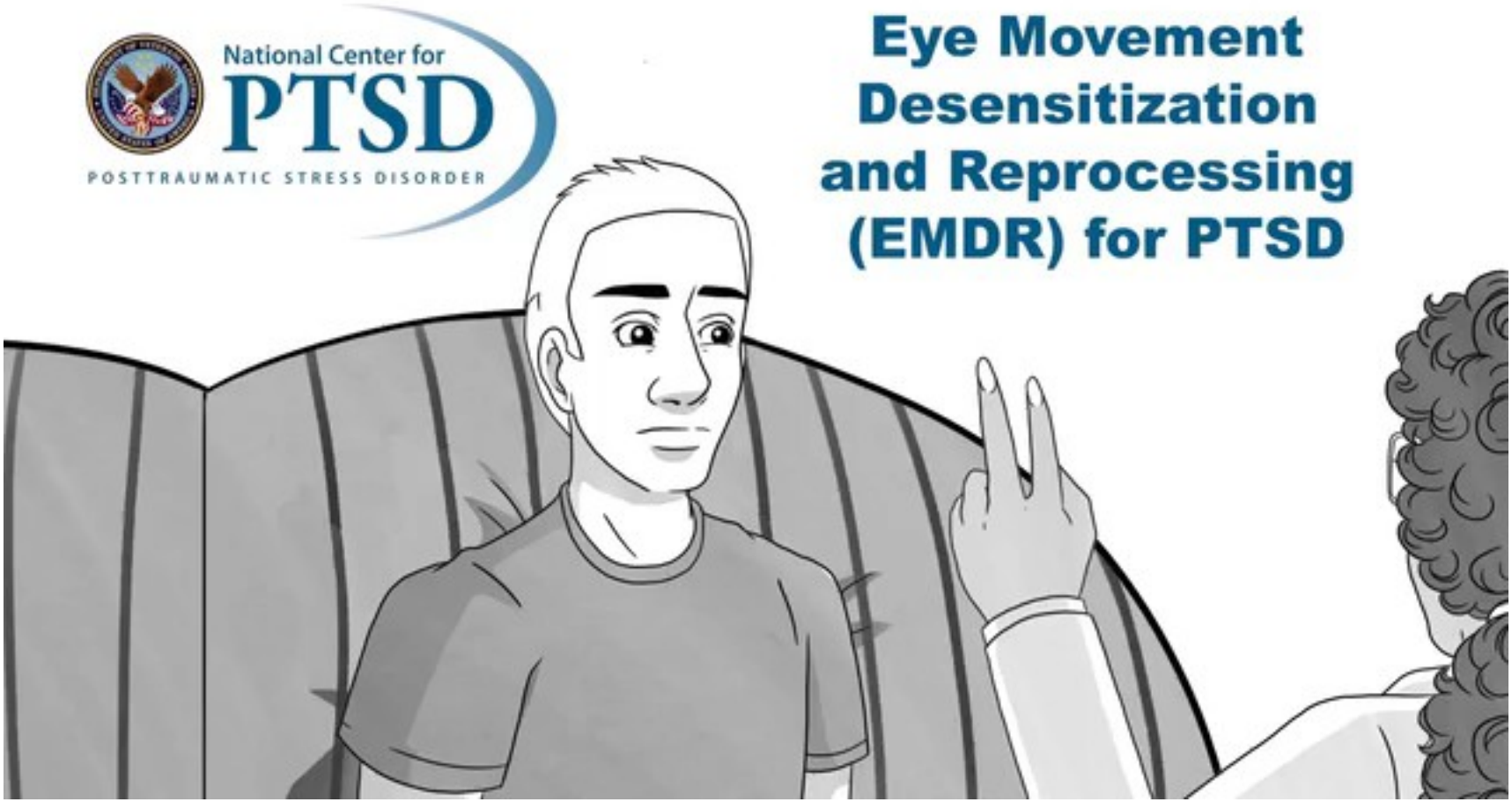
Medications	Effectiveness
SSRIs- antidepressant, but effective for PTSD by controlling serotonin levels as well as other neurotransmitters; but adverse effects Sertaline(Zoloft), Paraoxetine (Paxil), Fluoxetine (Prozac)	☺☺☺
SNRIs- Venilafaxine (Effexor)- 4 to 6 weeks required	☺☺☺
Classic medications: Benzodiazepines, Alprazolam (Xanax), Diaepam (Valium), Clonazepam (Klonopic), Lorazepam (Ativan)- Used for sleep problem and severe anxiety, but long-term use cause side-effects and recent studies found no effectiveness for PTSD.	☺

Interventions

☺☺☺ Very good evidence ☺☺ Good evidence ☺ Promising treatment

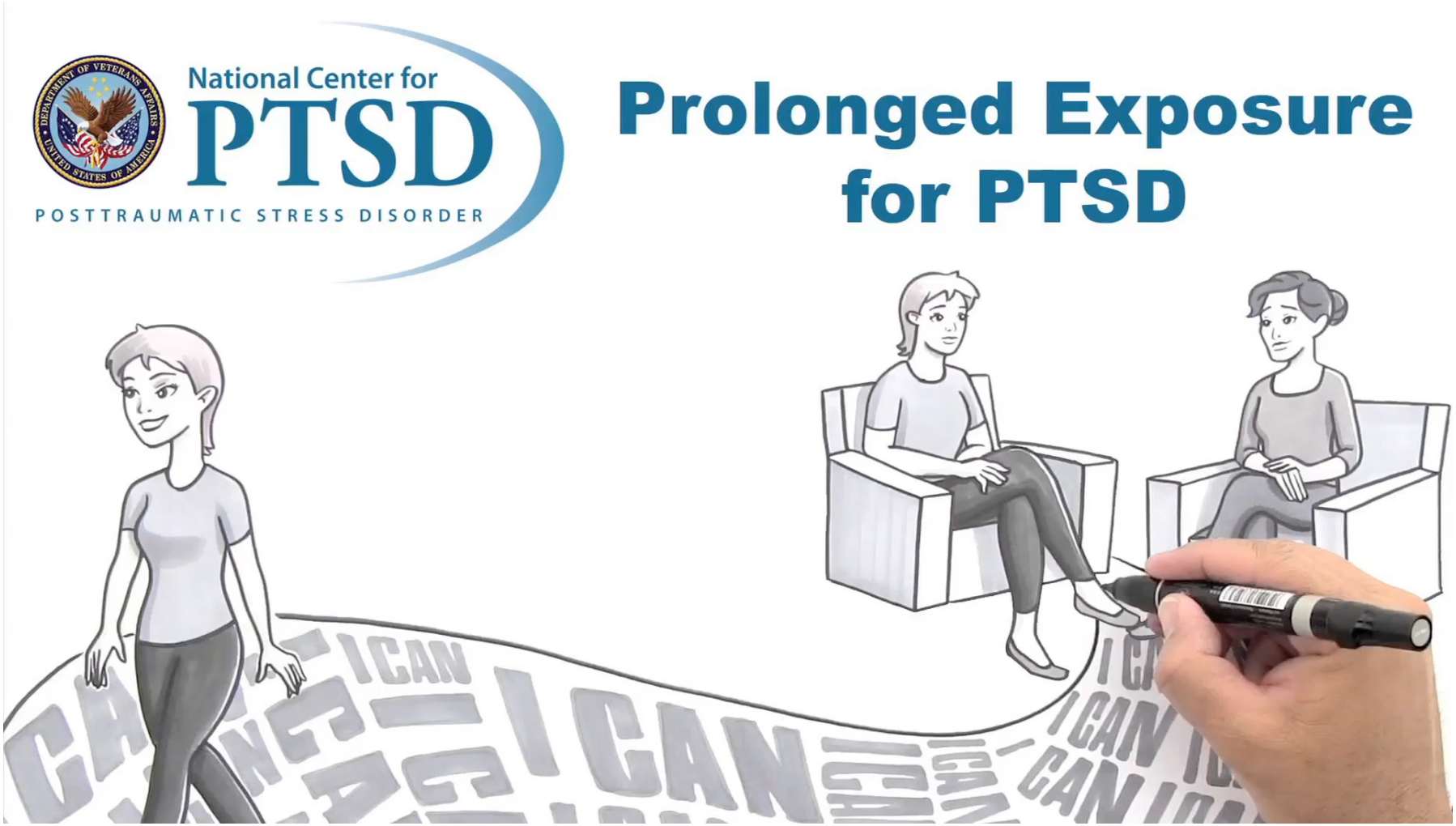
Individual Interventions	Effectiveness
CBT- Adjusting the hyperventilation response, the conditioned reactions to physical cues, the fear and avoidance behaviors, and cognitive aspects of the CT's anxiety Interventions Psychoeducation, monitoring anxiety symptoms, cognitive restructuring, breathing retraining , progressive muscle relaxation, problem solving, exposure	☺☺☺
Prolonged exposure	☺☺☺
EMDR for PTSD	☺☺☺

EMDR



Source: https://www.ptsd.va.gov/appvid/video/index.asp

Prolonged Exposure Therapy



Source: https://www.ptsd.va.gov/appvid/video/index.asp

4) Reactive Attachment Disorder (RAD)

- “RAD describes a constellation of aberrant attachment behaviors and other behavioral abnormalities that are believed to result from social neglect and deprivation” (Zeanah et al., 2016, p.992).

- Markedly disturbed and developmentally inappropriate social relatedness in most contexts that begins before the age of five and is associated with grossly pathological care.

- Ignored child’s needs or unmet with appropriate emotional response from caregivers may cause it

4) Reactive Attachment Disorder (RAD)

RAD can start from 9 months to 5 years old, but it remains uncertain whether it occurs in children older than 5 years.

Signs and symptoms may include:

- Not seeking comfort or showing no response when comfort is given
- Unexplained withdrawal, fear, sadness or irritability
- Sad and listless appearance
- Failure to smile
- Watching others closely but not engaging in social interaction
- Failing to ask for support or assistance
- Failure to reach out when picked up
- No interest in playing peekaboo or other interactive games

4) Reactive Attachment Disorder (RAD)

- **Risk factors**
  - Live in a children's home or other institution
  - Frequently change foster homes or caregivers
  - Dysfunctional family
  - Impaired parenting due to severe mental health problems,
    criminal behavior or substance abuse
  - Have prolonged separation from parents or other caregivers due to medical reason
- **Comorbidity**
  - PTSD

Similarities between RAD and autism

Children with either diagnosis may experience:

- Difficulty with social skills (including use of language)
- Struggles with emotional regulation
- Stimming
- Need for routine
- Unusual eye contact
- May seem calmer when alone
- Avoiding affection
- Listless or sad appearance

However, there are differences:

- RAD caused by childhood distress while autism is not caused by trauma
- RAD always have dysfunctional relationships, but autistic children may or may not
- Children with RAD can have problems with eating depending on who provides food, but children with autism may avoid certain foods due to texture or taste.
- Repetitive language is common for both; autistic children may use echolalia and use it for fun, while children with RAD create scripts to deal with stressful situations
- Autistic children are more solitary and organize their toys rather than creating storylines, while children with RAD seek out others and play out a story.

Source: https://www.wikihow.com/Distinguish-Between-Reactive-Attachment-and-Autism

5) Disinhibited Social Engagement Disorder (DSED)

- History of social neglect
- Socially disinhibited behavior with strangers
- Lack of restraint around adults whom they do not know
- Notably willing to leave caregivers and accompany
- Emotionally “over bright” and attention seeking such as aggression
- Form preferred attachments
- Caregivers as uncomfortable

5) DSED

The child has a developmental age of at least 9 months and specify if it lasts more than 12 months

A. A pattern of behavior at least two of the following:

1.Reduced or absent reticence in approaching and interacting with unfamiliar adults.

2.Overly familiar verbal or physical behavior.

3.Diminished or absent checking back with adult caregiver after venturing away, even in unfamiliar settings.

4.Willingness to go off with an unfamiliar adult with little or no hesitation

B. At least one of the following:

•Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation and affection met by caregiving adults.

•Repeated changes of primary caregivers that limit ability to form stable attachments (e.g., frequent changes in foster care).

•Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child to caregiver ratios).

5) DSED

- **Risk factors**
  - Diathesis stress
  - Neurodevelopmental abnormalities
  - Genetic factors
  - Insufficient caregiving

- **Comorbidity**
  - ADHD
  - PTSD

RAD vs. DSED

Common features

- The absence of adequate caregiving during childhood
- Children under the age of 18 who must have attachment-related trauma that occurred before age of 5.
- Social neglect or deprivation in the form of persistent lack of care
- Repeated changes in primary caregivers
- Rearing in institutional or other unusual settings that limit close attachment

Different features

- RAD demonstrate limited emotional responsiveness such as a lack of remorse, or an inability to register any emotions
- DSED is over-zealousness in their efforts to form attachment to others; impulsive or acting out behaviors can show up

Assessment

TABLE 1 Clinical Observation of Attachment[57]

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

Note: The general rationale for the procedure is to compare the child's behavior with the putative attachment figure to the child's behavior with the stranger, especially with regard to degree of comfort, showing warmth and affection, reliance for help, cooperation, and seeking comfort when afraid or distressed.
[a]Optional episode.

(Zeanah et al., 2016, p.998)

https://www.youtube.com/watch?v=QTsewNrHUHU

- Relationships Problem Questionnaire (RPQ)
- Reactive Attachment Disorder — Checklist (RAD-C)

Interventions

☺☺☺ Very good evidence ☺☺ Good evidence ☺ Promising treatment

Medications- No psychopharmacological intervention trials for RAD or DSED have been conducted

For symptoms of comorbid disorders including anxiety disorders, ADHD, or mood disorders, medication may help

Interventions

Treatment- Goal is supporting attachment Treating experienced trauma due to neglect and abuse
Attachment-based therapies- facilitates attachment through structure, nurturing, attunement, empathy, support, positive affect, etc.
Neurologically-based- EMDR
Occupational therapy- addressing sensory integration issues
Education for parenting- parenting with warmth and support, disciplining to facilitate trust and safety

Reference

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