Trauma & Stressors related Disorders

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- Reactive attachment disorder is a rare but serious condition in which an infant or young child doesn't establish healthy attachments with parents or caregivers.
- Reactive attachment disorder may develop if the child's basic needs for comfort, affection and nurturing aren't met and loving, caring, stable attachments with others are not established.

Reactive Attachment Disorder

Diagnostic Criteria 313.89 (F94.1)

A. A consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers, manifested by both of the following:
1. The child rarely or minimally seeks comfort when distressed.
2. The child rarely or minimally responds to comfort when distressed.
B. A persistent social and emotional disturbance characterized by at least two of the following:
1. Minimal social and emotional responsiveness to others.
2. Limited positive affect.
3. Episodes of unexplained irritability, sadness, or fearfulness that are evident even during nonthreatening interactions with adult caregivers.
C. The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:
1. Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.

2. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
3. Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).
D. The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the lack of adequate care in Criterion C).
E. The criteria are not met for autism spectrum disorder.
F. The disturbance is evident before age 5 years.
G. The child has a developmental age of at least 9 months.
***Specify* if:**
Persistent: The disorder has been present for more than 12 months.
***Specify* current severity:**
Reactive attachment disorder is specified as severe when a child exhibits all symptoms of the disorder, with each symptom manifesting at relatively high levels.

Comorbidity

Conditions associated with neglect, including cognitive delays, language delays, and stereotypies, often co-occur with reactive attachment disorder. Medical conditions, such as severe malnutrition, may accompany signs of the disorder. Depressive symptoms also may co-occur with reactive attachment disorder.

Signs and symptoms may include:

- Withdrawal, fear, sadness or irritability that is not readily explained
- Sad and listless appearance
- Not seeking comfort or showing no response when comfort is given
- Failure to smile
- Watching others closely but not engaging in social interaction
- Failing to ask for support or assistance
- Failure to reach out when picked up
- No interest in playing peekaboo or other interactive games
- Reactive attachment disorder is rare. Signs and symptoms can occur in children who don't have reactive attachment disorder or who have another disorder such as autism spectrum disorder.

- The risk of developing reactive attachment disorder from serious social and emotional neglect or the lack of opportunity to develop stable attachments may increase in children who:
- Live in a children's home or other institution
- Frequently change foster homes or caregivers
- Have inexperienced parents
- Have prolonged separation from parents or other caregivers due to hospitalization
- Have a mother with postpartum depression
- Are part of an unusually large family, such that parental time is scarce or available unequally or rarely
- However, most children who are severely neglected don't develop reactive attachment disorder.

What causes reactive attachment disorder and other attachment problems?

- Reactive attachment disorder and other attachment problems occur when children have been unable to consistently connect with a parent or primary caregiver. This can happen for many reasons:
- A baby cries and no one responds or offers comfort.
- A baby is hungry or wet, and they aren't attended to for hours.
- No one looks at, talks to, or smiles at the baby, so the baby feels alone.
- A young child gets attention only by acting out or displaying other extreme behaviors.
- A young child or baby is mistreated or abused.
- Sometimes the child's needs are met and sometimes they aren't. The child never knows what to expect.
- The infant or young child is hospitalized or separated from his or her parents.
- A baby or young child is moved from one caregiver to another (can be the result of adoption, foster care, or the loss of a parent).
- The parent is emotionally unavailable because of depression, an illness, or a substance abuse problem.

Common signs and symptoms of reactive attachment disorder

- **An aversion to touch and physical affection.** Children with reactive attachment disorder often flinch, laugh, or even say “Ouch” when touched. Rather than producing positive feelings, touch and affection are perceived as a threat.
- **Control issues.** Most children with reactive attachment disorder go to great lengths to remain in control and avoid feeling helpless. They are often disobedient, defiant, and argumentative.
- **Anger problems.** Anger may be expressed directly, in tantrums or acting out, or through manipulative, passive-aggressive behavior. Children with reactive attachment disorder may hide their anger in socially acceptable actions, like giving a high five that hurts or hugging someone too hard.
- **Difficulty showing genuine care and affection.** For example, children with reactive attachment disorder may act inappropriately affectionate with strangers while displaying little or no affection towards their parents.
- **An underdeveloped conscience.** Children with reactive attachment disorder may act like they don’t have a conscience and fail to show guilt, regret, or remorse after behaving badly.

Inhibited reactive attachment disorder vs. disinhibited reactive attachment disorder

- As children with reactive attachment disorder grow older, they often develop either an inhibited or a disinhibited pattern of symptoms:
- **Inhibited symptoms of reactive attachment disorder.** The child is extremely withdrawn, emotionally detached, and resistant to comforting. The child is aware of what's going on around him or her—hypervigilant even—but doesn't react or respond. He or she may push others away, ignore them, or even act out in aggression when others try to get close.
- **Disinhibited symptoms of reactive attachment disorder.** The child doesn't seem to prefer his or her parents over other people, even strangers. The child seeks comfort and attention from virtually anyone, without distinction. He or she is extremely dependent, acts much younger than his or her age, and may appear chronically anxious.

Types of treatment for reactive attachment disorder

- Treatment for reactive attachment disorder usually involves a combination of therapy, counseling, and parenting education, designed to ensure the child has a safe living environment, develops positive interactions with caregivers, and improves peer relationships.
- While medication may be used to treat associated conditions, such as depression, anxiety, or hyperactivity, there is no quick fix for treating reactive attachment disorder. Your pediatrician may recommend a treatment plan that includes:
- **Family therapy.** Typical therapy for attachment problems includes both the child and his or her parents or caregivers. Therapy often involves fun and rewarding activities that enhance the attachment bond as well as helping parents and other children in the family understand the symptoms of the disorder and effective interventions.

- Individual psychological counselling. Therapists may also meet with the child individually or while the parents observe. This is designed to help your child directly with monitoring emotions and behavior.
- **Play therapy.** Helps the child learn appropriate skills for interacting with peers and handling other social situations.
- **Special education services.** Specifically designed programs within child's school can help him or her learn skills required for academic and social success, while addressing behavioral and emotional difficulties.
- **Parenting skills classes.** Education for parents and caregivers centres on learning about attachment disorders as well as other necessary parenting skills.

Disinhibited Social Engagement Disorder

Diagnostic Criteria 313.89 (F94.2)

A. A pattern of behavior in which a child actively approaches and interacts with unfamiliar adults and exhibits at least two of the following:

1. Reduced or absent reticence in approaching and interacting with unfamiliar adults.

2. Overly familiar verbal or physical behavior (that is not consistent with culturally sanctioned and with age-appropriate social boundaries).

3. Diminished or absent checking back with adult caregiver after venturing away, even in unfamiliar settings.

4. Willingness to go off with an unfamiliar adult with minimal or no hesitation.

B. The behaviors in Criterion A are not limited to impulsivity (as in attention-deficit/hyperactivity disorder) but include socially disinhiblted behavior.

C. The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:

1. Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.

2. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
3. Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).
D. The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g:, the disturbances in Criterion A began following the pathogenic care in Criterion C).
E. The child has a developmental age of at least 9 months.
***Specify* if:**
Persistent: The disorder has been present for more than 12 months.
***Specify* current severity:**
Disinhibited social engagement disorder is specified as severe when the child exhibits all symptoms of the disorder, with each symptom manifesting at relatively high levels.

- The most obvious symptom of disinhibited social engagement disorder is the absence of normal fear or discretion when approaching strangers. The child is unusually comfortable talking to, touching, and leaving a location with an adult stranger. These behaviors are not the result of attention problems or other issues that might be associated with impulsive behavior.
- The DSM-5 explains that a background of severe social neglect is a diagnostic requirement (American Psychiatric Association, 2013). Because young infants are unable to form selective attachments, disinhibited social engagement disorder is not diagnosed in children younger than nine months old. Development of disinhibited social engagement disorder almost always occurs during the first two years of life (American Psychiatric Association, 2013).

- Because neglect is a diagnostic feature of disinhibited social engagement disorder, patients may also present other symptoms of neglect that are not directly related to disinhibited social engagement disorder. For example, a neglected child may present with developmental delays and malnutrition (American Psychiatric Association, 2013).
- Although developmental disability is not a diagnostic feature of disinhibited social engagement disorder, the disorder is more common in developmentally disabled infants because they are more likely than healthy children to be mistreated or institutionalized (Minnis, Fleming & Cooper, 2010).
- Children who are removed from abusive or neglectful environments tend to recover physically but still present symptoms of disinhibited social engagement disorder. Therefore, not all children with disinhibited social engagement disorder have physical symptoms (American Psychiatric Association, 2013).

Risk Factors

- Disinhibited social engagement disorder (DSED) is most common in children institutionalized during infancy and early childhood. Still, not all children raised in institutions develop disinhibited social engagement disorder or other attachment disorders.
- DSED is specifically related to the quality of attachment. Therefore, children living in institutions with adequate medical care, stimulation and nutrition can develop disinhibited social engagement disorder. In non-institutionalized children, parental adjustment problems are the most prevalent risk factors.
- Examples include poverty, teen parenting, substance abuse and mental health issues such as a depression or personality disorder that affect the parent’s ability to form an attachment with the child (Oliveira, et al, 2013).

Treatment for Disinhibited Social Engagement Disorder

- An integrative approach to psychotherapy is the most effective way to treat disinhibited social engagement disorder. The therapy must facilitate multisensory experiences, communication, social skills, emotional awareness and self-exploration (Malchiodi & Crenshaw, 2013).
- Establishing rapport between child and therapist is typically easy because, according to the DSM-5, overfriendliness and trust is a key feature of disinhibited social engagement disorder (American Psychiatric Association, 2013). Establishing a relationship, however, is more challenging because children with disinhibited social engagement disorder only develop shallow, superficial attachments.

- Play therapy and creative arts therapy are two effective approaches to treating disinhibited social engagement disorder (Malchiodi & Crenshaw, 2013)
- Because children naturally develop attachments through play, play therapy offers and opportunity to create attachments that did not occur during early infancy. In many cases, the primary caregiver is invited to join the play therapy sessions, so that the new attachment can extend beyond the therapist.
- Creative arts therapy is another effective approach to treating DSED. Creative arts therapy uses painting, drawing, dance, music and theatrical activities as a means of carrying out psychotherapy. Like play therapy, creative arts therapy is interactive and experiential (Malchiodi & Crenshaw, 2013).

- Infants develop healthy attachments to parents and primary caregivers through their five senses. Being held, fed, and talked to, for example, are important components of attachment development.
- These needs don't disappear with age. Children, teens, and adults experience relationships through hugging, touching, story-telling, and eating together.
- Both play therapy and creative arts therapy provide sensory experiences. Both approaches also normalize experiences for children with disinhibited social engagement disorder, because children in all cultures enjoy play and artistic expression.
- Another benefit to both play therapy and creative arts therapy is that both approaches can be done non-verbally. This is important because young children are not always willing to able to verbally discuss trauma, thoughts, and feelings (Malchiodi & Crenshaw, 2013).

Parent-Child Interaction Therapy (PCIT)

- Parent-Child Interaction Therapy (PCIT) is an empirically-supported treatment for conduct-disordered and DSED young children that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. In PCIT, parents are taught specific skills to establish a nurturing and secure relationship with their child while increasing their child's prosocial behavior and decreasing negative behavior.

Posttraumatic Stress Disorder Diagnostic Criteria 309.81 (F43.10)

Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see corresponding criteria below.

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 A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

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).

Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
Note: In children, there may be frightening dreams without recognizable 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.)Note: In children, trauma-specific re-enactment 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).
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.

D. **Negative alterations in cognitions and mood 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. 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 the world (e.g., “I am bad,” “No one can be trusted,” ‘The world is completely dangerous,” “My whole nervous system is permanently ruined”).
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).

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).

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 another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify if:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Posttraumatic Stress Disorder for Children 6 Years and Younger

A. In children 6 years and younger, 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, especially primary caregivers.

Note: Witnessing does not include events that are witnessed only in electronic media, television, movies, or pictures.

3. Learning that the traumatic event(s) occurred to a parent or caregiving figure.

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).

Note: Spontaneous and intrusive memories may not necessarily appear distressing and may be expressed as play reenactment.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

Note: It may not be possible to ascertain that the frightening content is related to the traumatic event.

3. Dissociative reactions (e.g., flashbacks) in which the child 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.) Such 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 reminders of the traumatic event(s).

C. 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):

Persistent Avoidance of Stimuli

1. Avoidance of or efforts to avoid activities, places, or physical reminders that arouse recollections of the traumatic event(s).

2. Avoidance of or efforts to avoid people, conversations, or interpersonal situations that arouse recollections of the traumatic event(s).

Negative Alterations in Cognitions
3. Substantially increased frequency of negative emotional states (e.g., fear, guilt, sadness, shame, confusion).
4. Markedly diminished interest or participation in significant activities, including constriction of play.
5. Socially withdrawn behavior.
6. Persistent reduction in expression of positive emotions.
D. 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 (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).
E. The duration of the disturbance is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in relationships with 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.

Acute Stress Disorder
Diagnostic Criteria 308.3 (F43.0)

A. Exposure to actual or threatened death, serious injury, or sexual violation 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 event(s) occurred to a close family member or close friend. Note: 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: This does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of nine (or more) of the following symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred:

Intrusion Symptoms

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). Note: In children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the event(s). Note: In children, there may be frightening dreams without recognizable 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.) Note: In children, trauma-specific reenactment may occur in play.
4. Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Negative Mood

5. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

Dissociative Symptoms

6. An altered sense of the reality of one's surroundings or oneself (e.g., seeing oneself from another's perspective, being in a daze, time slowing).
7. 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).

Avoidance Symptoms

8. Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
9. 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).

Arousal Symptoms

10. Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep).
11. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
12. Hypervigilance.
13. Problems with concentration.
14. Exaggerated startle response.

C. Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure.
Note: Symptoms typically begin immediately after the trauma, but persistence for at least 3 days and up to a month is needed to meet disorder criteria.
D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
E. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition (e.g., mild traumatic brain injury) and is not better explained by brief psychotic disorder._

- **What Trauma Therapy Looks Like**
- There is a three phase treatment protocol that is recommended by expert bodies on trauma:
- **Phase 1: Achieving patient safety, reducing symptoms and increasing :** is the skills building phase and clinicians can use any evidence based therapy that has outcomes of improving emotion regulation, increasing distress tolerance, mindfulness, interpersonal effectiveness, cognitive restructuring, behavioral changes, and relaxation. This phase can also help move someone out of crisis to prepare for the next phase.
- **Phase 2: Review and reappraisal of trauma memories**There are different techniques for doing this, and they are described below, but the success of this phase hinges on someone’s ability to tolerate the discomfort of reviewing the memories. People with single incident trauma may be ready to withstand exposure with minimal distress tolerance training, while people with complex trauma may need months of skills building support in order to be ready to process their trauma.
- **Phase 3: Consolidating the gains**The therapist is helping the client apply new skills and adaptive understanding of themselves and their trauma experience. This phase can also include “booster” sessions to reinforce skills, increase professional and informal support systems, and create an ongoing care plan.

Exposure therapies

- Prolonged Exposure Therapy (PE) is...
- a theoretically-based and highly efficacious treatment for chronic PTSD and related depression, anxiety, and anger
- empirically validated with more than 20 years of research supporting its use
- based on basic cognitive-behavioral principals
- a flexible therapy that can be modified to fit the needs of individual clients
- specifically designed to help clients process traumatic events and reduce trauma-induced psychological disturbances.
- A treatment that produces clinically significant improvement in about 80% of patients with chronic PTSD

- **In vivo exposure** involves repeatedly engaging in activities, situations, or behaviors that are avoided because of the trauma, but which are not actually dangerous. Over time, In vivo exposure reduces excessive fear, and other distressing emotions, and encourages the recognition that the avoided situations are not excessively dangerous, and that the client can cope effectively even when distressed.
- **Imaginal exposure** involves repeatedly revisiting the traumatic experience in memory describing the event aloud in detail. The narrative is recorded and the client listens to the recording between sessions to maximize therapeutic value. Revisiting the event in this way promotes processing of the trauma memory by activating the thoughts and emotions associated with the trauma in a safe context. Imaginal exposure also helps the client realize he or she can cope with the distress associated with the memory.

Trauma Focused behaviour therapy

TF-CBT is a conjoint child and parent psychotherapy approach for children and adolescents who are experiencing significant emotional and behavioral difficulties related to traumatic life events.

It is a components-based treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles and techniques.

Children and parents learn new skills to help process thoughts and feelings related to traumatic life events; manage and resolve distressing thoughts, feelings, and behaviors related traumatic life events; and enhance safety, growth, parenting skills, and family communication.

Who is TF-CBT for?

TF-CBT has proved successful with children and adolescents (ages 3 to 18) who have significant emotional problems (e.g., symptoms of posttraumatic stress disorder, fear, anxiety, or depression) related to traumatic life events.

This treatment can be used with children and adolescents who have experienced a single trauma or multiple traumas in their life.

Children or adolescents experiencing traumatic grief can also benefit from this treatment.

TF-CBT can be used with children and adolescents residing in many types of settings, including parental homes, foster care, kinship care, group homes, or residential programs.

How long does TF-CBT typically last?

TF-CBT is designed to be a relatively short-term treatment, typically lasting 12 to 16 sessions. Over 80 percent of traumatized children who receive TF-CBT experience significant improvement after 12 to 16 weeks of treatment.

Treatment may be provided for longer periods depending upon individual child and family needs.

TF-CBT can be used as part of a larger treatment plan for children with complex difficulties.

Cognitive Processing Therapy

- Cognitive Processing Therapy (CPT) helps you by giving you a new way to handle these distressing thoughts and to gain an understanding of these events. By using the skills learned in this therapy, you can learn why recovery from traumatic events has been hard for you. CPT helps you learn how going through a trauma changed the way you look at the world, yourself, and others. The way we think and look at things directly affects how we feel and ac

How Talk Therapies Help People Overcome PTSD

- Talk therapies teach people helpful ways to react to frightening events that trigger their PTSD symptoms. Based on this general goal, different types of therapy may:
- Teach about trauma and its effects.
- Use relaxation and anger control skills.
- Provide tips for better sleep, diet, and exercise habits.
- Help people identify and deal with guilt, shame, and other feelings about the event.
- Focus on changing how people react to their PTSD symptoms. For example, therapy helps people visit places and people that are reminders of the trauma

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. These symptoms or behaviors are clinically significant, as evidenced by one or both of the following:

1. Marked distress that is out of proportion to the severity or intensity of the stressor, taking into account the external context and the cultural factors that might influence symptom severity and presentation.
2. Significant impairment in social, occupational, or other important areas of functioning.

C. The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a preexisting mental disorder.

D. The 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.

treatment

- **Mirror Therapy:** Patients sit in front of a mirror and are asked to examine the image in the mirror. Acceptance of oneself as a whole person is encouraged. The results of this therapy when used for people who had heart attacks was superior when compared with Gestalt therapy and medical conversation in the treatment for adjustment disorder.
- **Activating Therapy:** This is a type of cognitive behavioral therapy that focuses on performing a set of activities to reclaim personal power over one's life or situation and to develop coping mechanisms. This therapy was effective for people experiencing long-term unemployment.
- **BICEPS:** BICEPS stands for "brevity, immediacy, centrality, expectancy, proximity, and simplicity." Known as a "first aid" application for emotions, it is used to focus upon the problem and come up with solutions that will work right away so the person can resume a normal life after a stressful event. It helps the person learn the coping mechanisms that can be applied to bring the client relief with immediacy.

- **Brief Dynamic Therapy** helps people identify what behaviors, thoughts, and feelings are contributing to their present difficulties in coping with their present situation. This has been found to help people with depressive symptoms with adjustment disorder.
- **Supportive Therapy** concentrates on helping people reason through their thoughts and emotions to get back control in their lives. Supportive Therapy focuses upon resolving feelings about the stressful situation or event, decreasing symptoms, and building the skills necessary to adapt and cope with the situation.

- **Eye Movement Desensitization and Reprocessing Therapy (EMDR):**Emotional turmoil, according to the principles of EMDR, is caused by past images and thoughts associated with a stressful event. When the stressful event is focused upon in therapy, the therapist has the client visually follow the therapist's finger across the client's "field of vision" and uses tapping and sounds in order to reprogram associations made with a painful past event. This therapy is effective with adjustment disorder with anxiety symptoms, but not as much with adjustment disorder with depressive symptoms.