Module 6: Differential Diagnosis, Scope of Practice, and the Addressing of Obsessive-Compulsive and Related Disorders, Dissociative Disorders, and Trauma and Stressor Related Disorders
Your Presenters

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Course Objectives

Upon completion of this program trainees will:

- Learn the etiology of obsessive-compulsive and related disorders based on current research
- Comprehend the complexities of diagnosis for this disorder
- Grasp appropriate assessment processes for determining obsessive-compulsive and related disorders, role clarification and differentiation for master’s level clinicians, and appropriate referrals to other professionals in establishing obsessive-compulsive and related disorders diagnoses
- Comprehend differential diagnosis from other disorders with similar presentations
- Apply common specifiers for obsessive-compulsive and related disorders
- Learn appropriate treatment strategies based upon diagnosis
Course Objectives

Upon completion of this program trainees will:

- Learn the etiology of dissociative disorders based on current research
- Comprehend the complexities of diagnosis for this disorder
- Grasp appropriate assessment processes for determining dissociative disorders, role clarification and differentiation for master’s level clinicians, and appropriate referrals to other professionals in establishing dissociative disorders diagnoses
- Comprehend differential diagnosis with other disorders with similar presentations
- Apply common specifiers for dissociative disorders
- Learn appropriate treatment strategies based upon diagnosis
Course Objectives

Upon completion of this program trainees will:

- Learn the etiology of trauma and stressor related disorders based on current research
- Comprehend the complexities of diagnosis for this disorder
- Grasp appropriate assessment processes for determining trauma and stressor related disorders, role clarification and differentiation for master’s level clinicians, and appropriate referrals to other professionals in establishing trauma and stressor related disorders diagnoses
- Comprehend differential diagnosis with other disorders with similar presentations
- Apply common specifiers for trauma and stressor related disorders
- Learn appropriate treatment strategies based upon diagnosis
Purposes Behind Diagnosis

• Accurate diagnosis allows for **consistency and standardization** throughout all disciplines that address mental health concerns: medical, nursing, psychiatric, psychological, counseling, social work, marriage and family therapy

• Accurate diagnosis allows for **common ground** to be established in terms of research concerning the **effectiveness of various kinds of treatment**

• Accurate diagnosis can be used for **shaping the client's treatment plan**, aligning the treatment approaches research has determined to be most effective with the various diagnostic categories
Boundaries around Assessment:

Who Makes the Diagnosis for Complex Disorders?
Ethics in Tools and Assessment

- What are the legal and ethical boundaries for Master’s level clinicians?
- How do we differentiate, ethically and legally, the diagnostic criteria in assessment?
- When do we refer for further testing and diagnostics?
- To whom do we refer for further assessment?
GA Composite Board states:
Rule 135-7-.05. Assessment Instruments

(c) Using unsupervised or inadequately supervised test-taking techniques with clients, such as testing through the mail, unless the test is specifically self-administered or self-scored.

(d) Administering test instruments either beyond the licensee’s competence for scoring and interpretation or outside of the licensee’s score of practice, as defined by law;
From the Social Work Code of Ethics

1.04 Competence

(a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.
Psychological Testing by Law

O.C.G.A. 377 states:

“‘Psychological testing’ means the use of assessment instruments to both:

(A) Measure mental abilities, personality characteristics, or neuropsychological functioning; and

(B) Diagnose, evaluate, classify, or render opinions regarding mental and nervous disorders and illnesses, including, but not limited to, organic brain disorders, brain damage, and other neuropsychological conditions.”
• Determining Your Educational Eligibility
Qualifications for Ordering Tests

• Qualification Level A: There are no special qualifications to purchase these products

• Qualification Level B: Tests may be purchased by individuals with:
  – A master’s degree in psychology, education, occupational therapy, social work, counseling, or in a field closely related to the use of the assessment, and formal training in the ethical administration, scoring and interpretation of clinical assessments

(www.pearsonclinical.com)
Qualification Level B, cont’d

OR

- Certification by full or active membership in a professional organization that requires training and experience in the relevant area of assessment

OR

- A degree or license to practice in the healthcare or allied healthcare field

OR

- Formal, supervised mental health, speech/language, occupational therapy, social work, counseling, and/or educational training specific to assessing children, or in infant and child development, and formal training in the ethical administration, scoring and interpretation of clinical assessments.
- Licensure or certification to practice in your state in a field related to the purchase.

OR

- Certification by or full active membership in a professional organization (such as APA, NASP, NAN, INS) that requires training and experience in the relevant area of assessment.
• Qualification Level C
  – Tests with a C qualification require a high level of expertise in test interpretation, and can be purchased with:
  – A doctorate degree in psychology, education, or closely related field with formal training in the ethical administration, scoring, and interpretation of clinical assessments related to the intended use of the assessment.

OR
- Certification by or full active membership in a professional organization (such as APA, NASP, NAN, INS) that requires training and experience in the relevant area of assessment.
- EXAMPLE: Minnesota Multiphasic Personality Inventory – 2

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Understanding 135-12-.01 and 135-12-.02 and Their Implications
(5) The use of these testing and assessment instruments

(a) By persons licensed as Professional Counselors, Social Workers, or Marriage and Family Therapists may include, but is not limited to, administering and interpreting educational and vocational tests; functional assessments; interest inventories; tests that evaluate marital and family functioning; and mental health symptom screening and assessment instruments that evaluate emotional, mental, behavioral, and interpersonal problems or conditions including substance abuse, health, and disability, provided that the use of these instruments does not include rendering a diagnosis or a mental or nervous disorder or illness, including but not limited to organic brain disorders, brain damage, or other neuropsychological functioning or conditions, and provided that the licensee has obtained university level training or substantially equivalent supervised experience in the use of the test or assessment instrument.
(b) By persons licensed as a Professional Counselor may also include other assessments or tests which the licensee is qualified to employ by virtue of his or her education, training, or experience, provided that the use of these instruments does not include rendering a diagnosis or a mental or nervous disorder or illness, including but not limited to organic brain disorders, brain damage, or other neuropsychological functioning or conditions.
135-12-.02 Diagnosis

(a) Persons licensed as Professional Counselors, Social Workers, or Marriage and Family Therapists who comply with this section shall be authorized to diagnose and treat mental, emotional, and behavioral disorders through the use of current classification systems such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the International Classification System of Diseases and Related Health Problems (ICD).
Section One

Assessment and Diagnosis of Obsessive-Compulsive and Related Disorders
Key Changes from DSM-IV-TR to DSM-5
New Diagnostic Terms and Categories Added in the DSM-5

- Hoarding Disorder (ICD-9: 300.3; ICD-10: F42)
- Excoriation/Skin Picking, Disorder (ICD-9: 698.4; ICD-10: L98.1)
New Diagnostic Terms and Categories Added in the DSM-5

- Substance/Medication-Induced Obsessive-Compulsive and Related Disorder (ICD-9: 292.89; ICD-10: F14.xxx and F15.xxx)
- Obsessive-Compulsive and Related Disorder Due to Another Medical Condition (ICD-9: 294.8; ICD-10: F06.8)

These diagnoses should be made by qualified medical and psychiatric personnel only
New Diagnostic Terms and Categories Added in the DSM-5

• Substance/Medication-Induced Obsessive-Compulsive and Related Disorder (ICD-9: 292.89; ICD-10: F14.xxx and F15.xxx)

Examples: L-Dopa induced obsessive-compulsive behavioral effects, including uncontrollable gambling or sexual behaviors for Parkinson’s patients or cocaine induced scratching, skin picking and hair pulling due to the disruption of the neurotransmitters at specific brain sites associated with obsessive and compulsive behaviors.

For the diagnosis to be used properly, the obsessive or compulsive symptoms must appear during or soon after substance intoxication or withdrawal for drugs, and after exposure for a medication. It must also cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

These diagnoses should be made by qualified medical and psychiatric personnel only
New Diagnostic Terms and Categories Added in the DSM-5

• Obsessive-Compulsive and Related Disorder Due to Another Medical Condition (ICD-9: 294.8; ICD-10: F06.8)

Example: Obsessive-compulsive and related disorder due to cerebral infarction.

If this condition is noted, it will be accompanied with the specifiers that clarify how the OCD behaviors are appearing. These are the options that will likely be noted:

• With obsessive-compulsive disorder-like symptoms (Akin to symptoms of OCD, e.g., hand washing, ritualistic behaviors)
• With appearance preoccupations (Akin to body preoccupation as in Anorexia or Bulimia Nervosa)
• With hoarding symptoms (Akin to symptoms of Hoarding Disorder which has been added as a diagnosis in the DSM-5)
• With hair-pulling symptoms (Akin to symptoms of trichotillomania)
• With skin-picking symptoms (Akin to symptoms of Skin-Picking Disorder which has been added as a diagnosis in the DSM-5)

These diagnoses should be made by qualified medical and psychiatric personnel only
Important Reformulations of Diagnoses in the DSM-5

- Obsessive-Compulsive and Related Disorders

1) A new specifier, “With poor insight”, has been added in the DSM-5 to allow for more subtle distinctions concerning degrees of insight about OCD beliefs held by clients. In the DSM-IV-TR, the only two choices were “good or fair insight” and “absent insight/delusional”.

Assessment Components for Diagnosis of Obsessive-Compulsive and Related Disorders
Gathering Information During Assessment of Obsessive-Compulsive and Related Disorders

- All components of a thorough biopsychosocial assessment should be addressed
- Gather present and past history of stresses, traumas, violence and abuse
- Careful gathering of the client’s history of obsessive and compulsive behaviors and thoughts, present and past
- Family history of problems with obsessive and compulsive behaviors, mental illness, or traumatic events
- Gather medical history – illness and injury, history of use of medications, nutritional supplements, toxic substance exposure
- Use of screening tools specifically designed to uncover presence of obsessive and compulsive behaviors and thoughts
Symptoms to Look for in Assessment of Obsessive-Compulsive Disorders

1.
Symptoms to Look for in Assessment of Obsessive-Compulsive Disorders

**Obsessions**
Unwanted, repetitive and intrusive ideas, urges or images. 
Persistent paranoid fears, an unreasonable concern with becoming contaminated, or an excessive need to do things perfectly.

**Compulsions**
Repetitive behaviors, or compulsions. The most common of these are putting things in order, checking, and washing. Other compulsive behaviors include rearranging, counting (often while performing another compulsive action such as lock-checking), mentally repeating phrases, list making, and avoiding.
Screening Tools Used in Assessment of Obsessive-Compulsive Disorders

1. Yale-Brown Obsessive-Compulsive Scale (Y-BOCS)
2. Florida Obsessive-Compulsive Survey
Core Problems of Obsessive-Compulsive Disorders

Research suggests that OCD involves problems in communication between various structures of the brain, including elevated brain activity in areas of the frontal lobes (particularly the orbital cortex) and the basal ganglia with disruptions in one or more neurotransmitters, specifically serotonin and dopamine. According to one model, the basal ganglia and its connections are turned on inappropriately in OCD, with over-activity in its neurotransmitter receptor sites.

Imaging studies have shown differences in the frontal cortex and subcortical structures of the brain in patients with OCD. There appears to be a connection between the OCD symptoms and abnormalities in certain areas of the brain, but that connection is not clear.
Many investigators have contributed to the hypothesis that OCD involves dysfunction in a neuronal loop running from the orbital frontal cortex to the cingulate gyrus, striatum (caudate nucleus and putamen), globus pallidus, thalamus and back to the frontal cortex.

Insel has proposed that inappropriately increased activity in the head of the caudate nucleus inhibits globus pallidus fibers that ordinarily dampen thalamic activity. The resulting increase in thalamic activity produces increased activity in orbitofrontal cortex, which, via the cingulate gyrus, completes the circuit to the caudate and produces increased activity in the head of the caudate. Hypothetically, primitive cleaning and checking behaviors are "hard-wired" in the thalamus.
Baxter et al. in 1992 hypothesized that the hyperactivity observed in this neuronal loop arises because of impaired caudate nucleus function. The impairment allows "worry inputs" from the orbitofrontal cortex to inhibit excessively the inhibitory output from the globus pallidus to the thalamus. The resulting excess in thalamic output then impinges on various brain regions involved in the experience of OCD symptoms, including the orbital frontal region, thus reinforcing hyperactivity in the neuronal loop.

In brief, the theory is that the caudate nucleus doesn’t function properly and causes the thalamus to become overactive, in which case it sends never-ending worry signals between the Orbital Frontal Cortex and the thalamus. The OFC responds by increasing anxiety.
Core Problems of Obsessive-Compulsive Disorders

Researchers are looking at deeper levels of brain functioning to see how genetic factors may contribute to the development of OCD. In particular, researchers are looking at the contributions of various protein factors that may contribute to the neurotransmitter dysfunctions at the core of OCD.

There are also other potential avenues that may lead to the development of OCD, including possible neurological damage from head injuries or bacterial infections that cross the blood-brain barrier, most notably a streptococcal infection, resulting in a type of OCD called Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS).
Core Elements of Successful Treatment
of Obsessive-Compulsive Disorders

Psychotherapy for Obsessive-Compulsive Disorders generally consists of:
Cognitive behavioral therapy (CBT), and/or Exposure and Response Prevention (ERP),

Antidepressants approved by the Food and Drug Administration (FDA) to treat OCD include:
Clomipramine (Anafranil) for adults and children 10 years and older
Fluoxetine (Prozac) for adults and children 7 years and older
Fluvoxamine for adults and children 8 years and older
Paroxetine (Paxil, Pexeva) for adults only
Sertraline (Zoloft) for adults and children 6 years and older
Core Elements of Successful Treatment of Obsessive-Compulsive Disorders

For clients with intractable OCD symptoms not responsive to other modes of treatment, neurosurgery is sometimes performed to sever connections between areas of the brain whose over-activity is responsible for ongoing OCD effects.
Neuroanatomy and Obsessive-Compulsive Disorders
Key Differential Diagnosis:

OCD versus Obsessive-Compulsive Personality Disorder
Obsessive-Compulsive and Related Disorders

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<td>F42</td>
<td>Obsessive-Compulsive Disorder</td>
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Criteria:
A. Presence of obsession, compulsions, or both:
   Obsessions are defined by (1) or (2)

1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).
Compulsions are defined by (1) or (2)

1. Repetitive behaviors or mental acts that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.

2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to behaviors or mental acts are aimed at preventing or reducing anxiety or distress; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly obsessive.

B. The obsessions or compulsions are time-consuming and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder.

Specify if:
With good or fair insight
With poor insight
With absent insight/delusional beliefs
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Personality Disorders

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<td>F60.5</td>
<td>Obsessive-Compulsive Personality Disorder</td>
<td>Personality Disorders</td>
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Criteria:

A. A pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. Is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost.
2. Shows perfectionism that interferes with task completion
3. Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships
4. Is over conscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification).
Personality Disorders

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1. Is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost.
2. Shows perfectionism that interferes with task completion
3. Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships
4. Is over conscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification).
Personality Disorders

Criteria:
A. A pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

5. Is unable to discard worn-out or worthless objects even when they have no sentimental value.
6. Is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things.
7. Adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes.
8. Shows rigidity and stubbornness

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Other Obsessive-Compulsive and Related Disorders
Obsessive-Compulsive and Related Disorders

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<tr>
<td>F45.22</td>
<td>Body Dysmorphic Disorder</td>
<td>Obsessive-Compulsive and Related Disorders</td>
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Criteria:

A. Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others.
B. At some point during the course of the disorder, the individual has performed repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (e.g., comparing his or her appearance with that of others) in response to the appearance concerns.
C. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The appearance preoccupation is not better explained by concerns with body fat or weight in an individual whose symptoms meet diagnostic criteria for an eating disorder.
Obsessive-Compulsive and Related Disorders

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Specify if:

**With muscle dysmorphia** - The individual is preoccupied with the idea that his or her body build is too small or insufficiently muscular. This specifier is used even if the individual is preoccupied with other body areas, which is often the case.

**Indicate degree of insight regarding body dysmorphic disorder beliefs:**

**With good or fair insight** - The individual recognizes that the body dysmorphic disorder beliefs are definitely or probably not true or that they may or may not be true.

**With poor insight** - The individual thinks that the body dysmorphic disorder beliefs are probably true.

**With absent insight/delusional beliefs** - The individual is completely convinced that the body dysmorphic disorder beliefs are true.
Obsessive-Compulsive and Related Disorders

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<tr>
<td>F42</td>
<td>Hoarding Disorder</td>
<td>Obsessive-Compulsive and Related Disorders</td>
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Criteria:
A. Persistent difficulty discarding or parting with possessions, regardless of their actual value.
B. This difficulty is due to a perceived need to save the items and to distress associated with discarding them.
C. The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas and substantially compromises their intended use. If living areas are uncluttered, it is only because of the interventions of third parties (e.g., family members, cleaners, authorities).
D. The hoarding causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
E. The hoarding is not attributable to another medical condition.
F. The hoarding is not better explained by the symptoms of another mental disorder (e.g., obsessions in obsessive-compulsive disorder, decreased energy in major depressive disorder, delusions in schizophrenia or another psychotic disorder, cognitive deficits in major neurocognitive disorder, restricted interests in autism spectrum disorder).
### Obsessive-Compulsive and Related Disorders

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**Specify if:**

**With excessive acquisition:** If difficulty discarding possessions is accompanied by excessive acquisition of items that are not needed or for which there is no available space.

**With good or fair insight:** The individual recognizes that hoarding-related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition) are problematic.

**With poor insight:** The individual is mostly convinced that hoarding-related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition) are not problematic despite evidence to the contrary.

**With absent insight/delusional beliefs:** The individual is completely convinced that hoarding-related beliefs and behaviors are not problematic despite evidence to the contrary.
Obsessive-Compulsive and Related Disorders

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<td>F63.2</td>
<td>Trichotillomania</td>
<td>Obsessive-Compulsive and Related Disorders</td>
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Criteria:

A. Recurrent pulling out of one’s hair, resulting in hair loss.

B. Repeated attempts to decrease or stop hair pulling.

C. The hair pulling causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The hair pulling or hair loss is not attributable to another medical condition (e.g., a dermatological condition).

E. The hair pulling is not better explained by the symptoms of another mental disorder.
Obsessive-Compulsive and Related Disorders

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<td>L98.1</td>
<td>Excoriation (Skin Picking)</td>
<td>Obsessive-Compulsive and Related Disorders</td>
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Criteria:

A. Recurrent skin picking resulting in skin lesions.

B. Repeated attempts to decrease or stop skin picking.

C. The skin picking causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The skin picking is not attributable to the physiological effects of a substance (e.g., cocaine) or another medical condition (e.g., scabies).

E. The skin picking is not better explained by symptoms of another mental disorder (e.g., delusions or tactile hallucinations in a psychotic disorder, attempts to improve a perceived defect or flaw in appearance in body dysmorphic disorder, stereotypies in stereotypic movement disorder, or intention to harm oneself in nonsuicidal self-injury).
Obsessive-Compulsive and Related Disorders

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<td>F15.xxx</td>
<td>Substance/Medication-Induced Obsessive-Compulsive or Related Disorder</td>
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Criteria:

A. Obsessions, compulsions, skin picking, hair pulling, other body-focused repetitive behaviors, or other symptoms characteristic of the obsessive-compulsive and related disorders predominate in the clinical picture.

B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):
   1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.
   2. The involved substance/medication is capable of producing the symptoms in Criterion A.
C. The disturbance is not better explained by an obsessive-compulsive and related disorder that is not substance/medication-induced. Such evidence of an independent obsessive-compulsive and related disorder could include the following:

The symptoms precede the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence suggesting the existence of an independent non-substance/medication-induced obsessive-compulsive and related disorder

D. The disturbance does not occur exclusively during the course of a delirium.

E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Obsessive-Compulsive and Related Disorders

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Note: This diagnosis should be made in addition to a diagnosis of substance intoxication or substance withdrawal only when the symptoms in Criterion A predominate in the clinical picture and are sufficiently severe to warrant clinical attention.

Specify if:

With onset during intoxication: If the criteria are met for intoxication with the substance and the symptoms develop during intoxication.

With onset during withdrawal: If criteria are met for withdrawal from the substance and the symptoms develop during, or shortly after, withdrawal.

With onset after medication use: Symptoms may appear either at initiation of medication or after a modification or change in use.
Obsessive-Compulsive and Related Disorders

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<td>F06.8</td>
<td>Obsessive-Compulsive Disorder Due to Another Medical Condition</td>
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Criteria:

A. Obsessions, compulsions, preoccupations with appearance, hoarding, skin picking, hair pulling, other body-focused repetitive behaviors, or other symptoms characteristic of obsessive-compulsive and related disorder predominate in the clinical picture.
B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.
C. The disturbance is not better explained by another mental disorder.
D. The disturbance does not occur exclusively during the course of a delirium.
E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Specify if:

**With obsessive-compulsive disorder-like symptoms:** If obsessive-compulsive disorder-like symptoms predominate in the clinical presentation.

**With appearance preoccupations:** If preoccupation with perceived appearance defects or flaws predominates in the clinical presentation.

**With hoarding symptoms:** If hoarding predominates in the clinical presentation. **With hair-pulling symptoms:** If hair pulling predominates in the clinical presentation.

**With skin-picking symptoms:** If skin picking predominates in the clinical presentation.
Obsessive-Compulsive and Related Disorders

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Criteria:

1. Body dysmorphic-like disorder with actual flaws: similar to body dysmorphic disorder except the flaws in physical appearance are clearly observable by others. The preoccupation with these flaws is excessive and causes significant impairment.

2. Body dysmorphic-like disorder without repetitive behaviors: Presentations that meet body dysmorphic disorder except the individual has not performed repetitive behaviors or mental acts in response to the appearance concerns.

3. Body-focused repetitive behavior disorder characterized by recurrent body-focused repetitive behaviors and repeated attempts to decrease or stop the behaviors. These symptoms cause clinically significant impairment.
4. Obsessional jealousy: This is characterized by preoccupation with a partner’s perceived infidelity. The preoccupations may lead to repetitive behaviors or mental acts in response to the infidelity concerns; they cause clinically significant impairment in important areas of functioning and are not better explained by another mental disorder.

5. Shubo-kyofu: A variant of taijin kyofusho that is similar to body dysmorphic disorder and is characterized by excessive fear of having a bodily deformity.

6. Koro: Related to dhat syndrome, an episode of sudden and intense anxiety that the penis (or the vulva and nipples in females) will recede into the body, possibly leading to death.

7. Jikoshu-kyofu: A variant of taijin kyofusho characterized by fear of having an offensive body odor (also termed olfactory reference syndrome).
Section Two

Assessment and Diagnosis of Dissociative and Related Disorders
Diagnostic Terms and Categories No Longer to Be Used in the DSM-5

- Dissociative Fugue [Now: Absorbed into Dissociative Amnesia]
- Depersonalization Disorder [Now: Depersonalization / Derealization Disorder]

*These diagnoses have typically been the domain of qualified psychiatrists or physicians*
Gathering Information During Assessment of Dissociative Disorders

• All components of a thorough biopsychosocial assessment should be addressed
• Clinical interview to gather present and past history of stresses, traumas, violence, neglect and abuse
• Careful gathering of the client’s history of dissociative symptoms
• Gather medical history – illness and injury, history of use of medications, nutritional supplements, toxic substance exposure
• Use of screening tools specifically designed to uncover presence of dissociative symptoms
• Examination of comorbid symptoms
Symptoms to Look for in Assessment of Dissociative Disorders

1. Fluctuating attention, such as trance states or “black outs.”
2. Autobiographical forgetfulness and fluctuations in access to knowledge
3. Fluctuating moods and behavior, including rage episodes and regressions,
4. Belief in alternate selves or imaginary friends
5. Depersonalization and derealization experiences
6. A pronounced inability to remember personally-relevant events without other underlying causative factor, like amnesia
Symptoms to Look for in Assessment of Dissociative Disorders

7. Confused and dazed wandering (known as a dissociative fugue)
8. Two or more identities or personality traits within a single person
9. Transfer of behavioral control to each identity
10. Perception or feeling that objects in the external world are changing in shape and size
11. Feeling that people are automated and inhuman
Screening Tools Used in Assessment of Dissociative Disorders

1. Dissociative Disorder Interview Schedule (DDIS).
2. Structured Clinical Interview for DSM-5 Dissociative Disorders (SCID-D-R)
3. Clinician Administered Dissociative State Scale (CADDSS)
4. Dissociative Experiences Scale (DES)
5. Questionnaire of Experiences of Dissociation (QED)
6. Dissociation Questionnaire (DIS-Q)
7. Somat0form Dissociation Questionnaire (SDQ-20)
8. Multidimensional Inventory of Dissociation (MID)
Core Problems of Dissociative Disorders

Affect dysregulation is one of the foundational problems for the person with a dissociative disorder. This consists of difficulty tolerating and regulating intense affective experiences. This may be the result of problems experienced during childhood where poor parenting and/or ongoing excessive trauma did not allow for the gradual development of internalized skills in self-soothing or modulating emotions. The inability to understand how to regulate and modulate emotions leads to an inability to control the sudden intrusion of evoked traumatic memories and the overwhelming emotions accompanying them.
Core Elements of Successful Treatment of Dissociative Disorders

Psychotherapy for dissociative disorders generally proceeds in 3 phases (Brand, et al 2006; International Society for the Study of Trauma and Dissociation, 2011).

- Phase 1 includes stabilization and symptom control, education about treatment, affect and impulse regulation skill building, increasing awareness of dissociated self-states, and establishment of a therapeutic alliance.

- Phase 2 includes processing of traumatic memories, resolution of trauma-related cognitive distortions, and development of a narrative of traumatic experiences.

- Phase 3 involves a resolution of dissociated self-state and a focus on current and future life issues.
Core Elements of Successful Treatment of Dissociative Disorders

According to the International Society for the Study of Trauma and Dissociation, individual talk psychotherapy, such as CBT, is the recommended treatment for Dissociative Disorders. DBT may also be utilized for treatment. EMDR is recommended only after the client has been stabilized.

Additionally, psychodeducation, skill building (e.g., emotional granularity skills), and intervention with the client’s family, environment, and social systems may be indicated. Elements of Relapse Prevention may also be used as a method to help the client learn how to avoid triggering cues while other elements of treatment are employed. Different components and/or approaches may be useful at different stages of treatment, as the client begins to develop improved emotional modulation and integration skills.
Dissociative Disorder

Criteria:
A. Disruption of identity characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption in identity involves discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual.

B. Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.

C. The symptoms cause clinically significant impairment in important areas of functioning.

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<th>Disorder</th>
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<tr>
<td>F44.81</td>
<td>Dissociative Identity Disorder</td>
<td>Dissociative Disorders</td>
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Dissociative Disorders

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D. The disturbance is not a normal part of a broadly accepted cultural or religious practice.

**Note**: In children, the symptoms are not better explained by imaginary playmates or other fantasy play.

E. The symptoms are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).
Dissociative Identity Disorder

This disorder is most commonly formed when repetitive childhood physical and/or sexual abuse and/or other forms of trauma occur in individuals whose normal adaptive responses to the trauma are insufficient to manage the traumatic experiences. Dissociation through the creation of separate identities or partial identities is an attempt at an adaptive response, trying to keep the memory of the traumatic experience separate so that it does not continuously evoke or activate overwhelming affective material. However, this can leave aspects of a person’s life not integrated, so there is not a cohesive sense of self.
Treatment of Dissociative Identity Disorder

Treatment for Dissociative Identity Disorder will have as a goal the creation of a unified sense of self that can be maintained across a full range of feeling states. This may be called variably “fusion”, “integration”, or “unification”.

Integration is a term for the work of bringing together dissociated mental processes throughout treatment. Fusion refers to the point at which two or more alternate identities experience themselves as joining together with a diminishment or loss of subjective separateness. Final fusion refers to the point at which the patient experiences him/herself as a unified self, as opposed to a collection of separate personalities. Unification has been proposed as term to prevent confusion about the difference between fusion and final fusion.
Dissociative Disorders

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<tr>
<td>F44.0</td>
<td>Dissociative Amnesia</td>
<td>Dissociative Disorders</td>
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Criteria:
A. An inability to recall important autobiographical information, usually of a traumatic or stressful nature, that is inconsistent with ordinary forgetting. Note: Dissociative amnesia most often consists of localized or selective amnesia for a specific event or events; or generalized amnesia for identity and life history.
B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
C. The disturbance is not attributable to the physiological effects of a substance or a neurological or other medical condition.
D. The disturbance is not better explained by dissociative identity disorder, posttraumatic stress disorder, acute stress disorder, somatic symptom disorder, or major or mild neurocognitive disorder.
Dissociative Disorders

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**Coding note:** The code for dissociative amnesia without dissociative fugue is 300.12 (F44.0). The code for dissociative amnesia with dissociative fugue is 300.13 (F44.1).

**Specify if ;** 300.13 (F44.1) With dissociative fugue:Apparently purposeful travel or bewildered wandering that is associated with amnesia for identity or for other important autobiographical information.
Dissociative Amnesia

This disorder is most commonly formed when repetitive childhood physical and/or sexual abuse and/or other forms of trauma occur in individuals whose normal adaptive responses to the trauma are insufficient to manage the traumatic experiences. Dissociation through the submerging of memory is an attempt at an adaptive response, trying to keep the memory of the traumatic experience separate from conscious experience so that it does not continuously evoke or activate overwhelming affective material.
Dissociative Disorders

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<tr>
<td>F48.1</td>
<td>Depersonalization/Derealization Disorder</td>
<td>Dissociative Disorders</td>
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Criteria:

A. The presence of persistent or recurrent experiences of depersonalization, derealization, or both:
   1. Depersonalization: Experiences of unreality, detachment, or being an outside observer with respect to one’s thoughts, feelings, sensations, body, or actions (e.g., perceptual alterations, distorted sense of time, unreal or absent self, emotional and/ or physical numbing).
   2. Derealization: Experiences of unreality or detachment with respect to surroundings (e.g., individuals or objects are experienced as unreal, dreamlike, foggy, lifeless, or visually distorted).

B. During the depersonalization or derealization experiences, reality testing remains intact.
Dissociative Disorders

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C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The disturbance is not attributable to the physiological effects of a substance or another medical condition.

E. The disturbance is not better explained by another mental disorder, such as schizophrenia, panic disorder, major depressive disorder, acute stress disorder, posttraumatic stress disorder, or another dissociative disorder.
Depersonalization/Derealization Disorder

This disorder is most commonly formed when a traumatic event, or a period of high stress or anxiety exceeding a person’s adaptive capacities is experienced. A prior history of abuse and/or other vulnerabilities, such as a family member with mental illness, insecure attachments, or prior traumatic experiences, may decrease the person’s resiliency or diminish the adaptive responses of the person and predispose them to this disorder during a period of high stress. This type of dissociation creates a type of psychic numbing, and is an attempt to create emotional distance from the distressing experiences and affective material.
Treatment of Depersonalization/Derealization Disorder

Treatment for Depersonalization/Derealization Disorder will have a three part focus: 1) address the current stressors that precipitate the emergence of the core symptoms; 2) address the underlying history of trauma, attachment problems or sequelae of family dysfunction that created the sensitivity to the emergence of the disorder; 3) increase the resilience and stress management capabilities of the client by building skills in at least the following areas: 1) anxiety and stress management, 2) emotional granularity, and 3) interpersonal effectiveness.
Treatment of Depersonalization/Derealization Disorder

Additionally, psychodeducation and intervention with the client’s family, environment, and social systems may be indicated. Elements of Relapse Prevention may also be used as a method to help the client learn how to avoid triggering cues for anxiety while other elements of treatment are employed.
Dissociative Disorders

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<tr>
<td>F44.89</td>
<td>Other Specified Dissociative Disorder</td>
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1. **Chronic and recurrent syndromes of mixed dissociative symptoms:**
   This category includes identity disturbance associated with less-than-marked discontinuities in sense of self and agency, or alterations of identity or episodes of possession in an individual who reports no dissociative amnesia.

2. **Identity disturbance due to prolonged and intense coercive persuasion:**
   Individuals who have been subjected to intense coercive persuasion (e.g., brainwashing, thought reform, indoctrination while captive, torture, long-term political imprisonment, recruitment by sects/cults or by terror organizations) may present with prolonged changes in, or conscious questioning of, their identity.

3. **Acute dissociative reactions to stressful events:**
   This category is for acute, transient conditions that typically last less than 1 month, and sometimes only a few hours or days. These conditions are characterized by constriction of consciousness; depersonalization; derealization; perceptual disturbances (e.g., time slowing, macropsia); micro-amnesias; transient stupor; and/or alterations in sensory-motor functioning (e.g., analgesia, paralysis).
Dissociative Disorders

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4. Dissociative trance: This condition is characterized by an acute narrowing or complete loss of awareness of immediate surroundings that manifests as profound unresponsiveness or insensitivity to environmental stimuli. The unresponsiveness may be accompanied by minor stereotyped behaviors (e.g., finger movements) of which the individual is unaware and/or that he or she cannot control, as well as transient paralysis or loss of consciousness. The dissociative trance is not a normal part of a broadly accepted collective cultural or religious practice.
Section Three

Assessment and Diagnosis of Trauma- and Stressor-Related Disorders
Trauma: A physiological, psychological, emotional and behavioral response to a perceived extreme negative event that exceeds a person’s adaptive capacity.
The Creation of Trauma

- Extreme Event
- Adaptive Capacity
  - Physiological Response
  - Emotional Response
  - Psychological Response
  - Behavioral Response
Diagnostic Terms and Categories No Longer to Be Used in the DSM-5

- Reactive Attachment Disorder Sub-types
  - Reactive Attachment Disorder Emotionally Withdrawn / Inhibited type
  - Reactive Attachment Disorder Indiscriminately Social / Disinhibited type

*Replaced by:*

- Reactive Attachment Disorder (ICD-9: 313.89; ICD-10: F94.1)
- Disinhibited Social Engagement Disorder (ICD-9: 313.89; ICD-10: F94.2)
Important Reformulations of Diagnoses in the DSM-5

- Post-traumatic Stress Disorder
- Acute Stress Disorder

Key change: The client’s subjective reaction to a stressful or traumatic event is no longer a criterion used in diagnosis. Instead, more objective markers are explored in order to determine the presence of these disorders.
• Acute Stress Disorder

Key change: There are now 14 listed symptoms in five categories: intrusion, negative mood, dissociation, avoidance and arousal.
Important Reformulations of Diagnoses in the DSM-5

• Post-traumatic Stress Disorder

**Key change:** In the DSM-IV-TR the three major symptom clusters were: *re-experiencing*, *avoidance/numbing*, and *arousal*. In the DSM-5, the avoidance/numbing cluster has been broken down into two separate clusters: 1) *avoidance* and 2) *persistent negative alterations in cognitions and mood*. 
Etiology of Trauma- and Stressor-Related Disorders

These disorders are created when a person is exposed to a trauma creating event(s) or other stressor(s) whereby the experience exceeds that person’s adaptive capacity for processing the event, coping with the event, and/or integrating the event into a cohesive sense of the world as a sufficiently safe and secure place. It is believed that the more direct the exposure to the trauma creating event, the more likely the person is to develop signs and symptoms indicating more severe Trauma- or Stress-Related Disorders. The level of trauma and exposure needed to create one of these disorders varies from individual to individual, and factors that increase the risk of developing these disorders include genetically and temperamentally driven sensitivity to trauma effects, prior history of traumatic experiences, deficiencies in early childhood bonding experiences, the presence of other kinds of mental disorder, and/or deficits in the availability of emotional support resources, such as close relationships.
Assessment of Trauma- and Stress-Related Disorders

An accurate diagnosis of these disorders will generally require a thorough history of the client and his/her exposure to the trauma producing event, and an inventory of the post-event signs and symptoms, including timelines for the development of those signs and symptoms. The history taking should include an exploration of prior historical events, such as prior trauma, family dysfunction, and/or other disorders and life circumstances that may be predisposing factors for the development of these disorders. The assessment should also include a detailed history of strengths and resources.
Symptoms to Look for in Assessment of Trauma- and Stress-Related Disorders

1. Fluctuating attention, such as trance states or “black outs.”
2. Autobiographical forgetfulness and fluctuations in access to knowledge
3. Fluctuating moods and behavior, including rage episodes and regressions,
4. Belief in alternate selves or imaginary friends
5. Depersonalization and derealization experiences
6. A pronounced inability to remember personally-relevant events without other underlying causative factor, like amnesia
Core Elements of Successful Treatment of Trauma- and Stress-Related Disorders

Psychotherapy for trauma- and stress-related disorders with adults will have several overlapping features with treatment for dissociative disorders:

• Establishment of a therapeutic alliance stabilization and symptom control, psychoeducation about treatment, affect and impulse regulation skill enhancements, increasing awareness of dissociative symptoms (if any), and identification and remediation of ongoing triggers and cues.

• Processing of traumatic memories, resolution of trauma-related cognitive distortions, and development of a narrative of traumatic experiences that integrates traumatic experiences into a cohesive sense of self in secure enough world.

• Resolution of dissociative elements (if any), integration of traumatic experiences into cohesive self in world, and a focus on current and future life issues.
Core Elements of Successful Treatment of Trauma- and Stress-Related Disorders

Psychotherapy for trauma- and stress-related disorders with adults will have several overlapping features with treatment for dissociative disorders:

• Identification and addressing of secondary and comorbid symptomatology (depression, anxiety, substance misuse, interpersonal disturbances, ADLs, and other secondary symptoms)
• Management of current and future life issues.
The Spread of Problems with Trauma

Primary Trauma

Fear

Guilt

Shame

Frustration

Sadness

Anger

Pessimism

Narrative of the Self
Environmental Effects on Trauma Recovery

Active Abuse  Support
Violence  Nurturance
Deprivation  Comfort
Chaos  Structure

Trauma Inducing  Neutral  Supportive
Core Elements of Successful Treatment of Trauma- and Stress-Related Disorders

Psychotherapy for trauma- and stress-related disorders with children will have additional treatment features related to developmental concerns:

- Establishment of secure attachment environment.
- Focus on personality development to include secure, unified sense of self and personal identity within value system and context.
- Multi-modal treatment approaches to include non-verbal methods of therapeutic interaction.
- Intellectual, interpersonal, and emotional development skill focus.
Focus of Intervention: Individual

- Cognitive
  - CBT
  - Psycho-ed

- Affective
  - Emotional Clarification & Other Skill Building
  - Relaxation Therapy
  - Narrative Exposure Therapy

- Experiential
  - EMDR
  - Narrative
  - Metaphor
  - Psycho-dynamic

- Emotional Clarification & Other Skill Building
  - Exposure Desensitization

- EMDR
  - Narrative
  - Exposure

- Psycho-dynamic

- Cognitive

- Affective

- Experiential
Focus of Intervention: Systemic

IPT ↔ IPT

Skill Training

Environmental Change

Self

Environment
Before any plan can be formulated that creates effective changes to the internal landscape of trauma within the client, clinicians should make every effort to evaluate and intervene, where possible, with any external or environmental elements that continue to traumatize or re-traumatize the client.
Trauma- and Stress-Related Disorders

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<tr>
<td>F94.1</td>
<td>Reactive Attachment Disorder</td>
<td>Trauma- and Stress-Related Disorders</td>
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Criteria:

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.
Trauma- and Stress-Related Disorders

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<tr>
<td>F94.2</td>
<td>Disinhibited Social Engagement Disorder</td>
<td>Trauma- and Stress-Related Disorders</td>
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Criteria:
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/hyper-activity disorder) but include socially disinhibited 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.
Trauma- and Stress-Related Disorders

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.

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<td>F43.2x</td>
<td>Adjustment Disorders</td>
<td>Trauma- and Stress-Related Disorders</td>
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Trauma- and Stress-Related Disorders

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Specify whether:

F43.21 *With depressed mood*: Low mood, tearfulness, or feelings of hopelessness are predominant.

F43.22 *With anxiety*: Nervousness, worry, jitteriness, or separation anxiety is predominant.

F43.23 *With mixed anxiety and depressed mood*: A combination of depression and anxiety is predominant.

F43.24 *With disturbance of conduct*: Disturbance of conduct is predominant.

F43.25 *With mixed disturbance of emotions and conduct*: Both emotional symptoms (e.g., depression, anxiety) and a disturbance of conduct are predominant.

F43.20 *Unspecified*: For maladaptive reactions that are not classifiable as one of the specific subtypes of adjustment disorder.
# Trauma- and Stress-Related Disorders

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.

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<td>F43.0</td>
<td>Acute Stress Disorder</td>
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Trauma- and Stress-Related Disorders

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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.
   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).
Trauma- and Stress-Related Disorders

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**Negative Mood**
5. Persistent inability to experience positive emotions

**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).
Trauma- and Stress-Related Disorders

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<th>Code</th>
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<tr>
<td>F43.0</td>
<td>Acute Stress Disorder</td>
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**Arousal Symptoms**

10. Sleep disturbance
11. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
13. Problems with concentration.

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 or another medical condition (e.g., mild traumatic brain injury) and is not better explained by brief psychotic disorder.
ASD versus PTSD

• Key differentiating features

- Acute stress disorder must not be diagnosed if the symptoms have persisted for more than one month and PTSD must not be diagnosed until the symptoms have persisted for more than one month.
Treatment for Trauma

Principle 1: The most effective treatment for trauma will prevent the creation of consolidated traumatic memory.

Preventive treatment for trauma will target processing of the traumatic experience in ways that prevent or preclude the movement to consolidation of traumatic memory.
Treatment for Trauma

Principle 2: Effective treatment will evaluate and target where the trauma effects may be stored below the surface of consciousness.

Well formulated treatment for trauma will bring the right treatment to the defined problem set. Where trauma is not accessible to cognitive interventions, the conscientious clinician will employ appropriate psychodynamic approaches to bring the traumatic material up to consciousness where it can be reshaped within the treatment relationship.
Treatment for Trauma

Principle 3: Effective treatment will evaluate and target both primary and secondary effects of trauma.

Well formulated treatment for trauma will not only target reduction of the primary effects, it will also address the secondary effects in order to reduce the presence of problem cascading and reduce the development of large automatic schemata dedicated to traumatic response.
Treatment for Trauma

Principle 4: In order to permit restructuring of the trauma schema, effective treatment must monitor and control the over-activation of the ergotrophic response system in accordance with the Yerkes-Dodson effect.

Well formulated treatment for trauma will monitor the presence of indicators of over-activation and work to keep the state of arousal within manageable limits, operating with a principle known as the Holding Environment.
All therapeutic interventions require that clients have the capacity to direct their focal attention to the tasks of treatment.

However, the capacity to direct focal attention is contingent upon the degree of over-arousal generated by the trauma producing cues, in accordance with a principle called the “Yerkes-Dodson Effect.”
The Yerkes Dodson Effect

Arousal

Threshold point

Focal Attention
The Yerkes-Dodson Effect

The ability to focus and pay attention - in ways that support improved performance - rises as the level of arousal increases up to an optimal point, then begins to diminish as the level of arousal becomes too high.

It is for this reason that a little bit of anxiety or worry sharpens your ability to pay attention, while too much anxiety impairs your ability to pay attention.
The Yerkes-Dodson Effect

Trauma and PTSD creates impairments in the ability to focus attention and utilize cognitive resources, due to automatic excessive elevations in arousal past the threshold point.

These threshold events make it more difficult for Cognitive techniques to be effective. Successful PTSD treatment requires the creation of a viable holding environment to manage the level of arousal in ways that allow for cognitive restructuring approaches to work.
Criteria:

**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.
Trauma- and Stress-Related Disorders

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. **Note:** In children, 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 internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

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### Trauma- and Stress-Related Disorders

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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, thoughts, or feelings about or closely associated with the traumatic event(s).

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).
Trauma- and Stress-Related Disorders

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2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world  
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  
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. 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

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 or another medical condition.
**Trauma- and Stress-Related Disorders**

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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).
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.
## Trauma- and Stress-Related Disorders

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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.
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 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. The duration of the disturbance is more than 1 month.
F. The disturbance causes clinically significant impairment in relationships
G. The disturbance is not attributable to the physiological effects of a substance or another medical condition.
PTSD Development

PTSD is formed when a cue elicits an extreme traumatic response for a person with a sufficient degree of susceptibility / insufficient resiliency so that traumatic memory is imprinted and consolidated in direct hippocampus/amygdala memory.

The memory is then cemented into place through operant conditioning in ways that produce hypervigilance, heightened cue sensitivity, and alterations to the arousal/relaxation homeostasis.
Successful treatment for PTSD appears to have some combination of the following treatment components:

1) a psychoeducational component that teaches patients about physiological and psychological aspects of trauma, stress and anxiety management
2) cognitive components that provide guidance in reframing or reshaping the cognitive meaning of the traumatic experience
3) an exposure based component, where patients are exposed to some degree of re-experiencing of the trauma, whether by imagining the trauma while remaining removed from real components of the trauma, seeing and/or hearing visual or aural recreations of the trauma on a video based format, or some degree of actual re-exposure to a partial recreation of the trauma utilizing a system of gradually increasing the intensity of exposure
4) a skill building component, where patients are led through acquisition of new skills for coping with components of the trauma;
5) a kind of relapse prevention based component, where information is gathered concerning what events might trigger a re-experiencing of the trauma and patients prepare a strategy for avoiding, managing or gaining mastery over those triggers

Source: Falsetti, S., Cognitive-Behavioral Therapy in the Treatment of Posttraumatic Stress Disorder, Primary Psychiatry | May 1, 2003
Best Practices PTSD Treatment Approaches: A 7-Phase Approach

Phase 1 - Psychoeducational phase: Teach about PTSD, trauma, co-morbid problems
Phase 2 - Coping Skills Development phase: Teach coping skills, anxiety control skills
Phase 3 - Imaginal Exposure phase: Exposure through imagination, rather than direct exposure to trauma creating triggers
Phase 4 - Cognitive phase: Education about connection between thoughts and feelings, teach skills in cognitive restructuring,
Phase 5 - Behavioral Task Scheduling phase: (systematic desensitization) Exposure first to panic causing cues, then moving up hierarchy of increasingly anxiety producing triggers
Phase 6 - Relapse prevention phase: Predict situations of high trigger cues, do preparation work for only taking on manageable triggers, prepare for situations in which baseline stress is higher, decreasing resiliency
Phase 7 - Evaluation phase: Evaluate what additional treatment services might be needed. (Source: Falsetti)
Who Is Sherry Falsetti?

Associate Professor in psychology at the University of Illinois College of Medicine at Rockford

Specialist in PTSD and its treatment
Interventions for Trauma and Stress-Related Disorders

**Primarily Exposure Based:**

Systematic Desensitization  
Multiple Channel Exposure Therapy (MCET)  
Prolonged Exposure (PE)

**Primarily Cognitively Based:**

Cognitive Behavioral Therapy  
Cognitive-Processing Therapy (CPT)  
Metaphor and narrative approaches to Cognitive Restructuring
Interventions for Trauma and Stress-Related Disorders

Primarily Skill Based:

Interpersonal Therapy (IPT)
Stress Innoculation Therapy (SIT)
Relaxation techniques

Other:

Eye Movement Desensitization and Reprocessing (EMDR)
Acceptance and Commitment Therapy (ACT)
Critical Incident Stress Debriefing (Mitchell Model)
Other Treatments for PTSD

The “Forget it” Pill (Propanolol)
Critical Incident Stress Debriefing (Mitchell Model)
Neurobiology of memory formation for traumatic memories is constructed differently, involving more immediate involvement of the hippocampus-amygdala connection.

Memories laid down in this area of the brain have easier access to the systems that generate arousal, anxiety and fear, and greater automaticity of expression.

Memories laid down in this area of the brain are less easily accessed by cognitive modes of treatment.
The Problem with Trauma

This different memory formation process increases the importance of the consolidation of memory from short-term or medium term memory storage to long-term memory storage.

Because memory consolidation occurs over the first 6 to 24-hour period after the traumatic experience, this can be a critical time for intervening with clients.