Diagnostic and Statistical Manual-5: Trauma & Stressor-Related Disorders in Children and Adolescents

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DSM-5: Proposed Metastructure

Neurodevelopmental Disorders
Schizophrenia Spectrum & Other Psychiatric Disorders
Bipolar & Related Disorders
Depressive disorders
Anxiety Disorders
Obsessive-Compulsive, Stereotypic & Related Disorders
Trauma- and Stressor-Related Disorders
Dissociative Disorders
Somatic Symptom Disorders etc.

Courtesy of Dr. Matthew Friedman, National Center for PTSD

DSM-IV Anxiety Disorders in DSM-5

- Anxiety Disorders
  - Panic, Specific Phobia, Social Phobia, GAD etc.
- O-C, Stereotypic & Related Disorders
  - OCD, Body Dysmorphic, Hoarding, Hair Pulling, Skin Picking, etc.
- Trauma- and Stressor-Related Disorders
  - PTSD, ASD, ADs, RAD, DSES.
- Dissociative Disorders
  - DID, Depersonalization/Derealization, Dissociative Amnesia, etc.

Courtesy of Dr. Matthew Friedman, National Center for PTSD

PTSD Major Changes: DSM-IV to DSM-5

- All 5x onset/exacerbation after trauma exposure
- Tightening A1 Criterion
- Eliminating A2 Criterion
- 3 New symptoms – Clarification of others
- 4 (rather than 3) Symptom Clusters
- Special Criteria for Pre-Schoolers
- Dissociative Sub-type

Courtesy of Dr. Matthew Friedman, National Center for PTSD
Proposed PTSD Criteria for DSM-5

A. The person was exposed to the following event(s): death or threatened death, actual or threatened serious injury, or actual or threatened sexual violation, in one or more of the following ways:
   1. Experiencing the event(s) him/herself
   2. Witnessing, in person, the event(s) as they occurred to others
   3. Learning that the event(s) occurred to a close relative or close friend; in such cases the actual or threatened death must have been violent or accidental.
   4. Experiencing repeated or extreme exposure to aversive details of the event(s) (e.g., first responders collecting body parts; police officers repeatedly exposed to details of child abuse); this does not apply to exposure through electronic media, television, movies or pictures unless this exposure is work-related.

B. Re-experiencing symptoms

C. Persistent avoidance of stimuli associated with the trauma

D. Negative alterations in cognitions and mood that are associated with the traumatic event

   1. Persistent & exaggerated negative expectations about one’s self, others or the world (e.g. “I am bad,” “no one can be trusted,” “my whole nervous system is permanently ruined,” “the world is completely dangerous” (C7)
   2. Persistent distorted blame of self or others about the cause or consequences of the traumatic event (e.g. self-blame) (new)
   3. Persistent negative emotional state (for example: fear, horror, anger, guilt, or shame) (new)
   4. Persistent inability to experience positive emotions
E. Alterations in Arousal & Reactivity

1. Irritable or aggressive behavior (e.g. yelling at other people, getting into fights or destroying things (revised D3)
2. Reckless or self-destructive behavior (e.g. driving too fast or while intoxicated, heavy drug or alcohol use, risky sexual behavior, or trying to injure or harm oneself). (new)

Proposed PTSD Criteria for DSM-5

E. Alterations in arousal and reactivity that are associated with the traumatic event
F. Duration of the disturbance is more than one month
G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

DSM-IV Acute Stress Disorder

A. PTSD A Criterion
   A₁ & A₂ symptoms
B. Dissociative symptoms (>3)
   1. Numbing, detachment, emotional responsiveness
   2. Reduction in awareness (“dazed”)  
   3. Derealization
   4. Depersonalization
   5. Dissociative Amnesia

C. ≥1 PTSD Intrusion Symptom
D. ≥1 PTSD Avoidance Symptom
E. ≥1 PTSD Arousal Symptom
F. Clinically Significant Distress or Impairment
G. Duration >2 days; <1 month
H. Not due to other cause
   Intoxication, medical condition, etc.
DSM-5 Acute Stress Disorder

A. PTSD A Criterion

B. No mandatory (e.g., dissociative, etc.) symptoms from any cluster

C. Nine (or more) of the following (with onset or exacerbation after the traumatic event)
   - Intrusion (4)
   - Negative Mood (1)
   - Dissociative (2)
   - Avoidance (2)
   - Arousal (5)

Dissociative Subtype

- Meets PTSD diagnostic criteria
- High levels of depersonalization & derealization

Preschool Subtype of PTSD

- No change from DSM-IV Criteria
- Retains various subtypes (depressed, anxiety, disturbed conduct, mixed)

- Criterion D:
  - The symptoms do not represent normal bereavement

Adjustment Disorders

- No change from DSM-IV Criteria
  - Retains various subtypes (depressed, anxiety, disturbed conduct, mixed)

- Criterion D:
  - The symptoms do not represent normal bereavement
Selection from DSM-5
Posttraumatic Stress Disorder

When the traumatic event produces violent death, there may be a significant interaction between problematic bereavement reactions and Posttraumatic Stress Disorder.

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Multidimensional Conceptual Domains for PCBD
Layne, Pynoos and Kaplow

Separation Distress (e.g. intense yearning, longing, sorrow, searching and preoccupation with the deceased person)

Reactive Distress and Behavioral (e.g. difficulty accepting the death, difficulty reminiscing about the deceased, excessive avoidance of loss reminders)

Disruption in Personal and Social Identity (e.g. feeling like part of oneself has died with the deceased, personal existential crises, for example, life is meaningless or empty without the deceased)

Preoccupation with Circumstances of the death

Persistent Complex Bereavement Disorder (PCBD)

• Onset > 12 months after death of loved one or for children 6 months after the death
• Yearning/Sorrow/Pre-occupation with deceased/pre-occupation with circumstances
• Reactive distress to the death
• Social/Identity disruption
• Significant distress or impairment
• Out of proportion/inconsistent with developmental, cultural and age appropriate norms
• Traumatic death specifier

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PCBD Criteria, continued

Specify if:
With traumatic bereavement: Bereavement due to homicide or suicide with persistent distressing preoccupations regarding the traumatic nature of the death (often in response to loss reminders), including the deceased’s last moments, degree of suffering and mutilating injury, or the malicious or intentional nature of the death.
Preschool Subtype < 6 yrs

- A – no fear, helplessness or horror
- B cluster – no change (1 Sx needed)
- 1 Sx from EITHER the C or D cluster
  - C cluster – no change (2 Avoidance Sx)
  - D cluster – 4/7 adult Sx
    - no amnesia; foreshortened future;
      persistent blame of self or others
- E cluster – 5/6 adult Sx (2 Sx needed)
  - no reckless behavior

Rationale for Changes/Modifications

- Rates too low in severely traumatized preschool children.
- Major difference in avoidance/numbing (DSM-IV) or avoidance/alterations in mood/cognition (DSM-5).
- Rates similar to older children and adults if criteria are altered.
- Threshold better for alternative than DSM-IV criteria.
- Stability in two independent samples.
Course of PTSD Symptomatology

Comparing DSM-IV and DSM 5 criteria for PTSD

- Study of 284 preschool children, experiences of mixed trauma exposures.
- 13% met criteria using DSM-IV criteria.
- 45% met criteria using DSM-5 criteria.
- Those diagnosed using DSM-5 but not DSM-IV were highly symptomatic (median 7 signs) and impaired (median two areas of impairment).

Reactive Attachment Disorder

Disinhibited Social Engagement Disorder

DSM-IV: Reactive Attachment Disorder

- RAD has been reconfigured from one disorder with two subtypes into two distinctive disorders in DSM-5
  - RAD- an emotionally withdrawn/inhibited phenotype
  - Disinhibited Social Engagement Disorder (DSES)- an indiscriminately social/disinhibited phenotype
Reactive Attachment Disorder

- Emotionally withdrawn behavior
- Social/emotional disturbance
  - reduced responsiveness, limited affect &/or irritability, sadness or fearfulness
- Exposure to extremes of insufficient care
  - social neglect/deprivation, repeated changes in caregivers, rearing in unusual settings

Disinhibited Social Engagement Disorder

- Reduced/absent reticence when interacting with unfamiliar adults
- Behaviors not limited to impulsivity but include socially disinhibited behavior
- Exposure to extremes of insufficient care
  - social neglect/deprivation, repeated changes in caregivers, rearing in unusual settings

RAD Among Institutionalized and Community Children

International Adoption Studies

- Two longitudinal studies of young children adopted from Romania
  - O’Connor, Rutter and Marvin study in the UK
  - Ames and Chisholm in Canada
- Emotionally withdrawn/inhibited not identified
- Indiscriminate behavior present & persistent
  - One of the most persistent behavioral abnormalities identified in adoptees
  - Linearly linked to length of deprivation
  - Diverges from measures of attachment
Signs of Emotionally Withdrawn/Inhibited RAD

Smyke, Dumitrescu & Zeanah, 2002

Signs of Indiscriminate/Disinhibited RAD

Smyke, Dumitrescu & Zeanah, 2002

RAD Withdrawn/Depressed

Institution
Foster Care

Group x Time
p = .031

RAD Emotionally Withdrawn/Inhibited Among Institutionalized Children

Stayed in institution
Left institution

Time Point
**Summary of RAD and DSED**

**RAD Inhibited**
- Arises from neglect
- Not evident following adoption
- Related to attachment behavior in the SSP
- Related to quality of caregiving concurrently
- Responsive to enhanced caregiving
- No clear evidence for biological vulnerability

**RAD Disinhibited**
- Arises from neglect
- Evident following adoption
- Not related to attachment behavior in the SSP
- Not related to quality of caregiving concurrently
- Less responsive to enhanced caregiving
- Preliminary evidence for biological vulnerability

**Graph: RAD Disinhibited**
- Baseline, 30 mos, 42 mos, 54 mos
- Institution vs. Foster Care
- Group: p = .06
- Time: p = .0001