We Can Diagnose PTSD in Very Young Children

- DSM-5 included “PTSD for Children 6 Years and Younger.”
- The first developmental subtype of a psychiatric disorder in the DSM!
- How did we get there?

It started with a simple question...

- Are the DSM-IV criteria for PTSD appropriate for very young children? (Scheeringa, Zeanah, Drell, & Larrieu, 1995)
- Phase 1: Found all of the well-described cases in the literature of traumatized children, 3-48 months of age (n=20). Zero could meet DSM IV PTSD.
- Phase 2: Cast a new net. Created checklist of all the symptoms shown by the 20 published cases. Created alternative diagnostic criteria based on frequency, reliability, and clinical utility of each.
- Phase 3: Applied new criteria to 12 new cases.
Empirical validation based on 4 principles:

1. Items distilled from real cases.
2. Focused on behaviors rather than subjective experiences.
3. Operationalized descriptors that were unclear in the cases.
4. Pay attention to frequency and reliability of items.

Developmental sensitivity was therefore built into this process.

**DSM-IV**

A. Exposed to traumatic event. Both are present:

1) Experienced, witnessed, or was confronted with event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or other.

2) Person’s response involved fear, helplessness, or horror.

**DSM-5**

PTSD in children 6 years and younger

A. Exposed to actual or threatened death, serious injury, or sexual violence in 1 or more of these ways:

1. Directly experienced.
2. Witnessed, in person, as it occurred to others. Note: witnessing does not include events that are witnessed only in electronic media, television, movies, or pictures.
3. Learning that the event occurred to a parent or caregiving figure.

Acute response deleted.

**DSM-IV**

B. 1 or more re-experiencing items:

1) Recurrent and intrusive, distressing recollections of the event.
2) Distressing dreams of the event. In children, there may be unrecognizable content.
3) Acting or feeling as if event were recurring (includes sense of reliving, illusions, hallucinations, and dissociative flashbacks).
4) Psychological distress to reminders.
5) Physiological distress to reminders.

**DSM-5**

B. 1 or more re-experiencing items:

1) Recurrent and intrusive, distressing recollections of the event. Note: distressing is optional.
2) Distressing dreams of the event. In children, there may be unrecognizable content.
3) Dissociative reactions (e.g., flashbacks) which feels like recurring. Such reactions may occur on a continuum with the most extreme being complete lack of awareness of present surroundings.
4) Psychological distress to reminders.
5) Physiological distress to reminders.

**DSM-IV**

C. 1 or more avoidance or numbing items:

1) Avoid thoughts, feelings, or conversations.
2) Avoid activities, places, or people.
3) Inability to recall an important aspect of the trauma.
4) Diminished interest in significant activities.
5) Feeling of detachment or estrangement from others.
6) Restricted range of affect.
7) Sense of a foreshortened future.

**DSM-5**

C. 1 or more avoidance or negative alterations in cognitions items:

1) Avoid activities, places, or physical reminders.
2) Avoid people, conversations, or interpersonal situations that are reminders.
3) Increased frequency of negative emotional states.
4) Diminished interest in significant activities, including constriction of play.
5) Socially withdrawn behavior.
6) Persistent reduction in expression of positive emotions.

Memory item deleted.
DSM-IV

D. 2 or more increased arousal items:
1) Difficulty with sleep.
2) Irritability or outbursts of anger.
3) Difficulty concentrating.
4) Hypervigilance.
5) Exaggerated startle response.

DSM-V

D. 2 or more alterations in arousal and reactivity items:
1) Difficulty with sleep.
2) Irritability and angry outbursts (including extreme temper tantrums).
3) Difficulty concentrating.
4) Hypervigilance.
5) Exaggerated startle response.

DSM-IV

Specify whether:
With dissociative symptoms, as shown by either:
1. Depersonalization: feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling in a dream; sense of unreality of self or time moving slowly).
2. Derealization: unreality of surroundings (e.g., the world around the person is experienced as unreal, dreamlike, distant, or distorted).

DSM-V

New DSM-5 PTSD Symptom that IS in the 6 Years and Younger Version

“Substantially increased frequency of negative emotional state (e.g., fear, guilt, sadness, shame, confusion).”

With all due respect to the DSM-5 planners, this should never have gotten into the criteria:
• poorly operationalized and dependent on knowing internal states,
• unsupported by empirical data, and
• a measure development nightmare because triggered versus non-triggered states was not made explicit.
New DSM-5 PTSD Symptoms that are NOT in the 6 Years and Younger Version

It is good that these new items were not applied to young children:

- "Reckless or self-destructive behavior." This may appear observable and behavioral, but it is really an internalized symptom. Classic problem of requiring knowledge of an internal phenomenon.

- "Persistent, distorted cognitions about the cause or consequence of the traumatic event(s)..." Highly internalized.

Construct Validation by Comorbidity Profile

Those with PTSD have a non-PTSD disorder 80-90% of the time.
Preschool Children (n=62, Scheeringa et al., 2003)

New Data on Discriminant Validation
From sample described in Scheeringa et al., 2012

- 3 types of trauma groups:
  1. Single blow trauma
  2. Repeated trauma
  3. Hurricane Katrina trauma
- Compared to non-trauma exposed normal.
- Disorders measured with structured psychiatric interview with caregivers.
- National Institute of Mental Health #R01 MH065884
- Acknowledgments: Frank Putnam, Charley Zeanah, Stacy Drury.
How Does the New Diagnosis Help?

- Many cases in the past have probably been undetected.
- Undetected cases would not have received appropriate treatment.

Preschool CBT for PTSD studies

3 randomized CBT studies on 3-6 yrs
2. Deblinger et al., 2001 (2-8 yrs children)
3. Scheeringa et al., 2011

CBT also works for preschool PTSD
Pre- and post-tx sx, n=25, 3-6 yrs old

<table>
<thead>
<tr>
<th>Number of symptoms</th>
<th>PTSD</th>
<th>MDD</th>
<th>SAD</th>
<th>ADHD</th>
<th>ODD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-treatment</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Post-treatment</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

*p<.001, **p<.0001, Scheeringa et al., 2011

Onward to the DSM-6: Are 7-12 year-old children more like preschoolers or more like teenagers?

- DSM-IV created with almost no data on children younger than 12 years with PTSD.
- Since then, only 3 studies have examined alternative diagnostic criteria for older youth; all suggested that 7-12 year-old children are better identified with the 6 Years and Younger criteria (reviewed in Scheeringa, Zeanah, & Cohen, 2011)
Conclusion

- Young children can get PTSD; developmentally-appropriate criteria have been validated.
- Better detection leads to better treatment.

References

Use of DSM-5 in Community Settings: Working with Parents and Young Children Who Have Experienced Trauma

Ruth Paris, Ph.D.
Boston University School of Social Work
Boston, MA

What Do We Know?
- Screening and assessing for trauma in parents and young children is essential for:
  - Understanding nature of the trauma: Single episode, multiple episodes or chronic exposure
  - Diagnosis and treatment planning
  - Targeting specific symptoms
  - Optimal help for clients
  - Evaluating outcomes and demonstrating treatment effectiveness
  - Promoting trauma-informed practice

What Else Do We Know?
- Relational assessment is essential for understanding:
  - Context of child’s symptoms
  - Disruptions in caregiving associated with child’s development
  - Parenting knowledge, attitudes and behaviors
  - Meaning of child’s behaviors for the parent (internal representations)

Important Changes in DSM-5
- Effort to make DSM-5 more developmentally-focused
- First time PTSD for children under 6 is a separate diagnosis
- Reactive Attachment Disorder (RAD- more focused on internalizing symptoms) and Disinhibited Social Engagement Disorder (DSED- more focused on externalizing symptoms) are now separate diagnoses
- DSM-5 is doing a better job of identifying the boundaries of traumatic stress disorders
- Enabling more young children to be diagnosed appropriately and to receive effective treatment (as Dr. Scheeringa described)
Very Young Children

- Must understand child’s symptoms and behaviors in the context of relationship with caregiver.
- Many are pre-verbal, so observation of parent-child interactions can be even more crucial than with older children.
- Individual diagnosis more difficult or at times not appropriate, yet treatment is necessary.
- What’s available to the community clinician to assess social-emotional development and attachment?

- DIPA (Diagnostic Infant and Preschool Assessment), PIE (Posttraumatic Stress Responses In Infancy And Early Childhood Interview), TESI, (Traumatic Events Screening Inventory for Children), TSC-YC (Trauma Symptom Checklist- Young Child)

Options for Diagnosis

- Diagnose the child and/or the relationship:
  - DSM-5 (Diagnostic and Statistical Manual)
  - DC: 0-3 R (Diagnostic Classification of Mental Health & Developmental Disorders of Infancy and Early Childhood: Revised)
    - Axis I-Clinical Disorders; Axis II-Relationship; PIR-GAS, RPCL; Axis III-Physical; Axis IV-Stressors; Axis V-Socio-Emotional functioning
  - ICD-9/10 (International Classification of Diseases)

Other Aspects of Relational Assessment and Diagnosis

- Child’s psychosocial and developmental functioning
- Presence and impact of trauma or stressors for child and/or parent
- Medical and development conditions
- Family context
Project BRIGHT I (Building Resilience through Intervention – Growing Healthier Together)

- Category III site
- Collaboration among 2 community agencies and 1 university clinical researcher
- Provide intervention based on the principles of Child-Parent Psychotherapy, to women with Substance Use Disorders/Co-Occurring Disorders and their children birth-5 living in residential treatment

Acknowledgements

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- Project Partners:
  - Institute for Health and Recovery, Cambridge, MA
  - Jewish Family and Children’s Service of Greater Boston, Center for Early Relationship Support
  - Boston University School of Social Work
  - Boston Medical Center Child Witness to Violence Project (CWVP)

Project BRIGHT Participants

- N=82 dyads
- Mean Age: Mother-29 years; Child-22 months
- Non-Hispanic white: 65%
- HS diploma/GED: 45%
- Unemployed: 96%
- Substance of choice: heroin, cocaine, crack
- Psychological distress (BSI): Mother M=.9; community M=.3
- Child’s social/emotional development-maternal report (ASQ-SE): 26% at risk

Reflecting on How Own Childhood Affects Current Parenting

“I didn’t have anybody, like my father was a crackhead and me and my mom used to not get along and I was a daddy’s girl so I was always sticking with daddy, you know, in and out of crack houses and at ten years old I learned how to hit a vein… I was shooting my father up and I was shooting all his friends up and it’s just kinda like, I never had that childhood where you like sit down and color. And I want that for my kids. It’s so important to me to like sit down and color with them.”
Trauma Exposure: Parent (LSC-R)

<table>
<thead>
<tr>
<th>Event</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family member(s) substance use caused worry or upset</td>
<td>92%</td>
</tr>
<tr>
<td>Abused physically, attacked or harshly punished by someone you knew</td>
<td>78%</td>
</tr>
<tr>
<td>Separated from your child against your will</td>
<td>78%</td>
</tr>
<tr>
<td>Someone close to you died</td>
<td>76%</td>
</tr>
<tr>
<td>Aborted, miscarriage, or still birth</td>
<td>76%</td>
</tr>
<tr>
<td>Emotionally abused or neglected</td>
<td>72%</td>
</tr>
<tr>
<td>Seen violence between family members before age sixteen</td>
<td>68%</td>
</tr>
<tr>
<td>Someone close to you died unexpectedly</td>
<td>64%</td>
</tr>
<tr>
<td>Close family member sent to jail</td>
<td>60%</td>
</tr>
<tr>
<td>Been touched or made to touch in a sexual way/forced sex</td>
<td>60%</td>
</tr>
<tr>
<td>Had to leave place where living because could not afford it</td>
<td>56%</td>
</tr>
<tr>
<td>Been sent to jail</td>
<td>53%</td>
</tr>
</tbody>
</table>

Trauma Exposure: Index Child (TESI)

<table>
<thead>
<tr>
<th>Event</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separated from parent or someone close to them</td>
<td>84%</td>
</tr>
<tr>
<td>Seen or heard physical fighting within the family</td>
<td>44%</td>
</tr>
<tr>
<td>Seen or heard family threaten to harm each other</td>
<td>28%</td>
</tr>
<tr>
<td>Seen or heard people outside family fighting</td>
<td>28%</td>
</tr>
<tr>
<td>Seen or known family member was arrested or jailed</td>
<td>24%</td>
</tr>
<tr>
<td>Undergone medical procedures</td>
<td>24%</td>
</tr>
<tr>
<td>Experienced illness of someone close to them</td>
<td>20%</td>
</tr>
<tr>
<td>Attempted suicide or to harm self</td>
<td>20%</td>
</tr>
<tr>
<td>Lacked appropriate care</td>
<td>16%</td>
</tr>
</tbody>
</table>

Case Example-

**Case Example-**

**Courtesy of Amy Sommer, LICSW**

- JJ and Alex; 30 month old Caucasian twin boys reunified with mother who was in residential treatment for SUD after a more than 1 year separation
- Both babies born early exposed to cocaine and methadone with low birth weight
- First year of life mother using drugs, partners were physically/sexually violent towards her, moved frequently and sometimes struggling for food
- Twins experienced and witnessed violence, heard fighting and threats, and no consistent environment (chronic trauma/stressors)
- Boys placed together in foster care
- Infrequent visits with mother

**Case Continued**

- Reunified in noisy chaotic residence with little predictability; frequently cared for by others while mother was in treatment groups
- Mother concerned about JJ; wondered if he had ADHD; wanted to consider medication
- Clinician observed that JJ displayed impulsive behavior and mild expressive language delay; he also had an early trauma history and disrupted caregiving relationships
- Considered PTSD and/or ADHD diagnosis
- How did clinician proceed given the environment?
Assessment

- Cannot diagnose child of 30 months without considering the social, emotional, and functional abilities of the caregiver(s).
- How best to understand JJ’s difficulties trusting his surroundings and caregivers, sleep disturbance, difficulties focusing and regulating, disorganized and constricted play, and dysphoric affect?
- Chronic early trauma (before age 1) major destabilizing impact on cognitive/social/emotional development; How to tease apart “trauma” from the relationship with his primary caregiver?
- Why did JJ have symptoms and not Alex?

Diagnosis

- Clinician observed mothers interactions with her children
- Mother: highly distractible and often abruptly ended interactions with her children; difficulty with impulse control; limited vocabulary, spoke to children in directives
- Physical interactions could be affectionate or rough; twins did not know what to expect; how would their changing needs be met?
- Lack of consistency in routines, stimulation level, and expectations; mother and informal caregivers had different expectations and behavior management strategies

Treatment

- Focus on JJ’s relationship with his mother
- Help mother support his abilities to attend, regulate, and control his impulses
- Defer treatment of his individual difficulties until he could show us more about his experiences and his mother could help him function at his best.

One Project BRIGHT Mother’s Understanding of How to Be Trauma-Informed

“Yeah, she told me to just like, you know, hold them, love them, and like let them know that I’m here and like they’re safe and nothing is gonna happen to them and if they witness something that’s big, ‘I’m sorry that you had to see that,’ and like, ‘it’s not going to happen to you and it wasn’t because of you,’ you know what I mean, whatever the situation was.”
Questions

- Another approach to diagnosis and treatment?
- TF-CBT in conjunction with dyadic treatment of mother and child?
- Early Intervention?
- How best to support the mother and the entire family system?

Conclusion

- When assessing young children, crucial to evaluate whether single exposure, multiple exposure or chronic trauma
- DSM-5 more developmentally focused
- DC: 0-3 R offers the option of a caregiver-child diagnosis
- Remember to diagnose in the context of the caregiving relationship