Trauma- and Stressor-Related D/os

Require exposure to a traumatic event or a stressor that triggers behavioral and/or emotional symptoms that are either clinically significantly distressing or functionally impairing or both.

Trauma exposure varies across people (i.e., for military conflict related trauma, exposure is higher for males than females; for rape it is higher for females than males; for sudden loss of parents (e.g., in December 2006 tsunami), it is higher for children than adults, etc.)

Not all people exposed to a trauma develop a trauma-related disorder, likewise, not all people who have a trauma-related disorder have similar levels of exposure to traumatic events

Examples of Traumatic Events

Experiencing or witnessing a natural disaster such as a tornado or flood

Being in or witnessing a serious accident

Having a sudden life-threatening illness or a serious injury

Being in or having been in military combat or military service in a war zone

Having a close friend or family member killed in an accident or murdered

Having a close friend or family member die suddenly

Being attacked with a weapon (e.g., gun, knife) or witnessing such an attack

Being attacked without a weapon but with intent to cause you harm or death or witnessing such an attack

Being severely beaten as a child or witnessing violence between family members

Having sexual contact as a child with someone meaningfully older

Being pressured, coerced, or forced by someone to have unwanted sexual contact or witnessing such an event occurring to someone else

Reactive Attachment Disorder (1/3)

Only diagnosed in children.

A. A consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers, manifested by both of the following:

1. The child rarely or minimally seeks comfort when distressed.
2. The child rarely or minimally responds to comfort when distressed.

B. A persistent social and emotional disturbance characterized by at least two of the following:

1. Minimal social and emotional responsiveness to others.
2. Limited positive affect.
3. Episodes of unexplained irritability, sadness, or fearfulness that are evident even during nonthreatening interactions with adult caregivers.

Reactive Attachment Disorder (2/3)

C. The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:

1. Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.
2. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
3. Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).

D. The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the lack of adequate care in Criterion C).

Reactive Attachment Disorder (3/3)

E. The criteria are not met for autism spectrum disorder.

F. The disturbance is evident before age 5 years.

G. The child has a developmental age of at least 9 months.

Specifiers:

Persistent (if the disorder has been present for more than 12 months)
Severe (if all symptoms are manifest to a significant degree)

Disinhibited Social Engagement Disorder (1/3)

Only diagnosed in children.

A. A pattern of behavior in which a child actively approaches and interacts with unfamiliar adults and exhibits 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 (that is not consistent with culturally sanctioned and with age-appropriate social boundaries)
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 minimal or no hesitation.

B. The behaviors in Criterion A are not limited to impulsivity (as in ADHD) but include socially disinhibited behavior.

Disinhibited Social Engagement Disorder (1/3)

Only diagnosed in children.

A. A pattern of behavior in which a child actively approaches and interacts with unfamiliar adults and exhibits 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 (that is not consistent with culturally sanctioned and with age-appropriate social boundaries)
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 minimal or no hesitation.

B. The behaviors in Criterion A are not limited to impulsivity (as in ADHD) but include socially disinhibited behavior.

Disinhibited Social Engagement Disorder (2/3)

C. The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:

1. Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.
2. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
3. Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).

D. The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the pathogenic care in Criterion C).

Disinhibited Social Engagement Disorder (2/3)

E. The child has a developmental age of at least 9 months.

Specifiers:

Persistent (if present for more than 12 months)

Severe (if all symptoms are manifest to a significant degree)

Attachment Theory

Generally based on the research of:

Bowlby (1969), Bowlby (1973), and Bowlby (1980)
Ainsworth, Blehar, Waters, & Wall (1978)
Main & Solomon (1990)

Four types of attachment between early caregivers and children:

Secure – child becomes distressed when separated from primary caregiver and when reunited, is able to receive comfort and be comforted

Insecure/Avoidant – child may be distressed when separated from primary caregiver or appear indifferent and when reunited, avoids or ignores the caregiver

Insecure/Ambivalent – child becomes distressed when separated from primary caregiver and when reunited may resist parental attempts to comfort

Disorganized – child may freeze upon separation, become distressed, and freeze again upon reunion, and be indifferent to comfort

Posttraumatic Stress Disorder (1/9)

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

   Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

   For children under the age of 6: Criterion A4 does not apply

Posttraumatic Stress Disorder (2/9)

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

   Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

   For children under the age of 6: May not be experienced as distressing.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

   Note: In children, there may be frightening dreams without recognizable content.

Posttraumatic Stress Disorder (3/9)

Continuation of Criterion B:

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

   Note: In children, trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Posttraumatic Stress Disorder (4/9)

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
   1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
   2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
   1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

Posttraumatic Stress Disorder (5/9)

Continuation of Criterion D:

2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently ruined”).
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).

   For children under the age of 6: Substantially increased negative emotional states.
5. Markedly diminished interest or participation in significant activities (including play for children under 6)
6. Feelings of detachment or estrangement from others.

   For children under the age of 6: Socially withdrawn behavior.

Posttraumatic Stress Disorder (6/9)

Continuation of Criterion D:

7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

   For children under the age of 6: Expression of positive emotions persistently reduced.

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.

   Not noted **For children under the age of 6**

3. Hypervigilance.
4. Exaggerated startle response.

Posttraumatic Stress Disorder (7/9)

Continued from Criterion E:

5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Posttraumatic Stress Disorder (7/9)

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Posttraumatic Stress Disorder (9/9)

Specify if:

- **With delayed expression:** If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Acute Stress Disorder (1/6)

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse)

Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or picture, unless this exposure is work related.

Acute Stress Disorder (2/6)

B. Presence of 9 (or more) of the following symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred:

Intrusion Symptoms:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

   Note: In children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

   Note: In children, there may be frightening dreams without recognizable content.

Acute Stress Disorder (3/6)

B. Intrusion Symptoms:

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring (such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

   Note: In children, trauma-specific reenactment may occur in play

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Negative Mood:

5. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

Acute Stress Disorder (4/6)

B. Dissociative Symptoms:

6. An altered sense of the reality of one's surroundings or oneself (e.g. seeing oneself from another's perspective, being in a daze, time slowing).
7. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

Avoidance Symptoms:

8. Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
9. Efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Acute Stress Disorder (5/6)

B. Arousal Symptoms:

10. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).
11. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
12. Hypervigilance.
13. Problems with concentration
14. Exaggerated startle response.

C. Duration of the disturbance (symptoms in Criteria B) is 3 days to 1 month after trauma exposure.

Acute Stress Disorder (6/6)

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition and is not better explained by Brief Psychotic Disorder.

PTSD – Prevalence, etc.

Prevalence -

- Community-based samples range from 1-14%
- Lifetime prevalence is estimated to be about 7-8% of the adult US population, F:M = 2:1 (10.4% vs. 5%)
- For at-risk populations, prevalence ranges from 3-58% (e.g., combat veterans, victims of volcanic eruptions or criminal violence)

PTSD – Prevalence, etc.

20% of burn victims have symptoms of PTSD (Andreasan, Norris, & Hartford, 1971)

7.5-20% of NYC residents post 9/11 (Schlenger et al., 2002)

Estimated lifetime prevalence of PTSD among American Vietnam veterans is 30.9% for men and 26.9% for women. 22.5% of both genders have had partial PTSD at some point in their lives. 15.2% of all male Vietnam veterans and 8.1% of all female Vietnam veterans have current cases of PTSD.

A study yielded trauma exposure rates of 69% of the general female population (Resnick et al., 1993), approximately 25% of them met criteria for PTSD at some point in their lives

Estimated 39%-75% of the general population has experienced a traumatic stressor (Briere, 1997). The CDC has found that about 60% of US adults have experienced a traumatic event in childhood.

PTSD - Comorbidity

Comorbidity -

- Depressive disorders, Anxiety disorders
- Personality disorders
- Dissociative disorders
- Substance-related disorders (estimated lifetime prevalence of alcohol abuse or dependence among male Vietnam veterans is 39.2%, and the estimate for current alcohol abuse or dependence is 11.2%)
- Eating Disorders
- Sexual dysfunctions or increased sexual behaviors

- Suicide
- Low self-esteem, social isolation
- Unemployment, homelessness, disruptions in family (e.g., conflict, divorce, secondary wounding, child/spousal abuse)
- Loss of faith, guilt, cynicism
- Revictimization

Trauma-related Dsrdrs - Etiology

Diathesis-Stress, with the necessary stressor being a traumatic event

Risk factors include: previous history of trauma, isolation/lack of meaningful emotional supports, substance abuse

Protective factors include: lack of previous exposure to trauma, having supportive relationships

One theory suggests that people have a certain amount of hardiness and resilience and that successive exposure to traumatic events decreases an individual's overall capacity for hardiness. Some theorists believe that severely abused children never fully develop hardiness (PTSD – Type II)

PTSD - Etiology

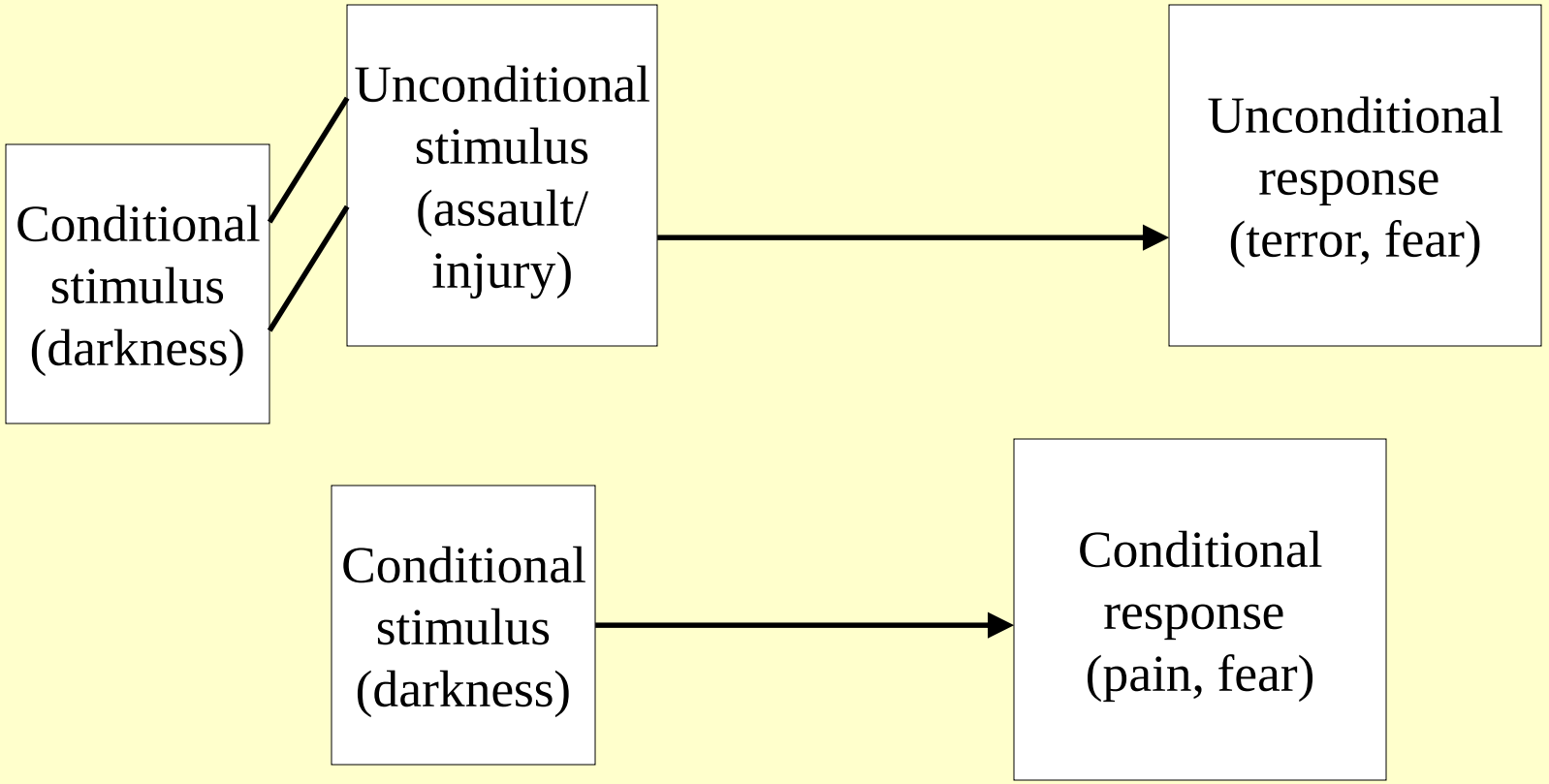
Family Systems Theory

- intergenerational secondary traumatization through parental PTSD that results in violence, neglect (emotional numbing or truncated feelings of love)

- as a form of maintaining attachment, children may take on the symptoms and/or concerns of their parents:

  e.g., fears of separation, avoidance of intimacy, fears of people, places, situations that remind the parent of the traumatic experience

PTSD – Etiology



ASD/PTSD - Treatment

Predominantly CBT, although integrates some gestalt principles, family/marital therapy, pharmacological treatments (for anxiety)

Problematic symptoms need to be identified and addressed:

- dissociative symptoms (grounding techniques, redirection of cognitive processes, mindfulness)
- emotional detachment/numbing (experiential techniques)
- re-experiencing (addressing the distressing thoughts about the re-experiencing)
- avoidance
- anxiety, increased arousal (relaxation training)
- if individual's ability to pursue some necessary task is impaired (i.e., obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience), problem-solving strategies are used, such as improving communication skills, role plays of interpersonal interactions, family or marital therapy

PTSD- Treatment

Cognitive/Behavioral Therapy

- Among the most effective methods for reducing PTSD (Chambless & Ollendick, 2001)

1. Effective treatment requires exposure to corrective information
   - imaginal exposure

     imagining the trauma until emotional habituation occurs, thereby breaking the link between the traumatic event and conditioned emotional arousal

   - in vivo exposure

     to distressing but harmless stimuli

   - Eye Movement Desensitization and Reprocessing (EMDR)

     requires the patient to recall trauma-related memories while engaging in a set of rhythmic eye movements that are thought to facilitate the integrated processing traumatic memories

PTSD- Treatment

Cognitive/Behavioral Therapy

2. Cognitive restructuring that addresses maladaptive thoughts related to the traumatic event and/or PTSD symptoms

- helps patients to identify maladaptive thoughts and question their automatic assumptions

e.g., “I’ll never be able to work again.”

- uses Socratic questions such as:

What’s the evidence that you’ll never be able to work again?
What might happen if you do go back to work again?

- helps patients to re-frame their maladaptive thoughts into more adaptive ones

e.g., My skills/knowledge haven’t changed so it’s not about work but about the setting.

Maybe I can work as long as the setting is safe.

PTSD- Treatment

Pharmacological Interventions

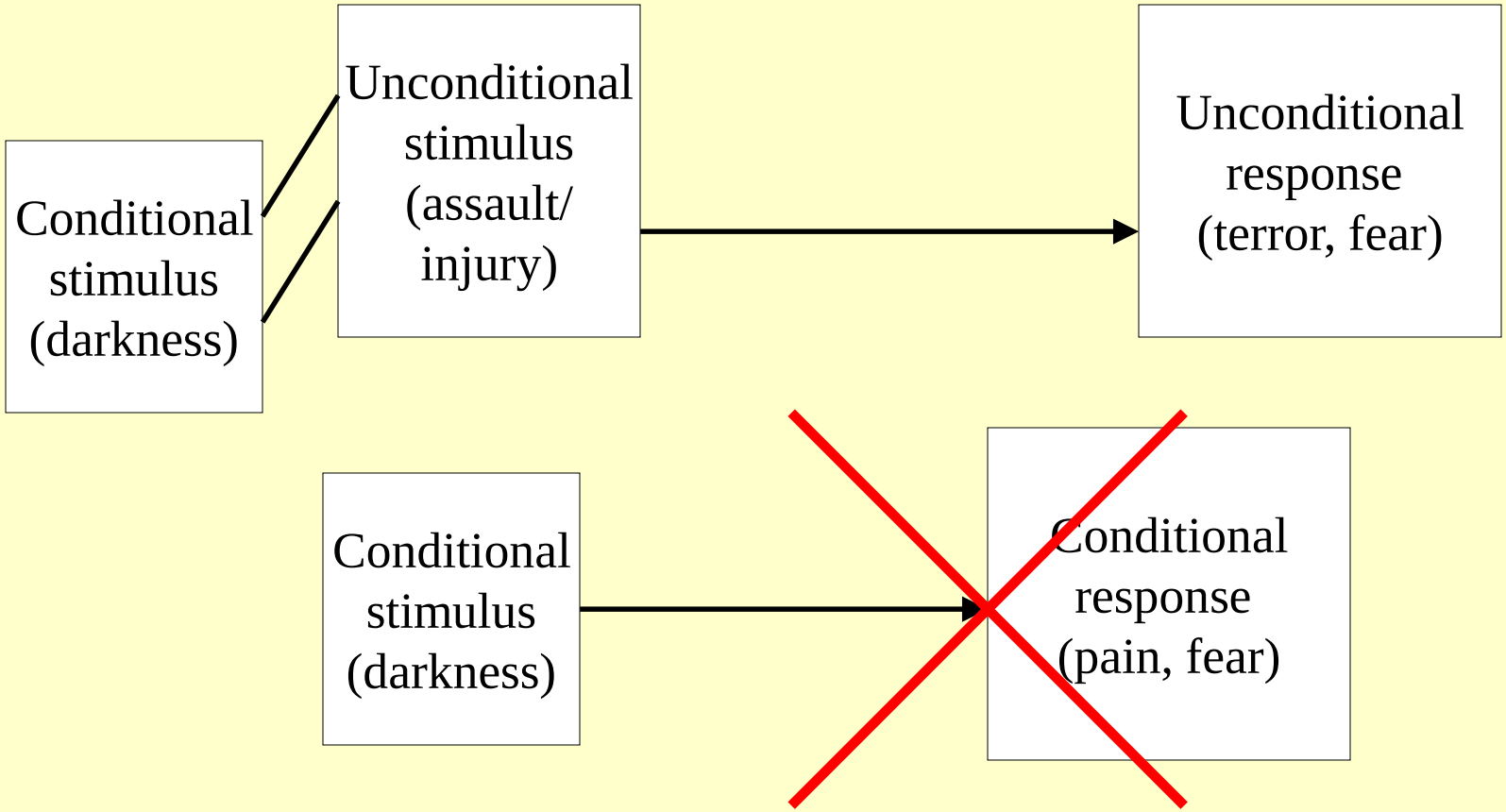
Selective Serotonin Reuptake Inhibitors (e.g., Prozac, Lexapro)

- to address hyperarousal symptoms and improve the effectiveness of therapy/counseling

Remember – therapy asks patients to re-experience their fear and many patients have difficulty tolerating this.

Therefore trust is a vital part of the therapy's effectiveness.

PTSD – Treatment



Adjustment Disorder

A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).

B. These symptoms or behaviors are clinically significant as evidenced by either of the following:

1. Marked distress that is out of proportion to the severity or intensity of the stressor, taking account the external context and the cultural factors that might influence symptom severity and presentation.
2. Significant impairment in social or occupational (academic), or other important areas of functioning.

Adjustment Disorder

C. The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a preexisting mental disorder.

D. The symptoms do not represent normal Bereavement.

E. Once the stressor or its consequences have terminated, the symptoms do not persist for more than an additional 6 months.

Adjustment Disorder

Current Specifiers:

- With Depressed Mood
- With Anxiety
- With Mixed Anxiety and Depressed Mood
- With Disturbance of Conduct
- With Mixed Disturbance of Emotions and Conduct
- Unspecified

Prevalence:

- Ranging from 5-20% in outpatient mental health settings
- Most common diagnosis in hospital psychiatric consultation setting