Trauma & Stressor-Related Disorders with Emphasis on the Mental Health of Women

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Trauma- and Stressor-Related Disorders Workshop Learning Objectives

- Participants will understand “Trauma-and Stressor-Related Disorders” according to the DSM-5
- New Diagnostic Criteria for Post Traumatic Stress Disorder will be reviewed
- Conditions and co-morbidities related to PTSD will be examined
- Best practices and trauma-informed care will be discussed with an emphasis on the mental health of women

Trauma in the DSM-IV-TR and Trauma Now

- Post Traumatic Stress Disorder and Acute Stress Disorder both address diagnoses related to trauma in the DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders- 4th edition, Text Revision)
- In the DSM-IV-TR, these disorders are classified as Anxiety Disorders
- In the DSM-5, these disorders are classified under a new category: Trauma-and Stressor-Related Disorders

Trauma-and Stressor-Related Disorders

Disorders in this sub-group include those in which exposure to a traumatic or stressful event is listed explicitly.

Source: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition DSM-5 (American Psychiatric Association)

Changes from the DSM-IV-TR in Trauma-and Stressor-Related Disorders

- PTSD and Acute Stress Disorder are now classified as Trauma-and Stressor-Related Disorders
- Reactive Attachment Disorder was previously classified as a Disorder Usually First Diagnosed in Infancy, Childhood, or Adolescence
- Reactive Attachment Disorder is re-classified as one of the Trauma-and Stressor-Related Disorders.
- A new diagnosis in the DSM-5 which is classified in the Trauma-and Stressor-Related category is the Disinhibited Social Engagement Disorder

Source: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition DSM-5 (American Psychiatric Association)

Changes from the DSM-IV-TR in Trauma-and Stressor-Related Disorders

- Post Traumatic Stress Disorder in the DSM-5 lists criterion for children 6 years of age and younger along with criteria for adults, adolescents, and children over the age of 6
- Adjustment Disorders are listed as Trauma-and Stressor-Related Disorders in the DSM-5. In the DSM-IV-TR, Adjustment Disorders were their own separate category
- Trauma-and Stressor-Related Disorders now include Specified Disorders, as well as Unspecified Disorders

Source: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition DSM-5 (American Psychiatric Association)

Trauma-and Stressor-Related Disorders

- Reactive Attachment Disorder 313.89 (F94.1)
- Disinhibited Social Engagement Disorder 313.89 (F94.2)
- Posttraumatic Stress Disorder 309.81 (F43.10)
- Acute Stress Disorder 308.3 (F43.0)
- Adjustment Disorders
  - Depressed Mood 309.0 (F43.21)
  - Anxiety 309.24 (F43.22)
  - Mixed Anxiety and Depressed Mood 309.28 (F43.23)
  - Disturbance of Conduct 309.3 (F43.24)
  - Mixed Disturbance of Emotions and Conduct 309.4 (F43.25)
  - Unspecified 309.9 (F43.20)

Trauma-and Stressor-Related Disorders (Continued)

- Other Specified Trauma-and Stressor-Related Disorder 309.89 (F43.8)
- Unspecified Trauma-and Stressor-Related Disorder 309.9 (F43.9)

Source: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition DSM-5 (American Psychiatric Association)

Posttraumatic Stress Disorder 309.81 (F43.10)

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 4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

Posttraumatic Stress Disorder 309.81 (F43.10) (CONTINUED)

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). (Children over 6 may have repetitive play)*
2. *Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). (Children may not recognize content)*
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.) (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 309.81 (F43.10) (CONTINUED)

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).*

Posttraumatic Stress Disorder 309.81 (F43.10) (CONTINUED)

D. Negative alterations in cognitions and mood associated with 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).*
2. *Persistent and exaggerated negative beliefs or expectations about oneself, others, or of the world (e.g., "I am bad," "No one can be trusted,"etc.)*
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).*
5. *Markedly diminished interest or participation in significant activities.*
6. *Feelings of detachment or estrangement from others.*
7. *Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).*

Posttraumatic Stress Disorder 309.81 (F43.10) (CONTINUED)

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.*
3. *Hypervigilance.*
4. *Exaggerated startle response.*
5. *Problems with concentration.*
6. *Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).*

Posttraumatic Stress Disorder 309.81 (F43.10) (CONTINUED)

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 to another medical condition.

Source: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition DSM-5 (American Psychiatric Association)

Specifiers for PTSD

- With Dissociative Symptoms (not attributable to substances or other medical condition)
  - Depersonalization
  - Derealization
- With Delayed Expression (when full diagnostic criteria is not met until at least 6 months after the event)

Source: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition DSM-5 (American Psychiatric Association)

Posttraumatic Stress Disorder for Children 6 years and younger

- Criteria A is the same as adults except the 4th criteria is not valid because it deals with repeated exposures for first responders
- Criteria B is the same as adults except that spontaneous and intrusive memories may not appear distressing and may be expressed in play reenactment and it may not be possible to ascertain that frightening content is related to the traumatic event.
- Criteria C states that One (or more) of the following symptoms, representing either persistent avoidance of stimuli associated with the traumatic event(s) or negative alterations in cognitions and mood associated with the traumatic event(s) must be present, beginning after the event(s) or worsening after the event(s). In children, Persistent Avoidance of Stimuli and Negative Alterations in Cognitions differs from the adult criteria.

Posttraumatic Stress Disorder for Children 6 years and younger (CONTINUED)

Criteria D differs somewhat compared to the adult criteria and includes criteria from the adult E criteria. Child PTSD criteria D is:

- *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 nor provocation) typically expressed as verbal or physical aggression toward people or objects (including extreme temper tantrums).*
  2. *Hypervigilance.*
  3. *Exaggerated startle response.*
  4. *Problems with concentration.*
  5. *Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).*

Posttraumatic Stress Disorder for Children 6 years and younger (CONTINUED)

F and G differ due to the child's age and are as follows:

F. The disturbance causes clinically significant distress or impairment in relationship parents, siblings, peers, or other caregivers or with school behavior.

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

Specifiers are the same as in the adult disorder

Source: Diagnostic and Statistical Manual of Mental Disorders, Fifth Editio DSM-5 (American Psychiatric Association)

Risk and Prognostic Factors for PTSD

- Usually risk factors are divided into categories of pretraumatic, peritraumatic, and posttraumatic
- Pretraumatic Factors include:
  - Temperamental
  - Environmental
  - Genetic and physiological
- Peritraumatic Factors include:
  - Environmental
- Posttraumatic Factors include:
  - Temperamental
  - Environmental

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paring PTSD Criteria for DSM-5 *(and* DSM-IV*) for Adults, Adolescents, and Children Older than 6*

rion	Symptom category	# Symptoms required	Specific symptoms
	Exposure to a traumatic event (A_1)		1. Directly experiencing the event(s) 2. Witnessing the event(s) 3. Learning that the event(s) occurred to a close relative or close friend[a] 4. Experiencing repeated or extreme exposure to aversive details of the event(
			Eliminated in *DSM-5* (i.e., fear, helplessness, or horror)
	Intrusion symptoms	1	1. Intrusive distressing memories of the traumatic event(s) (*DSM-IV* B_1) 2. Recurrent distressing trauma-related dreams (*DSM-IV* B_2) 3. Dissociative reactions (e.g., flashbacks) (*DSM-IV* B3) 4. Intense psychological distress when exposed to traumatic reminders (*DSM-IV* B_4) 5. Marked physiological reactions to reminders of the traumatic event(s) (*DSM-IV* B_5)
	Avoidance symptoms	1	1. Persistent avoidance of thoughts and memories (*DSM-IV* C_1) 2. Persistent avoidance of external reminders (*DSM-IV* C_2)
	Negative alterations in cognitions and mood	2	1. Dissociative amnesia of the traumatic event(s) (*DSM-IV* C_3) 2. Persistent negative expectations (*DSM-IV* C_7) 3. Persistent distorted blame of self or others about the traumatic event(s) (ne 4. Persistent negative emotional state (new) 5. Diminished interest or participation in significant activities (*DSM-IV* C_4) 6. Feeling of detachment or estrangement from others (*DSM-IV* C_5) 7. Persistent inability to experience positive emotions (*DSM-IV* C_6)
	Alterations in arousal and reactivity	2	1. Irritable behavior or angry outbursts (*DSM-IV* D_2) 2. Reckless or self-destructive behavior (new) 3. Hypervigilance (*DSM-IV* D_4) 4. Exaggerated startle response (*DSM-IV* D_5) 5. Problems with concentration (*DSM-IV* D_3) 6. Sleep disturbance (*DSM-IV* D_1)
	Duration of symptoms is > 1 month		
	Symptoms cause significant distress or functional impairment		
	Symptoms are not due to alcohol, drugs, or medication		1. Specify if: dissociative subtype (full PTSD + derealization or depersonalization 2. Specify if: preschool subtype (1 B and 2 E, but only 1 C or D symptoms ar needed)[c] 3. Specify if: with delayed expression of symptoms

PTSD = posttraumatic stress disorder; *DSM* = *Diagnostic and Statistical Manual of Mental Disorders*.

not include traumatic exposure through electronic media. [b]All B, C, D, and E symptoms began or worsened after exposure to the traumatic event(s). [c]Only f
mptoms are included (D_{1-3}); reckless behavior (E_2) is not included.

DSM-5 Criteria Changes for PTSD

- Fear, Hopelessness, or Horror have been eliminated from Criteria A for PTSD, as compared to the DSM-IV.
- In Criteria D, two new symptoms have been added:
  - Persistent distorted blame of self or others about the traumatic event
  - Persistent negative emotional state
- In Criteria E, 1 new symptom has been added:
  - Reckless or self-destructive behavior

Source: Friedman (2013); Finalizing PTSD in DSM-R Getting Here from There and Where to Go Next. Journal of Traumatic Stress. pp 548-556.

DSM-5 Criteria Changes for PTSD

Discussion:

- As Clinicians, what do these criteria changes mean for us in our practice?

Accurately Diagnosing PTSD

What is the difference in an Adjustment Disorder and Post Traumatic Stress Disorder Diagnosis?

Accurately Diagnosing PTSD

- There must be a stressful/traumatic event, but this is not sufficient for a diagnosis
- There must be “re-experiencing responses”
- There must be psychological distress regarding internal and external triggers
- There must be 3 or more “avoidance and numbing responses”
- Symptoms must persist at least one month

Source: Knight, C (2006); Groups for Individuals with Traumatic Histories: Practice Considerations for Social Workers, Social Work, Volume 51, Number I, pp. 20-30

Accurately Diagnosing PTSD

Complex PTSD/ PTSD II

What is Complex PTSD?

Complex PTSD/ PTSD II

- CPTSD was first proposed by Herman (1992)
- CPTSD was a syndrome observed in survivors of repeated and prolonged trauma
- CPTSD is closely related to DESNOS (Disorders of Extreme Stress, not otherwise specified)
- In the literature, there is: "significant variability in descriptions of the types of traumatic events that precipitate CPTSD"

Source: Resick, Bovin, et.al. (2012), A Critical Evaluation of the Complex PTSD Literature: Implications for DSM-5, Journal of Traumatic Stress 25, pp. 241-251.

Complex PTSD/ PTSD II

- Symptoms:
  - Reexperiencing, Avoidance, Numbing, and Hyperarousal as in PTSD
  - Disturbance in self-regulatory capacities:
    - Emotion Regulation
    - Relational Capacities
    - Attention and Consciousness (Dissociation)
    - Adversely affected belief systems
    - Somatic distress or somatization

  Note: there are additional proposed symptoms such as self-harm and hopelessness that do not fall in these clusters and a lack of consistency in defining CPTSD at this time.

Source: Resick, Bovin, et.al. (2012), A Critical Evaluation of the Complex PTSD Literature: Implications for DSM-5, Journal of Traumatic Stress 25, pp. 241-251.

Diagnosing CPTSD

- The Structured Interview for Disorders of Extreme Stress (SIDES) measures DESNOS, but DESNOS and CPTSD are often used interchangeably
- There are documented limitations to using SIDES for a diagnosis
- A positive diagnosis on SIDES only indicates symptoms are presented. An individual must also report trauma exposure
- Other measures have been used such as a Negative Mood Regulation Scale and the State-Trait Anger Expression Inventory. The Trauma Symptom Inventory is also a scale that is used and the Dissociation Scale (DES). Multiple other scales and assessment measures have been used. Efforts are being made to develop measures for CPTSD

Source: Resick, Bovin, et.al. (2012), A Critical Evaluation of the Complex PTSD Literature: Implications for DSM-5, Journal of Traumatic Stress 25, pp. 241-251.

Comorbidities in Trauma and Stressor-Related Disorders

Comorbidities in Trauma and Stressor-Related Disorders

What Comorbidities do you find in your practice?

What seems to be the most dominant or prevalent comorbidity that you see in your practice?

Posttraumatic Stress Disorder Prevalence

- According to Seng, Graham-Bermann, Clark, et.al., in adults, PTSD is twice as common in women and is associated with increased risk for a range of diseases, chronic conditions, and reproductive-health problems.
- In young girls who receive Medicaid benefits, PTSD was associated with increased prevalence and a range of adverse health conditions

Comorbidities to Consider particularly in PTSD- Health Factors, The Brain, Etc.

http://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime

Comorbidities in Trauma and Stressor-related Disorders, particularly PTSD

According to Nadine Burke Harris in her Ted Talk (2014):

“High doses of adversity not only affect brain structure and function, they affect the developing immune system, developing hormonal systems, and even the way our DNA is read and transcribed.”

Comorbidities to Consider- Homelessness, Addiction, Bereavement, Suicide Ideation

https://www.youtube.com/watch?v=5m6Vn1LuMe8&index=3&list=PLh6FCUFIJEL9nxEW1Ii2NWtQ33UURjkEW

Comorbidity

- 80% of those with PTSD have symptoms that indicate that they meet diagnostic criteria for at least one other mental disorder
- More common among males than females are Comorbid Substance Use Disorder and Conduct Disorder
- Most common among children is Oppositional Defiant Disorder and Separation Anxiety Disorder
- There is considerable comorbidity between PTSD and major neurocognitive disorder
- For veterans in recent wars, the co-occurrence with mild TBI (Traumatic Brain Injury) is 48%

Source: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition DSM-5 (American Psychiatric Association: 2013)

Comorbidity

According to Jennifer M. Howes, LCSW-C in her article in the NASW Specialty Practice Sections, as well as stated in the Nadine Harris Ted Talk:

The Adverse Childhood Experience (ACE) study, found that those who had adverse experiences (trauma) had the following:

- Twice as likely to smoke
- Twelve times more likely to have attempted suicide
- Seven times more likely to be addicted to alcohol
- Ten times more likely to have injected street drugs (Redding, 2003).

Comorbidity
Victims of Crime

- Studies found that due to fear of involvement in the criminal justice system, crimes are not reported
- Of those who do report crimes, “victims were either ignored or viewed as “tools” to use to identify and punish offenders”
- The most comprehensive study shows that in male and female crime victims with PTSD, there is a prevalence of other psychological disorders: 88% for males and 79% for females
- Those victimized are likely to be re-victimized
- Secondary trauma is a risk for practitioners working with victims

Source: Crime Victim Assistance, Social Work Speaks (2012), pp. 65-69

Comorbidity
Complicated Grief

- Complicated Grief (CG) is not a formal diagnosis but is a topic for study in the DSM-5
- CG is defined as “a debilitating syndrome that is comprised of symptoms interfere with adaptation and reengagement in life after bereavement
- CG will be in the same category as PTSD and Adjustment Disorders, as a stress response disorder
- Death is “a clearly identifiable event that is expected to trigger a time-limited psychological response in most people”

Source: Simon, N. (2012). Is Complicated Grief A Post-Loss Stress Disorder? Depression and Anxiety: 29: 541-544

Comorbidity
Complicated Grief

- Features of Complicated Grief overlap with PTSD
- Complicated Grief can be summarized as a “Post-loss Stress Disorder”
- Significant losses can lead to stress-related symptoms such as those seen in PTSD and can overlap and cause risks for PTSD and CG

Source: Simon, N. (2012). Is Complicated Grief A Post-Loss Stress Disorder? Depression and Anxiety: 29: 541-544

Comorbidity
Depression and Suicide Risk

- According to the DSM-5 (APA 2013), Major Depression may or may not be preceded by a trauma
- Symptoms do not over-lap. Depression and PTSD are differential diagnosis'
- *However*, PTSD is associated with suicidal ideation and childhood abuse increases a person's suicide risk

Source: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition DSM-5 (American Psychiatric Association: 2013)

Treatment Modalities

What do you find to be the most effective treatment in your practice?

Trauma Treatment with Strongest Efficacy

- All cognitive behavioral programs that include variants of Exposure Therapy, Stress Inoculation Training (SIT), EMDR, and combinations of these.
- Exposure may not be important if social supports are in place
- Studies are going on now to compare exposure-based treatment to interpersonal

What is Trauma Informed Care?

According to Jennifer M. Howes, LCSW-C in her article in the NASW Specialty Practice Sections, Trauma Informed Care (TIC) incorporates our understanding that there is a high prevalence of trauma in the clients we see.

Treatment Modalities

- All types of psychotherapy
- Group Therapy
- Critical Incident Stress Management (CISM)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Medication
- MDMA and talk therapy
- Combination Therapies
- Other Techniques (Attachment & Relationship-based treatments, multi-modal approach, Yoga Nidra for soldiers)
- Twelve Step Groups

Treatment/Recovery through Education

- Many survivors of trauma, often do not recognize that they have experienced “abuse” or “trauma”
- Education in a non-threatening, safe atmosphere is a way to begin the healing process
- Common results from trauma are normalized as the survivor realizes that what he or she is experiencing is simply a result of the trauma
- Survivors are typically educated in groups and sometimes in individual therapy
- Survivors learn about their own mental health and ways that they can heal

Exposure Therapy

- Assists trauma survivors in therapeutically confronting distressful trauma memories
- May include imagined confrontation with a memory
- May include real-life exposure to trauma reminders

Treatment/Recovery Through Containment

- Containment provides a provision of safety
- Containment can be used in several ways to assist client in feelings of safety
- A “safe” or “calm” place can be established. If not appropriate, the place can be “a place of control” or “a courageous place”
- Guided Imagery
- Parameters and Boundaries

Important

- Complete a thorough assessment
- Let the client tell their story
- Be a team with the client- empathize, understand, build rapport, support them in decisions, provide emotional and social support, identify, listen, reflect
- Work on a genogram together/complete client history, as client is able
- Refer for meds if necessary and/or monitor mental health
- Begin intervention (CBT, EMDR, Containment, Groups, etc.)

Conclusion

- The study of trauma can take years, we need to keep in mind that anyone we see may have trauma. Hodas (2003) believes that our approach should be like that of taking universal precautions- assuming that each person we see could have trauma because of what we know about the pervasiveness of it.
- According to Howe, although not everyone can provide Traumatic Specific Services, we can provide TIC (Trauma Informed Care) in our approach with individuals