Post Traumatic Stress Disorder Redefined: The move from DSM-IV™ to DSM-5™

Like many, I've got my dog-eared blue-and-gray copy of the DSM-IV™ and am trying to figure out how it differs from the plum-colored DSM-5™. This morning I'm starting in on post-traumatic stress disorder (PTSD). To begin, the DSM-5™ has removed post-traumatic stress disorder (PTSD) from the chapter on anxiety disorders and put it in a new section, trauma and stressor-related disorders. This makes sense when considering the unique nature of PTSD, that while there are genetic and temperamental susceptibilities, the condition only occurs following exposure to a traumatic event.

There is a second reason to separate PTSD from anxiety disorders. While intense anxiety and fear are common responses to trauma, there are other emotional clusters that fall outside the anxiety spectrum. Many individuals with PTSD experience symptoms more compatible with clinical depression - with or without an anxious component. Additionally, as seen in many veterans and individuals with complex PTSD, the predominant symptoms can be anger, rage and reckless and dangerous behaviors. The next notable change is the separation of PTSD into two diagnoses: a) one specific to children under the age of six, and b) the other for everyone else. For the purpose of this essay we'll stick to the latter.

The DSM-5™ has removed the criterion A requirement that a person responds to the trauma with "intense fear, helplessness, or horror." (4th ed., text rev.; DSM–IV–TR; American Psychiatric Association, 2000). This deletion speaks to the heterogeneous responses people have to traumatic events. While one person might be frozen with fear, another could be overcome with rage. Or, as many first responders need to do, shut down emotional responses in the present so they can get their jobs done. The DSM-5™ also expands the criterion A exposure types, but specifically excludes violence and traumatic events experienced through the media. From there the changes from DSM-IV™ to DSM-5™ are largely a reorganization and re-articulation of 20 core symptoms. Criterion B contains the intrusive symptoms, which include flashbacks, nightmares, intrusive remembering of the event(s), and both psychological distress and physiological changes triggered by cues that represent the event. Criterion C is the avoidant symptoms. These include trying to not think about the event, as well as avoiding people, places and situations that are likely to remind the person of the trauma. Criterion D lists the negative emotions and thoughts tied to the event(s). Among these are traumatic/dissociative amnesia, excessive negativity, blaming oneself out of proportion to what actually occurred, persistent negative emotions: fear, anger, shame, diminished interest in usual activities, feelings of isolation, and inability to experience positive emotions. Criterion E contains the arousal symptoms, such as angry outbursts, reckless and dangerous behavior, hypervigilance, an increased startle response, diminished
concentration, and sleep disturbance. To make the DSM-5™ diagnosis, symptoms must be present for at least one month (Criterion F); the symptoms must cause significant distress and impairment (Criterion G); and the symptoms cannot be better accounted for by another condition, such as substance abuse or a medical condition (Criterion H).

The specifiers have changed slightly, and the specifiers for acute and chronic have been replaced with whether or not the individual has dissociative symptoms of depersonalization and/or derealization. As in the earlier manual, there remains a specifier for delayed onset/expression, in which the full spectrum of symptoms does not manifest until at least six months after the event. The process for making the diagnosis in the new manual, is essentially the same, symptoms need to be present in each of the specified criterion (i.e., one or more from A, B, and C, and two or more from D and E).

After reading the two, DSM-IV™ and DSM-5™ side by side, I find the changes to be subtle and thoughtful. I suspect this reworking and rewording will increase clinicians' confidence in making the diagnoses and will decrease the use of not otherwise specified (NOS) diagnoses. Although, to be accurate, in the DSM-5™ the NOS has been eliminated throughout and changed to the options of "Other Specified________" and "Unspecified______". But, that is another essay.

Submitted by Charles Atkins, M.D.
chronic and potentially fatal conditions such as heart disease, stroke, cancer, and diabetes. People in recovery often do not attain optimal diet and nutrition standards for a variety of reasons: a) the topic is often overlooked by service providers in favor of “more pressing” treatment issues; b) recovering individuals may assign a low priority to healthy eating; c) recovering individuals may not be familiar with current healthy eating recommendations; d) many recovering individuals live on limited incomes and assume they cannot afford to eat healthier; and e) recovering individuals may not have the skills to shop for and prepare healthy food. Agencies, programs, and individual providers should stress the importance of healthy eating patterns and nutrition to their clients in recovery and provide relevant information and skills:

• Start by asking about a client’s eating preferences and habits.
• Use motivational interviewing based on the stages of change model (Prochaska & DiClementi, 2006). Next, determine the client’s stage of change in recovery relative to healthy eating and use stage-appropriate interventions.
• Present and discuss the federal government’s newly revised nutrition recommendations.
• Identify real and perceived barriers, such as the inability to afford healthy food, difficulty shopping for or securing healthy food, and preparing healthy food; then work with the client to reduce or eliminate those barriers.

**Basic guidelines for healthy eating include:**

• Consume fruits and vegetables, whole grains, lean protein (e.g., beans, fish) and low fat dairy products
• Reduce sugar intake (e.g., soft drinks, processed food and desserts); reduce sodium intake (e.g., processed foods, added salt, and snack foods) and reduce fat intake (e.g., snack foods, processed foods, fatty meats, and whole milk and dairy products)
• Eat three meals a day and avoid snacking other than a piece of fruit (e.g., an apple) or vegetable (e.g., carrot and celery sticks).

Recovery is not just about symptom reduction - it is about developing a new way of living and living well!

Submitted by Stephen Bistran

References
For a more comprehensive review of improving one’s diet, see the federal government’s (USDA-sponsored) website, http://www.choosemyplate.gov.


Helping to make behavioral health agencies trauma-informed and gender-responsive has been an ongoing project of the State of Connecticut, Department of Mental Health and Addiction Services (DMHAS) Trauma and Gender (TAG) Initiative since 2004. The CT Women’s Consortium, funded by DMHAS, contracts a team of experts - Stephanie Covington, PhD; Roger Fallot, PhD; and Eileen Russo, MA, LADC, to guide the selected DMHAS-funded agencies through a two year transition. The process includes training, technical assistance, focus groups, and site visits that incorporate client feedback by peer organization Advocacy Unlimited. The numerous agencies previously trained under this initiative include Alcohol and Drug Recovery Center, Inc., (ADRC), APT Foundation, BH Care (Birmingham), Capitol Region Mental Health Center, Catholic Charities, Community Health Resources (Community Prevention and Addiction Services (CPAS) site-now merged), Crossroads, Intercommunity, Recovery Network of Programs, Wellmore, Western CT Mental Health Network (Torrington, Waterbury and Danbury), and Wheeler Clinic. Most recently in January 2013, River Valley Services, Reliance House, and Community Health Resources were selected.

The TAG agencies’ project under the TAG Initiative has significantly influenced staff to make changes to their programs, cultures, and environments by looking at opportunities to promote trauma-informed and gender-responsive care. Some of the more universal modifications to agencies include an awareness of trauma and gender across staff and departments, male or female (as opposed to coed) treatment groups, and welcoming receptionists and lobbies. Although these changes were anticipated as part of the initiative’s design, others reflect unique input from each agency’s hardworking staff. In December 2012, the multiple generations of agencies, also known as the TAG cohorts, gathered to discuss the initiative. At the meeting the following best practices were highlighted:

• Provide a welcoming atmosphere (e.g. changing wall color, entrances, chairs, artwork, food, and computers);
• Create spaces for privacy and relaxation for staff and consumers;
• Create a safe environment (e.g. a well-lit parking lot);
• Change signs to symbols that are understood in many languages;
• Establish a “no page” pledge within the agency to minimize distractions during interventions;

• Streamline intake to increase accessibility and minimize delays;

• Revise strategic plans and mission statements to be trauma and gender sensitive;

• Share documents between staff and clients to increase transparency;

• Create simplified, easy-to-use policies, including cancellation policies;

• Embed a trauma screening instrument into the health record;

• Develop a brochure for clients that includes an overview of the TAG Initiative;

• Include a trauma and gender presentation as part of new employee orientation;

• Build trauma as a specialty into staff competencies and employee evaluations;

• Have ongoing focus groups with consumers to enhance the change process;

• Have individuals in recovery as part of the hiring process;

• Encourage individuals in recovery to co-facilitate trauma groups;

• Provide classes that increase positive experiences (e.g. yoga or process painting);

• Include lesbian, gay, bisexual, transgender, questioning and intersex (LGBTQ) groups;

• Provide clients a gender choice on intake or screening; and

• Educate local domestic violence shelters and police departments to better understand symptoms of trauma and PTSD.

Despite these significant trauma-informed and gender-responsive improvements, agencies have encountered many challenges and continue to work through obstacles. The most difficult hurdle for agencies has been staff training. Many sustainability issues can be linked back to the need for ongoing education after the TAG Initiative and consultation is completed. The TAG Initiative requires a basic understanding of the principles of trauma and gender. Unfortunately, the difficulties of training all shifts and non-clinical staff, and staff turnover can make it hard to maintain the level of education that is needed to implement and sustain change. Oftentimes, important ideas and perspectives are gleaned from nonclinical personnel indicating the importance of including all staff in developing a trauma-informed culture.

A major component to the success of an agency’s transformation is a focus on staff care and staff feedback, especially relative to safety concerns such as proper lighting in parking lots, use of security, and panic buttons. In order for staff safety concerns to be addressed agencies must also consider security measures for staff safety in client situations that can become volatile. Offering a forum to address concerns via a newsletter or bulletin board gives staff a formal way to offer input and suggestions.

Looking at the successes and challenges of the TAG cohorts gives a starting point to discuss the next steps, some of which have already been accomplished. The Connecticut Women’s Consortium (CWC) will support agency efforts by providing facilitator training in Healing Trauma by Stephanie Covington (a five-session version of the longer Beyond Trauma curriculum), and access to Mental Health First Aid training opportunities for nonclinical staff. Agencies can also access the DMHAS Learning Management System (LMS) online training system. This system has both gender-responsive and trauma-informed trainings created by the TAG Initiative that can be used for new staff, as a refresher for seasoned staff, or for those who have difficulty attending trainings in person.

Finally, the TAG Guide Team is working with the contracted team of experts to measure improvements in system changes. With so much having already been accomplished, we look forward to the future growth that the TAG Initiative brings to the behavioral health system of care.

Submitted by Richard Stillson, Ph.D. and Olivia Yetter
Evaluation of a Five Session Trauma Treatment Model For Women

Despite the growing recognition that many women in the criminal justice system have histories of domestic violence, there are few treatment interventions designed to help women offenders deal with the psychological trauma that have been left by abusive relationships and learn the skills needed to develop healthy relationships, and lead happier lives. With funding from the Department of Public Health (DPH), the Connecticut Women’s Consortium developed a program to implement Healing Trauma as part of an Intimate Partner Violence (IPV) Project. The program began in 2007 to provide resources about psychological trauma to women who are incarcerated or recently released from prison. Healing Trauma (Covington & Russo, 2011) is a five-session gender responsive treatment model adapted from Stephanie Covington’s (2003) Beyond Trauma curriculum. Healing Trauma is an integrated approach to women’s treatment that is based on theory, research, and clinical experience. It is specifically designed for working with women in a setting where short-term intervention is needed.

To date, Healing Trauma has been administered to 303 justice-involved women across 31 groups in prison-based and community based settings. We are evaluating the effectiveness of Healing Trauma by collecting consumer satisfaction reports and measuring symptoms of depression and psychological trauma before and after treatment. Our initial findings from a sample of 176 women (58.1% of the women served) are quite promising.

**Consumer Satisfaction**

Of the 176 women, 89.2% (157 women) said they achieved the treatment goals that they identified for themselves during the first session, and 94.3% (166 women) said they would recommend Healing Trauma to others. Women reported that the most helpful aspect about Healing Trauma was having a safe place to discuss their experiences with other women like themselves. Most women were positive about the group facilitators. Women who were served at York Correctional Center frequently reported that it was helpful to have facilitators who had similar experiences and understood the problems facing incarcerated women who have trauma histories. Women in both community-based and prison-based settings reported that the group helped them realize that they were not alone and that other women had the same issues with relationships. Several women pointed out that Healing Trauma helped them learn what a healthy relationship was, often coming to realize that aspects of their past relationships were abusive. The women also indicated that the experiential exercises were helpful and that they enjoyed learning grounding skills.

**Reductions in Symptoms of Depression and Post-Traumatic Stress**

For a subgroup of 160 women (90.9% of the sample), data was collected to measure symptoms of depression using the Center for Epidemiological Studies-Depression Scale (CES-D; Radloff, 1977) and the PTSD Checklist (PCL-C; Weathers, Huska, &Keane, 1991). Of these women, 84.4% or 135 women had moderate to severe depression severity at the start of treatment. Among 65 women who completed both the pre- and post-treatment depression screener, estimated rates of major depression decreased from 81.5% (53 women) before taking Healing Trauma to 60.0% (39 women) after completion of the intervention. The decrease in symptoms of depression was statistically significant (t=5.72, df=64, sig.=.000). Findings related to PTSD symptom severity were similar; 143 women (81.3% of the sample) completed the PTSD screener before Healing Trauma. Of these women, 10.6% or 26 women reported having symptoms consistent with a diagnosis of full PTSD. Among 73 women who completed the PTSD Checklist both before and after Healing Trauma, the estimated rate of PTSD decreased from 12.3% (9 women pre-treatment) to 8.2% (6 post-treatment) (Chi Sq=8.47, df=1, sig.=.003).

These finding support the use of Healing Trauma to help women in their recovery. This brief intervention, can be used to introduce women to new skills that help them deal with psychological trauma, build healthy relationships, sustain their recovery and potentially shield them further criminal involvement.

Submitted by Josephine Hawke, Ph.D.

**References**


Thoughts on Self-Care

Shopping for Joy

Many years ago, I attended a workshop and the facilitator made the comment that reading the newspaper or watching the news is like shopping for junk. While I do encourage people to stay up to date on current affairs, I understand the facilitator’s sentiment. I often ask people to analyze their day by asking “How much time do you spend per day being exposed to painful stories and violent material?” This includes not only what you might be exposed to during working hours (e.g., vicarious trauma), but also what you read or hear in the news, and watch on television. A couple of years ago I was feeling particularly downhearted and realized I was good at noticing the bad and feeling hopeless about the state of the world. I was out of practice of noticing the good around me. As a result, I gave myself the shopping for joy challenge. The challenge was to identify things outside of what I knew I was grateful for in my life (e.g., health, family, friends and career) and that are joyful or uplifting. I made the challenge more difficult by stating that the joys had to be unrelated to holidays or media-grabbing situations that compelled others to be generous with their time or money (e.g., large-scale disasters or problems). I looked for everyday events that outweighed the pain in life. Within two weeks, I had a folder stuffed with good news stories relegated to the back pages of the newspaper, comics that made me laugh, and new memories from my experience. I have continued this practice and no longer need a folder to capture joy. Some of my favorite joyous moments include a young man who gave my elderly aunt his seat; witnessing three teenagers experiencing two hours of fun and laughter by making up a game with three plastics cups, while their iphones sat on the table untouched; watching a group of children play outside; and observing a man routinely bring his dog to the local nursing home. When the dog died, the residents pooled their money and bought him a puppy. What about you? What are you shopping for?

Submitted by Eileen Russo