A WALK THROUGH THE DSM 5: CHILDHOOD TRAUMA AND NEURODEVELOPMENTAL DISORDERS

Marybeth A. Graham, Ph.D.  
(mgraham2@salud.unm.edu)

Dina E. Hill, Ph.D.  
(dhill@salud.unm.edu)

Cynthia King, MD  
(cyking@salud.unm.edu)

UNM Department of Psychiatry
Disclosures

• Dr. Graham has no financial relationships or conflicts of interest related to this presentation.

• Dr. Hill has a contract with IHS for neuropsychological assessment of children through her private practice.

• Dr. King has no financial relationships or conflicts of interest related to this presentation. She is not involved in any clinical drug trials.
Overview of Neurodevelopmental Series

• **Session 1**: Intellectual Disabilities

• **Session 2**: Communication Disorders

• **Session 3**: ADHD/Externalizing Disorders

• **Session 4**: Specific Learning Disorders

• **Session 5**: Motor Disorders

• **Session 6**: Special Topics
DSM 5:
Trauma and Stressor-Related Disorders

• Reactive Attachment Disorder

• Disinhibited Social Engagement Disorder

• Posttraumatic Stress Disorder

• Acute Stress Disorder

• Adjustment Disorders
Session 6: Childhood Trauma and Neurodevelopmental Disorders

Goals/Objectives

• Practitioners will be able to identify children with childhood trauma, while considering differential and co-morbid diagnoses.

• Practitioners will be able to provide families with directions to accessing resources and interventions.

• Practitioners will be able to identify the impact of culture/language/race in identifying and treating individuals with childhood trauma.
Why is it important to consider the impact of trauma, toxic stress or adverse experiences on children?
The brains of traumatized children develop as if the entire world is chaotic, unpredictable, violent, frightening, and devoid of nurturance.

~Bruce Perry, M.D., Ph.D., founder ChildTrauma Academy, Houston, TX
Not every child who is exposed to or experiences a traumatic event goes on to develop PTSD.
Normative, developmentally appropriate stress

Emotionally costly (Toxic) stress

Traumatic stress

8 Things to remember about Child Development

• All children, including very young children are affected adversely when significant stresses threaten their family and caregiving environment.

• Development is a highly interactive process, and life outcomes are not determined solely by genes.

• While attachments to parents are primary, young children can also benefit from other responsive and nurturing relationships (e.g., childcare workers, teachers, grandparents).
8 Things to remember about Child Development

• A great deal of brain architecture is shaped during the first three years after birth, but the window of opportunity for its development does not close after a child’s third birthday.

• Severe neglect appears to be as great a threat to health and development as physical abuse – perhaps even greater.
8 Things to remember about Child Development

• Young children who have been exposed to adversity or violence do not invariably develop stress-related disorders or grow up to be violent adults.

• Simply removing a child from a dangerous environment will not automatically reverse the negative impacts of the experience.

• Resilience requires relationships.

http://developingchild.harvard.edu/resources/8-things-remember-child-development/
Reactive Attachment Disorder: Diagnostic Criteria

• A. Consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers.

• B. Persistent social and emotional disturbance.

• C. Child has experienced a pattern of extremes of insufficient care.
Reactive Attachment Disorder: Diagnostic Criteria

• D. The care on Criterion C is presumed to be responsible for the disturbed behavior in Criterion A.

• E. Criteria not met for autism spectrum disorder.

• F. Disturbance evident prior to age 5.

• Child has a developmental age of at least 9 months
Disinhibited Social Engagement Disorder: Diagnostic Criteria

• A. Pattern of behavior in which a child actively approaches and interacts with unfamiliar adults

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

• C. Child has experienced a pattern of extremes of insufficient care
Disinhibited Social Engagement Disorder: Diagnostic Criteria

• D. The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A.

• E. Child has a developmental age of at least 9 months.
Posttraumatic Stress Disorder: Diagnostic Criteria

For adults, adolescents, children older than 6 years:

A. Exposure to actual or threatened death, serious injury, or sexual violence

Beginning after traumatic event occurs:

B. Presence of intrusion symptoms associated with the traumatic event

C. Persistent avoidance of stimuli associated with traumatic event
Posttraumatic Stress Disorder: Diagnostic Criteria

*Beginning or worsening after the traumatic event(s):*

D. Negative alterations in cognitions and mood associated with the traumatic event(s).

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

F. Duration of the disturbance is more than 1 month

G. Disturbance causes clinically significant distress or impairment in functioning.

H. Not due to substances or other medical condition.
Posttraumatic Stress Disorder: Diagnostic Criteria

For children 6 and younger:

• A. Exposure to actual or threatened death, serious injury, or sexual violence.

Beginning after traumatic event occurs:

• B. Presence of intrusion symptoms associated with the traumatic event
Posttraumatic Stress Disorder: Diagnostic Criteria

• C. Persistent avoidance of stimuli OR negative alterations in cognitions.

• D. Alterations in arousal and reactivity associated with the traumatic event(s).

• E. Duration is more than 1 month.

• F. Disturbance causes clinically significant distress or impairment in functioning.

• G. Not due to substances or other medical condition.
Acute Stress Disorder:
Diagnostic Criteria

• A. Exposure to actual or threatened death, serious injury, or sexual violation

• B. Presence of nine (or more) symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance, and arousal beginning or worsening after the traumatic event(s).
Acute Stress Disorder: Diagnostic Criteria

F. Duration of the disturbance is 3 days to 1 month

G. Disturbance causes clinically significant distress or impairment in functioning.

H. Not due to physiological effects of substances or another medical condition and is not better explained by a brief psychotic disorder.
Adjustment Disorders: Diagnostic Criteria

• 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. Symptoms or behaviors are clinically significant.

• C. The stress-related disturbance does not meet criteria for another mental disorder and is not merely an exacerbation of a preexisting mental disorder.
Adjustment Disorders: Diagnostic Criteria

• D. 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.

• Specifiers:
  • With depressed mood; anxiety; mixed anxiety and depressed mood; disturbance of conduct; mixed disturbance of emotions and conduct; unspecified.
Trauma- and Stressor-Related Disorders: Comparison DSM-IV & DSM-5

• DSM-5 Acute Stress Disorder: qualifying events are now explicit as to being experienced directly, witnessed, or experienced indirectly.

• DSM-5 Adjustment Disorders: reconceptualized as an array of stress-response syndromes rather than as a residual category for individuals with clinically significant distress but who do not meet criteria for a more discrete disorder.
• DSM-IV childhood diagnosis reactive attachment disorder had two subtypes: emotionally withdrawn/inhibited and indiscriminately social/disinhibited. In DSM-V, these subtypes are defined as distinct disorders.
Trauma- and Stressor-Related Disorders: Comparison DSM-IV & DSM-5

• DSM-5 criteria for PTSD is significantly different.
  • More explicit regarding criterion stressors that qualify as “traumatic.”
  • Four major symptoms clusters instead of three – re-experiencing, avoidance, persistent negative emotional states (retains most of DSM-IV numbing symptoms as well as new or reconceptualized symptoms), and alterations in arousal and reactivity
  • Developmentally sensitive with lower thresholds for children and adolescents and separate criteria for children under 6.
Trauma- and Stress-Related Disorders: Comorbid Conditions

• Reactive Attachment Disorder
  • Cognitive and language delays; medical conditions (severe malnutrition); depressive symptoms

• Disinhibited Social Engagement Disorder
  • Limited research; conditions associated with neglect – delays, ADHD
Trauma- and Stress-Related Disorders: Comorbid Conditions

• Posttraumatic Stress Disorder
  • Individuals with PTSD 80% more likely to have symptoms that meet diagnostic criteria for at least one other mental disorder (e.g., depression, bipolar, anxiety or substance use)
  • Most young children with PTSD also have at least one other diagnosis, with oppositional defiant disorder and separation anxiety disorder predominating.
Trauma- and Stress-Related Disorders: Comorbid Conditions

• Adjustment Disorders
  • Can accompany most mental disorders and any medical disorder. Commonly occur with medical illness and may be major response to a medical disorder.
Trauma- and Stress-Related Disorders: Differential Diagnosis

- Autism spectrum disorder
- Intellectual disability
- Depressive disorders
- ADHD
- Acute Stress Disorder
- Panic Disorder/OCD
- Major Depressive Disorder
- Dissociative Disorder
- Psychotic Disorder
Alternative conceptualizations in assessing childhood trauma

• Terr (1991)
  • Type I trauma: single, sudden, and unexpected traumatic experiences.
  • Type II trauma: Involves repeated events which can sometimes be anticipated (e.g., physical/sexual abuse). Children less likely to access protective social supports or establish positive coping strategies.
• Terr’s work contributed to a clinical description of a developmental trauma disorder
CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study

- Original study from 1995-1997 asked over 17,000 HMO members from Southern California to complete surveys about their childhood experiences and their current health status and behaviors.

- Family Health History and Health Appraisal Questionnaire
  - (measures are in the public domain and are free of charge.)
Conceptual framework for the ACE study
ACE questions

• Emotional abuse
• Physical abuse
• Sexual abuse
• Mother treated violently
• Household substance abuse
• Mental illness in the household
• Parental separation or divorce
• Criminal household member
• Emotional neglect
• Physical neglect
Major Study Findings – Increased risk for the following:

- Alcoholism and alcohol abuse
- Chronic obstructive pulmonary disease
- Depression
- Fetal death
- Health-related quality of life
- Illicit drug use
- Ischemic heart disease
- Liver disease
- Poor work performance
- Financial stress
- Risk for intimate partner violence
- Multiple sexual partners
- Sexually transmitted diseases
- Smoking
- Suicide attempts
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity
- Adolescent pregnancy
- Risk for sexual violence
- Poor academic achievement
Trauma- and Stress-Related Disorders: Identification/Evaluation

• Why are we looking at this issue?

• What are we looking for?
  • Who to assess and when

• How do we find it?
  • Questionnaires, direct interview
  • How to document

• What do we do once we have found it?

Trauma- and Stress-Related Disorders: Interventions

- It is important to identify children who have experienced adverse life events and subsequent negative reactions and begin appropriate interventions as soon as possible.

- Early referral and intervention may help improve the child's overall development and lead to better long-term functional outcomes.
Accessing Local or State-wide Resources and Interventions

- Indian Health Services (hospitals, health centers, field clinics)
- Local department of public health
- Local department of human services
- Child abuse hotlines
- Larger child care centers, including Head Start
- Local Title V division or state program for CYSHCN (through DOH in NM)
- Local United Way organization
- Local 211/311 program
- Local chapters of Family-to-Family Network or other family-centered organizations such as Family Voices, child protective services, and Children’s Advocacy Center
- Nonprofit social service organizations that offer a broad range of programs and services for youth and families
Core Components of Interventions

• Motivational interviewing (to engage clients)

• Risk screening (to identify high-risk clients)

• Triage to different levels and types of intervention (to match clients to the interventions that will most likely benefit them/they need)

• Systematic assessment, case conceptualization, and treatment planning (to tailor intervention to the needs, strengths, circumstances, and wishes of individual clients)
Core Components of Interventions

• Engagement/addressing barriers to service-seeking (to ensure clients receive an adequate dosage of treatment in order to make sufficient therapeutic gains)

• Psychoeducation about trauma reminders and loss reminders (to strengthen coping skills)

• Psychoeducation about posttraumatic stress reactions and grief reactions (to strengthen coping skills)

• Teaching emotional regulation skills (to strengthen coping skills)
Core Components of Interventions

• Maintaining adaptive routines (to promote positive adjustment at home and at school)

• Parenting skills and behavior management (to improve parent-child relationships and to improve child behavior)

• Constructing a trauma narrative (to reduce posttraumatic stress reactions)

• Teaching safety skills (to promote safety)

• Advocacy on behalf of the client (to improve client support and functioning at school, in the juvenile justice system, and so forth)
Core Components of Interventions

• Teaching relapse prevention skills (to maintain treatment gains over time)

• Monitor client progress/response during treatment (to detect and correct insufficient therapeutic gains in timely ways)

• Evaluate treatment effectiveness (to ensure that treatment produces changes that matter to clients and other stakeholders, such as the court system)

National Child Traumatic Stress Network

http://nctsn.org/training-guidelines

http://www.nctsn.org/content/identifying-and-providing-services-young-children-who-have-been-exposed-trauma-professionals
Cultural Considerations for Diagnosis & Intervention

• Diagnostic evaluations to occur in settings where children and their families feel most safe and protected.

• Improving access to quality care—such as increasing the number of service facilities (especially in geographically remote areas) and of staff fluent in the languages spoken in the surrounding communities.
Cultural Considerations for Diagnosis & Intervention

• Reevaluating costs versus benefits of providing culturally appropriate and responsive services.

• Reducing obstacles (e.g., cultural differences, language barriers) in managed care that can result in underutilization of services, lower-quality care, and poor outcomes.
Cultural Considerations for Diagnosis & Intervention

• Helping to overcome individuals’ objections to seeking mental health services (such as shame, stigma, and discrimination).

• Developing and evaluating culturally responsive services with community input and participation.

• Encouraging positive ethnic identity.
Cultural Considerations for Diagnosis & Intervention

• Addressing social adversities (e.g., poverty, community violence, racism, discrimination) and helping to strengthen families—including building on existing supports (such as churches and other spiritual communities).

• Intervention goals must be appropriate to the particular culture of the child and family and informed by their input and beliefs.