

Trauma, Attachment and DSM 5 Diagnoses

IHS Trauma Informed Care & Historical Trauma Informed Care
Webinar Series: Part I in 3 Part Series for Healthcare Providers

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Introduction

- IHS has partnered with the University of New Mexico School of Medicine Division of Community Behavioral Health to
- Present an integrated approach to Historical Trauma, Trauma, and Trauma Informed Care in health and behavioral health settings
- Rollout of:
 - A series of webinars
 - Monthly case consultations
- Today's webinar is Part II in a 3 part series for healthcare providers

Objectives

- As a result of having participated in this webinar, participants will be able to:
 - Identify how childhood trauma and attachment problems can lead to psychiatric diagnoses and adverse health behaviors.
 - Summarize the clinical characteristics of acute stress disorder, PTSD, and complex PTSD and appropriate clinical management of these disorders.
 - Describe trauma specific treatments and indications for patient referral for these treatments

Polling Question

- What is your primary professional affiliation?
 1. MD/DO, Nurse practitioner, Physicians Assistant
 2. Nurse
 3. Medical assistant
 4. Psychiatrist
 5. Psychologist
 6. Social worker (LCSW, LISW)
 7. Other therapist (LPCC, etc.)
 8. Supervisor/administrator
 9. Front Desk Staff
 10. Community health representative
 11. Peer support worker

Trauma & attachment

What Is Trauma?

“trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual’s functioning and physical, social, emotional, or spiritual well-being”

Types of Trauma

- Single event
 - E.g. being in a car crash, natural disaster, sexual assault, medical procedure
- Multiple events, over time
 - E.g. incest, war, racism, micro-aggressions, multiple medical procedures
 - Can lead to Complex Trauma
- Vicarious or secondary trauma
- Multigenerational including historical trauma

Caveats

- What is traumatic to 1 person may not be to another
- Trauma affects a person's neurobiology in ways that are long lasting or permanent
- Trauma can lead to
 - adverse health outcomes
 - PTSD
- Not everyone who has experienced trauma develops PTSD or adverse health outcomes
- Cumulative trauma has cumulative effects
- There are effective treatments for trauma

Culture and Trauma

Culture determines acceptable responses to trauma and shapes the expression of distress

- Culture affects what qualifies as a legitimate health concern and which symptoms warrant help

Culture can provide a source of strength, unique coping strategies, and specific resources.

Cultural assessment is essential for appropriate diagnosis and care

Historical Trauma and Unresolved Grief

- **Historical trauma** - Cumulative emotional and psychological wounding from massive group trauma across generations, including lifespan
- **Historical trauma response** (HTR) is a constellation of features in reaction to massive group trauma, includes **historical unresolved grief** (similar to Child of Survivors Complex re: Jewish Holocaust survivors and descendants, Japanese American internment camp survivors and descendants), depression, PTSD

(Brave Heart, 1998, 1999, 2000)

Healthy and Toxic Stress

- Healthy stress

- Stress is a normal part of life, part of healthy development
- Helps us to grow and change
- Moderate degree, short lived, E.g. meeting new people, taking a new job
- Occurs in the context of stable, supportive relationships

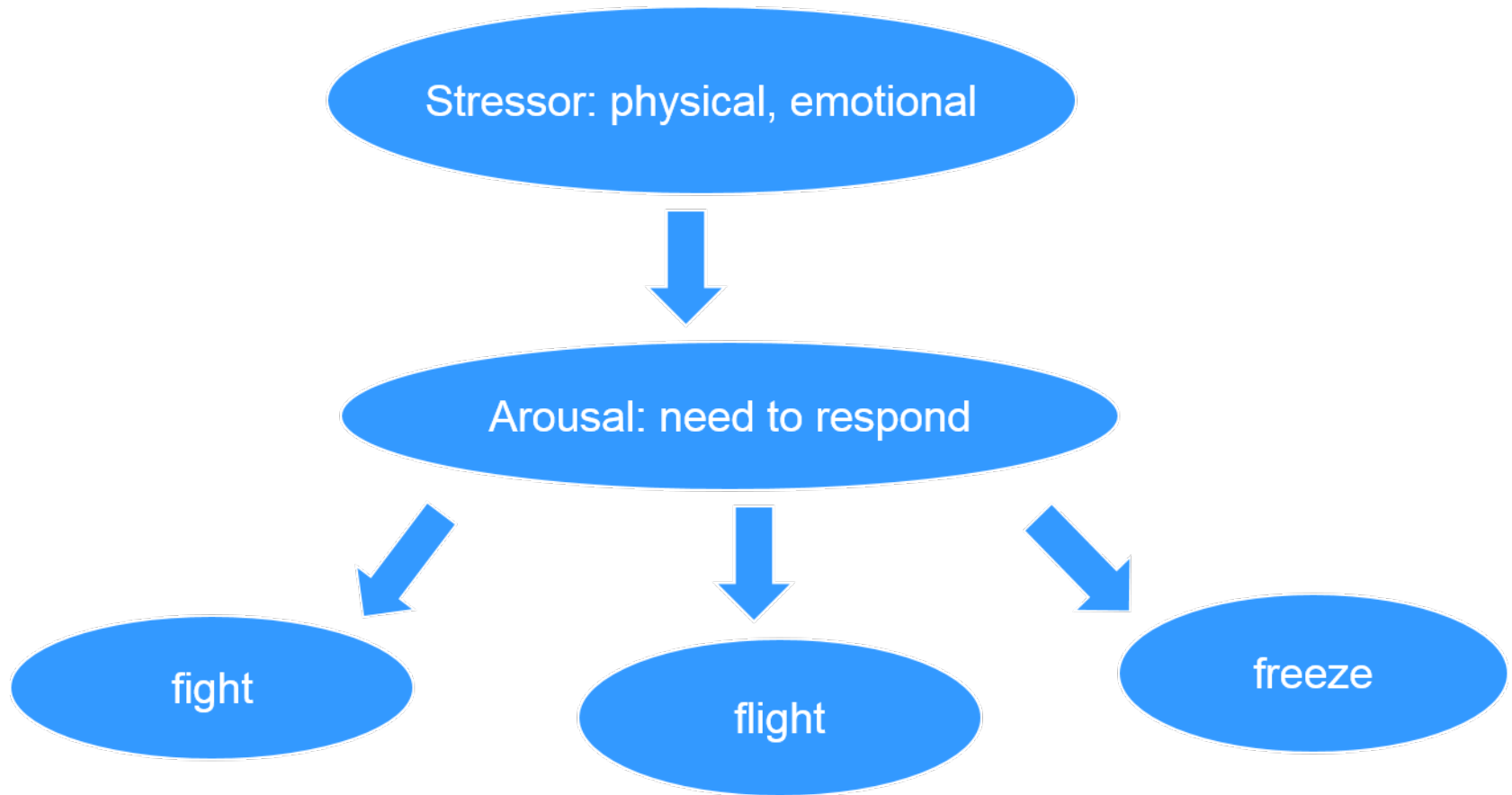
- Toxic stress

- Level or chronicity of stress that overwhelms coping systems (both biological and supportive relationships)

Acute Stress

- Our bodies are designed to deal with acute stress
- Fight/flight/freeze reaction is initiated
- This stress response system increases our ability to survive danger
- Once stress is over systems return to normal (homeostasis) via negative feedback loops

Defense Cascade: Fight, Flight, or Freeze



Freeze Response

- Attentive immobility
- Usually lasts for only a few seconds
- Allows person to assess the danger and decide whether to fight or flee
- Often begins with freeze (assess the situation, hide from predator, then respond)
- Includes opioid-mediated analgesia, lower HR
- Increased occurrence in people with trauma histories when person is exposed to a cue associated with a previously negative event
- Can lead to immobility, dissociation

Dissociation

- Our mind's "safety valve"
- When overstimulated, we shut down, or dissociate thoughts from feelings/body from thoughts
- Can manifest as:
 - Fainting
 - Emotional numbing
 - Amnesia
 - Conversion into physical symptoms
 - Fragmentation of sense of self
- Can lead to dissociative disorders (DSM 5)

Chronic Stress

- Chronic stress
 - Our bodies are not designed to deal with stress that doesn't go away
 - Same systems are activated as in acute stress, but are activated over and over
 - This has adverse effects
 - Initial high levels of cortisol then blunted corticosteroid release
 - Brain changes (high levels of cortisol are toxic)
 - Impairs neural plasticity, damages the hippocampus which impairs memory
 - Epigenetic changes
 - These adverse effects lead to increased risk of physical and psychiatric illness

Normal Brain Development

- The brain isn't structurally complete at birth
- It is designed to develop based upon cues from the environment
 - Brain growth requires
 - Interaction with loving, predictable people
 - A healthy physical environment
- Children haven't yet developed fully the ability to regulate arousal
- They require help from adults

Sensitive Periods for Attachment & Normal Infant Development

- Language <15 months
- Attachment <24 months

How Trauma Interferes With Normal Brain Development

- Trauma interferes with normal biological maturation
 - Adversely effects neurodevelopment
 - Structurally
 - Neuroendocrine systems
 - Immune system
 - Epigenetics
- Traumatized parents often have difficulty helping their children's brain development

Clinical Effects Of Stress Induced Neurobiological Changes

- Decreased ability to put experience into words
 - Problems with declarative memory
- Decreased ability to think through a situation
 - Especially when emotionally aroused
 - =problems with executive functioning
- Memory problems
 - Difficulty with time frame
 - Difficulty sequencing (what came first, when, what came next)

This Leads To...

- People with trauma histories may experience strong emotions, sounds, smells, impressions (often nonverbal)
- This combines with
 - Decreased ability to problem solve
 - Difficulty with time sequencing
- Can result in emotional outbursts

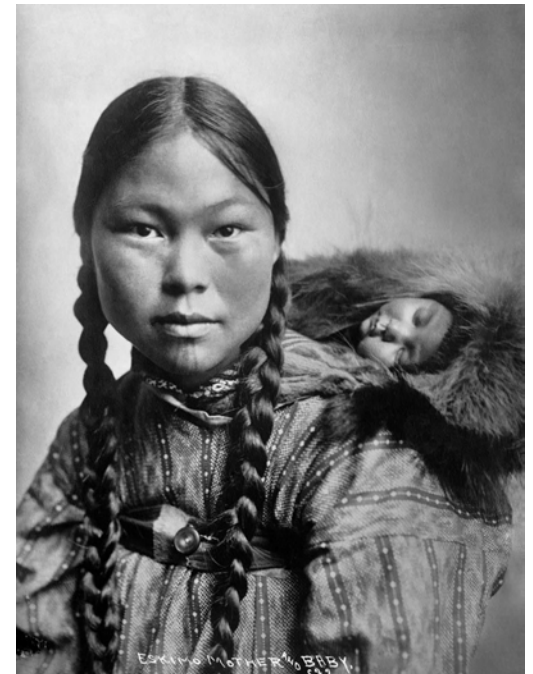
Overarousal and Underarousal

- Hypervigilance or underarousal are adaptive in times of danger
 - Fight, flight, or freeze
- These same behaviors are maladaptive in school, work, medical settings
 - Overreactions
 - Triggered by sights, smells, tone of voice
 - Lack of reaction/passivity

Prevention of Trauma/Trauma Responses

- Adequate nurturing/attachment in childhood
- Adequate social support in adulthood

Attachment



Attachment

- Social contact is as necessary to our survival as food and water
 - Failure to thrive in orphanages, can lead to death
- Babies are dependent upon their caregivers
- They develop attachment to their primary caregivers—other adults won't do (Stranger anxiety at 6-9 months)
- They develop attachment to caregivers even if the caregiving is abusive or neglectful
- With loss of caregiver child protests, then falls into despair
- Eventually, child loses interest in attachment (see RAD)
- Lack of attachment figures is a type of trauma

Harry Harlow and Monkey Experiments

Attachment-continued

- Attachment between child and caregiver makes child feel safe, secure, protected
- Primary attachment figures help regulate the infant's brain
- Infant learns through attachment figure(s) how to self soothe, recognize emotions
- Without good attachment, infant is at higher risk of psychological problems, abnormal brain development
- Attachment protects against social and emotional maladjustment

Mirror Neurons

- Network of neurons in the brain
- Our neurons fire when performing and behavior and when observing the same behavior in others
- We understand the other's intention
- This allows us to imitate behavior, and understand what others feel

Theory of Mind

- The ability to understand that we have mental states (beliefs, intents, desires) and that others have mental states different from our own
- Thought to begin around age 4

Mary Ainsworth and The Strange Situation

- Mary Ainsworth was a developmental psychologist who helped to develop attachment theory
- “Strange Situation” is a laboratory procedure to study attachment in children age 10 months-5 years
- Evaluates
 - how much infant/child explores
 - Reaction to caregiver’s absences/return

Types of Attachment-Secure

- Secure 55%-60% general population
 - Caregiver consistently responds to distress in sensitive, responsive ways
 - Infant goes to caregiver for soothing, also able to play/explore
 - Infant sees caregiver as caring and loving, and self as worthy
 - As child grows, they are more able to get along with peers, handle conflict

Types of Attachment-Insecure/Avoidant

- Insecure/Avoidant 23%
 - Caregiver is rejecting of infant's needs/non-responsive
 - Infant doesn't go to caregiver for soothing
 - Infant learns to deal with distress by itself, be independent

Types of Attachment-continued

- Insecure/ Resistant 8%
 - Caregiver responds in inconsistent manner, or needs infant to respond to her own needs
 - Infant has trouble being soothed by caregiver, can be angry/rejecting
- Disorganized
 - Caregiver responds in frightening/atypical ways
 - Infant behaves in contradictory ways e.g. fear of caregiver, freezing
 - Nearly 80% of maltreated children have this attachment style

Repairing Ruptures

- There are always ruptures in attachment
- The important thing is to repair them
- Repair acknowledges the rupture, and attempts to reconnect

Failure to Thrive

Attachment Can be Improved

- Via enriched environment
- Attentive caregiver
- E.g. Bucharest Early Intervention Project
 - Prior to the study 65% of institutionalized children had disorganized attachment, 13% had no attachment
 - At 42 months 49% of children in foster care had secure attachments versus 18% in institutionalized group versus 65% living with their parents
 - Decrease in RAD and improvement in cognitive functioning found as well

Adult Attachment is Important

- Attachment status of the parent can be evaluated
 - Adult attachment interview
- If parent is securely attached, infant is likely to be securely attached
- If parent is insecurely attached, infant is likely to be insecurely attached

DSM 5- Trauma and Stressor Related Disorders

- Trauma and Stressor Related Disorders (across the lifespan)
- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder
- Posttraumatic Stress Disorder
- Acute Stress Disorder
- Adjustment Disorders

Trauma and Stressor Related Disorders

- Disorders listed in DSM 5 in which exposure to a traumatic or stressful event is an explicit diagnostic criterion
- Other psychiatric conditions are often associated with exposure to a trauma or stressful event
 - Dissociative disorders
 - Anxiety disorders
 - Depression

Reactive Attachment Disorder (RAD) and Disinhibited Social Engagement Disorder

- Absence of adequate caregiving (social neglect) during childhood is a diagnostic criterion
- Neglect is emotional, interferes with attachment
- Neglect may also be physical
- Neglect can be due to
 - Repeated changes in primary caregiver e.g., foster care
 - Rearing in an institutional setting e.g., orphanage
 - Emotional unavailability of primary caregiver e.g., maternal depression or substance use

Difference between RAD and DSED

- In RAD child is emotionally withdrawn,
 - may be depressed
 - May appear unattached
- In DSED, child is indiscriminately social, indiscriminately attached
 - same behavior to adults child barely knows as to caregivers

Posttraumatic Stress Disorder

- Involves exposure to “actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways”
 - Direct experience
 - Witnessing the event occur to others
 - Learning that the event occurred to a family member or friend
 - Experiencing “repeated or extreme” exposure to details of the traumatic events (can include occupational exposure e.g., first responders)

PTSD Diagnostic Criteria-continued

- Presence of symptoms in different domains:
 - intrusion
 - avoidance
 - negative cognition or mood
 - change in arousal and reactivity
 - Lasts for more than 1 month
- Onset usually within 3 months after trauma but can be delayed

PTSD-Intrusion Symptoms

- Recurrent, involuntary, and distressing memories of the trauma
- Distressing dreams (nightmares) related to the trauma
- Dissociative reactions (flashbacks) in which it feels as if the trauma is recurring
- Psychological distress when exposed to cues of the trauma
- Physiological reactions to cues of the trauma
- In children <6 may manifest as play reenactment

PTSD-Avoidance Symptoms

- Avoidance of memories, thoughts, feelings of/about the trauma
- Avoidance of external reminders of the trauma
 - Activities
 - Objects
 - Situations

PTSD-Negative Alternations in Cognitions and Mood

- Inability to remember an important aspect of the trauma
 - Due to dissociative amnesia
- Negative beliefs about oneself, others, or the world
 - “I am bad”
 - “I can’t trust anyone”
 - “the world is a dangerous place”
- Distorted cognitions about the cause or consequences of the event/blames self or others
- Negative emotional state-shame, anger, guilt
- Diminished interest or participation in activities
- Feeling detached or estranged from others
- Inability to experience positive emotions

PTSD-Alterations in Arousal and Reactivity

- Irritable behavior, angry outbursts, aggression
- Reckless or self-destructive behavior
- Hypervigilance
- Exaggerated startle response
- Problems concentrating
- Sleep problems

Prevalence of PTSD in USA

- Lifetime risk for development of PTSD by age 75 is 8.7%
- Lower rates among children
- Lower rates among elderly
- Higher rates among veterans, occupational exposure
- Certain ethnicities have higher rates compared to non Hispanic white: AI/AN, Latinos, African Americans
- Lower rates among Asian Americans
- Survivors of rape, military combat and captivity, ethnically or politically motivated internment and genocide especially high rates of PTSD
 - More than 1/3 to 1/2 of those exposed develop PTSD

PTSD in AI/AN Population

- AI/AN communities in general have higher risk of experiencing trauma than any other ethnic group
- Twice as likely as general population to develop PTSD
- Higher levels of PTSD reflect higher exposure to trauma
- Related problems: body pain, lung disorders, general health problems, substance abuse, pathological gambling
- Most frequently implicated trauma is military combat
- 2nd most common is interpersonal violence
- Protective factors:
 - Traditional non Christian religious practices
- Little research on effective treatments

Trauma Exposure in American Indian Men

- American Indian males have non-interpersonal trauma exposure rates of 25.2% in SW and 36.4% in NP, including natural disasters, life-threatening accidents (Manson, et al., 2005)
- Interpersonal trauma exposure rates (assault, rape, abuse, combat) – 25.5% in SW and 31% in NP for Native men
- Witness to trauma – 46.7% SW & 46.3% NP
- **Many Native military and veterans may be *wakiksuyapi*, carrying both historical trauma and modern combat trauma**

Complex Trauma

- Sometimes also referred to as
 - Complex developmental trauma or developmental trauma disorder (if in children)
 - Complex PTSD
 - Disorders of extreme stress
- Found in people who have experienced multiple, chronic or prolonged traumas

Complex Trauma Isn't a DSM Diagnosis

- Not a DSM 5 diagnosis or a Condition for Further Study
 - Is planned for inclusion in ICD-11
 - DSM IV field trial showed that 92% of people with complex PTSD also met diagnostic criteria for PTSD
- However, PTSD doesn't cover the complexity of complex trauma
- Many researchers and clinicians see it as a valid, essential diagnosis

Complex Trauma-2

- Often present with symptoms that don't fit into DSM 5 categories
 - Dissociation, anger, depression, change in self concept, change in response to stressful events
 - Dysregulation of multiple symptom domains Body-sensory and motor
 - Affect-explosive/irritable or frozen/restricted
 - Cognition-flashbacks, dissociation, altered perceptions/beliefs
 - Behavior-regression (in children)

Complex Trauma-3

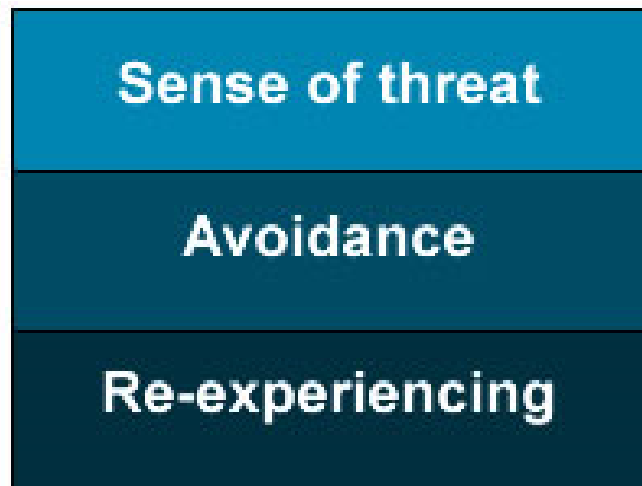
- There is no established standard for the assessment of complex trauma in children
- Prolonged, repeated trauma may result in different or additional symptoms and need for special attention
 - Involves prolonged trauma in which the person was “in a state of captivity” physically or emotionally (Herman, J. (1997).
 - May result in personality disorder diagnosis (e.g. borderline PD) or multiple other diagnoses (bipolar, ADHD, conduct disorder)
 - Treatment involves need for person to regain sense of control and power, and work in interpersonal relationships

Complex PTSD Symptoms

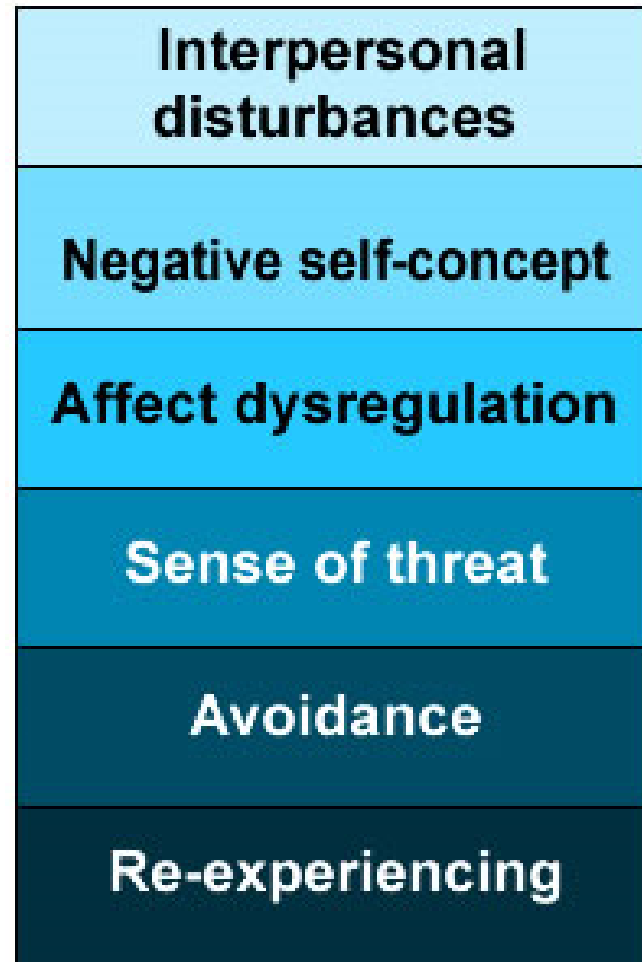
- Interpersonal problems
- Negative self-concept
- Interpersonal sensitivity
- Affect dysregulation
- Increased risk of self-injury and repeated victimization

PTSD and complex PTSD symptoms

source: European Journal of Psychotraumatology
2013, 4: 20706
<http://dx.doi.org/10.3402/ejpt.v4i0.20706>



PTSD



Complex PTSD

<http://traumadissociation.com/complexptsd>

Acute Stress Disorder

- Involves exposure to a trauma as in PTSD
- Involves intrusion symptoms, negative mood, dissociative symptoms, avoidance symptoms, and arousal symptoms
- Lasts for 3 days to 30 days
- If lasts for more than a month, diagnose PTSD

Adjustment Disorders

- Involve development of emotional or behavioral symptoms in response to an identifiable stressor
 - Different types based upon predominant problems:
 - Anxiety
 - depression
 - behavioral disturbance
- Occur within 3 months of onset of the stressor
- Resolve within 6 months of resolution of the stressor

Dissociative Disorders

- Loss of continuity of subjective experience
- Inability to control normal mental functions such as memory—amnesia
- Often but not always associated with trauma
- Both Acute Stress Disorder and PTSD include dissociative symptoms

Types of Dissociative Disorders

- Dissociative Identity Disorder
 - Previously known as multiple personality disorder
 - Disruption of identity into 2 or more personality states
- Dissociative Amnesia
 - Inability to recall important autobiographical information
- Depersonalization/Derealization Disorder
 - Depersonalization: feelings of unreality, detachment, being an outside observer of oneself, not feeling feelings
 - Derealization: surroundings seem unreal, in a fog

Treatment of Trauma

- Make systems trauma informed
 - Corrective emotional experiences
- Therapeutic relationship
- Increase social support
- Trauma specific treatments

Trauma-Specific Treatments

- Trauma focused cognitive behavioral therapy (CBT)
- Dialectical Behavioral Therapy (DBT)
- Eye movement desensitization and reprocessing (EMDR)
 - Tapping
- Prolonged Exposure (PE)
- Treatment for historical trauma e.g. HTUG
- Psychodynamic therapy
- Pharmacotherapy
- Traditional healing

Trauma-Specific Treatments-continued

- Body therapies “sensorimotor”
 - Breathing techniques
 - Acupuncture
 - Exercise
 - Rhythmic activities- drumming, dancing
 - Mindfulness meditation
 - Massage
 - Neurosequential model of therapeutics
 - Hakomi therapy
 - Equine therapy

Prolonged Exposure Therapy (PE)

- Evidence based, manualized treatment for PTSD
- Reduces symptoms of PTSD, depression, anger, and anxiety, and increases confidence/mastery
- Based on emotional processing theory
 - Blocks avoidance
 - Introduces corrective information
- Components:
 - Psychoeducation,
 - anxiety reduction techniques,
 - develop list of avoided people, places, activity
 - imaginal and in vivo exposure

Cognitive Processing Therapy (CPT)

- A form of cognitive behavioral therapy
- 12 sessions
- Involves cognitive restructuring
 - Challenging cognitive distortions and assumptions

Trauma Focused CBT

- Evidence based treatment for children and adolescents and their caregivers
- Developed by Drs. A Mannarino, J Cohen, E Deblinger
- Structured
- Short term treatment (8-25 sessions)
- Can be used in children and youth even without PTSD diagnosis
- Involves psychoeducation, teaching stress management, affect expression and modulation, cognitive coping, creating and sharing the trauma narrative, behavior management training, parent-child sessions
- Proprietary, requires official training

Dialectical Behavior Therapy (DBT)

- A type of cognitive behavioral treatment developed by Marsha Linehan
- Evidence based
- Developed to treat chronically suicidal patients with BPD,
 - now wider application including PTSD
- 4 components:
 - Skills training group (mindfulness, distress tolerance, interpersonal effectiveness, emotion regulation)
 - Individual therapy
 - Phone coaching
 - Therapist consultation team

Eye Movement Desensitization & Reprocessing (EMDR)

- Developed by Francine Shapiro for people with PTSD, trauma
- Works more rapidly than other therapies
- Uses bilateral stimulation (eye movement or tactile)
- Therapist works with patient, who recalls a traumatic event while tracking therapist's fingers, or a light, or tapping, or musical tones
- Patients moves from traumatic memory to more positive memories
- Evidence based, but still debated

Neurosequential Model (NMT)

- An evidence-based approach rather than a therapy
- Neurobiologically informed
- Developmentally sensitive
- For working with at-risk children
- Developed by Bruce Perry and colleagues
- Components:
 - Structured assessment
 - Articulation of primary problems
 - Key strengths/current functioning
 - Interventions (educational, enrichment, and therapeutic)

Pharmacotherapy

- Antidepressants
 - Sertraline, paroxetine, fluoxetine, venlafaxine
- Medication for nightmares/sleep problems
 - prazosin
- Topiramate may be helpful (also with alcohol use disorder)
- Avoid benzodiazepines if possible
 - Disinhibition, difficulty integrating the traumatic experience, abuse potential
- Use antipsychotics only for comorbid symptoms

HTUG Development & the Takini Network/Institute 1980s-2017

Tunkasila Tatanka Iyotake, Mother Her Holy Door, Daughter, and Grandchild



Historical Trauma and Unresolved Grief Intervention

- HTUG facilitates: (1) not being alone in depression; (2) reduction of stigma through the emphasis on the collective context (3) decrease in depression;
- Research team members/providers dealing with own HT and ongoing family and community trauma;
- Traditional tribal culture as protective factors;
- Participants' testimonies of perceived positive response to interventions and not having had an opportunity to address HT before

Historical Trauma Intervention Research & Evaluation: Qualitative Evaluation of Parental Responses

- **Increased sense of parental competence**
- **Increase in use of traditional language**
- **Increased communication with own parents and grandparents about HT**
- **Improved relationships with children, parents, grandparents, and extended kinship network**
- **Increased pride in being Lakota and valuing own culture, i.e. Seven Laws**

Post Traumatic Growth

- Positive psychological change after trauma
- People do not return to the way they were before trauma, but they can experience positive change
 - Spiritually
 - Value the day to day “small” things in life
 - Value life more deeply
 - Relationships enhanced (valued more)
 - Changed view of self

Upcoming Webinars and Case Consultations for Healthcare Providers

- Part III: Vicarious Trauma & Burnout in Healthcare Providers & How a Trauma Informed System Can Help

August 24 12-1 MST

- Monthly case consultations 10:00-11:00 MST
 - July 5, Aug 23, Sept 20, Oct 18,. Nov 15, Dec 13, 2017
 - Jan 17, Feb 14 2018

Websites

ACES Connection <http://www.acesconnection.com/>

ACES Too High www.acestoohigh.com

Child Trauma Academy <http://childtrauma.org/nmt-model/>

International Society for Traumatic Stress Studies (ISTSS)

www.istss.org

The National Council for Behavioral Health

<https://www.thenationalcouncil.org/topics/trauma-informed-care/>

National Child Traumatic Stress Network (NCTSN)

<http://www.nctsn.org/>

Websites-continued

PTSD: National Center for PTSD (US Department of Veterans Affairs)

<https://www.ptsd.va.gov/>

SAMHSA National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint (NCTIC)

<https://www.samhsa.gov/nctic>

SAMHSA National Child Traumatic Stress Initiative (NCTSI)

<https://www.samhsa.gov/child-trauma>

TF-CBTWeb <https://tfcbt.musc.edu/>

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Relevant Recent HT Publications

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