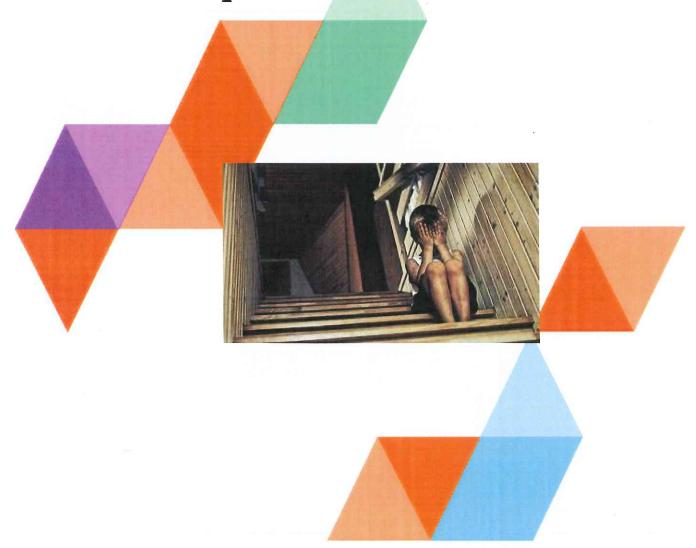
# The Impact of Trauma on Children and Adolescents and Treatment Options to Utilize



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Slide 1		
	THE IMPACT OF TRAUMA ON CHILDREN AND ADOLESCENTS AND TREATMENT OPTIONS TO UTILIZE  Gary J Lewis Coordinator of the PA PTSD Project Westmoreland County Juvenille Probation	
Slide 2	PTSD Signs and Symptoms  Although there are many different signs and symptoms that a person may experience when suffering from Post Traumails Chress Disorder, the symptoms are classified into three main clusters:  Resymmetric Symptoms  Avoidance or Numbing Symptoms  Hyperarcusal Symptoms	
Slide 3	Reexperiencing Symptoms  Recurrent and intrusive recollections of the traumatic event, which can include images, thoughts, perceptions, sounds, scents, feelings, etc.  Recurrent distressing dreams (nightmares) of the traumatic event.  Flashbacks: acting or feeling as if the traumatic event were recurring, including a sense of reliving the experience through illusions, halluctrations, and dissociative episodes.	
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	Reexperiencing Symptoms	
	<ul> <li>Intense psychological distress or reactivity at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.</li> </ul>	
	Example: People that experienced a hurricane may become flightened anytime there is a sign of a storm approaching.	
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Slide 5	Avoidance and Numbing Symptoms	
	Avoidance and vertibing symptoms	
	<ul> <li>Persistent avoidance of stimull associated with the traumatic event and numbing of general responsiveness as indicated by presence of the following symptoms;</li> </ul>	
	Effort to svoid thoughts, feelings, or conversations associated with the trauma     Efforts to avoid activities, places, or people that cause recollection.	
	of the treums  Denial that Something is wrong  Self-medicating with drugs and/or alcohol	
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#### Avoidance and Numbing Symptoms

- Inability to remember an important aspect of the Irauma
  Markedly diminished interect or participation in significant activities thobises, work, school, etc.)
  Feelings of detachment or sixrangement from others
  Restricted range of affect (unable to feel love, belonging, etc.)
  Sense of a foreshortened future (ex. Person does not expect to have career, marriage, femily, or normal life spen)
  May also experience Dissociation, Depression, or Survivor Guill

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#### Hyperarousal Symptoms

· Persistent symptoms of increased arousal as indicated by the following:
Difficulty falling or staying asleep

- Irritability or outbursts of anger Exaggerated startle response
- Difficulty concentrating
   Hypervigilance
- Some training victime start to think of the world as an overly dangerous place and feel that they are never safe. They also may struggle to trust in enview or anything.

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#### PTSD Signs and Symptoms

· People also may experience physical symptoms such as Nausea, Headaches, Weakness, Fallgue, Muscle Tension, and Panic Attacks.

Young children may experience different symptoms (Reexperiencing play/drawing, general anxiety and avoidance)

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#### Complex Trauma

When kids are abused from an early age, especially by parental figures, or they are faced with multiple traumas or repeated traumas, they often suffer from complex trauma or developmental trauma disorder. These youth will suffer more symptoms than the youth with PTSD. They will face cognitive deficils, developmental delays, problems with self-regulation, attachment disorders or related relational problems, somatic problems, problems with affect and emotions, low self-esteem, aggression and self-destructive behavior, and often self-blame.


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#### **Evolution of PTSD Diagnosis**

- · DSM-II (1968): Hysterical Neurosis
- DSM-III (1980): PTSD (Anxiety Disorders)
- · DSM-IV (1994): PTSD + "associated features"
- DSM-V (2013): PTSD is no longer classified in Anxlety Disorders, as it is now in a new classification called "Trauma and Stress Related Disorders."

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#### Evolution of PTSD Diagnosis

• Prior to the publication of the DSM-V. Dr. Bessel van der Kolk and a group of colleagues lobbled the DSM Board to have Developmental Trauma Disorder (DTD) added as a diagnosis under the new classification of \*Trauma and Stress Related Disorders.\* Their efforts were ultimately denied due to "a lack of clear evidence and proof" of the existence of DTD, despite the fact that they did a study of over 20,000 children to validate their findings. Since the DSM-M refers the disposels. Dr. van der Kolk decides to DSM-V rejects the diagnosts. Dr. van der Kolk decides to write his own book "The Body Keeps the Score," which has drastically outsold the DSM-V.

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#### What is the problem?

Since these symptoms are not covered by the DSM-V diagnostic criteria for PTSD, youth are often given comorbid diagnosis in an effort to explain all their behaviors and/or symptoms. This results in overtreatment or incorrect treatments being administered. Examples?

- We also do not treat the actual cause of these symptoms, which is complex trauma.
- · To treat Complex Trauma or DTD, we must look at what major symptoms are being presented and craft a treatment plan.
- No one modality will work well. If you therapist identifies

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#### Childhood Trauma Exposure

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 Study by the National Child Traumatic Stress Network of about 30,000 children.

- Mean Age of Onset is 5.22 years old with a Range of 1-10 years.
- Mean Number of Types of Trauma is 3.36 with a Range of 1-11 types.
- Over 82% had multiple event or chronic trauma.
- Studies show that when trauma exposure happens prior to age 9, the child is at an increased risk to suffer from DTD.

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#### Childhood Trauma Exposure

- · Only 13% were acute trauma
- So are we giving our traumatized youth the right treatment modalities?

 EMDR and other forms of treatment may be helpful but only in the right situations, so it is imperative that we learn how to treat all the symptoms of complex trauma or DTD if we are going to be successful in helping these youth.

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#### Complex Trauma Sequelae

61.5% will suffer from Self-Regulation problems.
59.2% will suffer from Attention and Concentration problems.

- 57.9% will have a Negative Self-Image
- 53.1% will have Impulse Control
- 45.8% will show tendency toward Aggression and Risk-Taking Behaviors.

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#### DTD Symptoms

- · Problems with Self-Regulation; overactive adrenal response due to constant or repeated threats in childhood, which also often leads to an underactive cortisol production.
- Do not know when it is going to happen.
   Frontal Lobe shuts done when ilmbic system is activated, which is why many treatment modalities fall traumatized kids.

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#### Self-Regulation Solutions

Yoga, Thal Chi, Marlial Arts, Deep Breathing, Meditation, Drum Circles, Dance and/or Theater. Anything that involves rhythmic movements and mastery of breath.

- Yoga has been proven to be more helpful for traumatized youth experiencing self-regulation problems than any pill or form of talk therapy.
- Talk Therapy-Northern European descent, Talk Therapy only has limited use in trauma therapy, Talk about body postures, non-verbals.

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#### Self-Regulation Solutions

 Dopamine Blockers: used to treat limbic system and help with self-regulation. However, these are a disaster for learning and lead to even more cognitive deficits and educational issues.

Mostly antipsychotics used to treat schizophrenia and bipolar disorder. (Risperdal)

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#### Affect and Emotions

Youth with flat affect are our most damaged clients and those that are most in need of our help. Unfortunately, they often slip through the cracks.

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- Ivan Paviov: Trauma is the loss of the instinct of
- We must ignite these kids curiosity and drive them lowards being goal oriented.
- · Review APA Pamphlet.
- Bessel van der Kolk: "Trauma is an illness of not feeling fully alive in the present," So where are they at then?
- Black Hole of Trauma...

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#### Affect and Emotions

- · We must try to open up new avenues of pleasure.
- · Pro-social activities.
- Be aware: Traume can often lead to a change in the reward center of the brein. This can lead to pain being perceived as pleasure and vice-versa in traumatized individuals.

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#### Somatic Symptoms

- ACE Study
- As your ACE Score goes up, so does your risk for heart disease, cancer, autoimmune disease, liver disease, felal death, early mortality, depression, STD's, etc...

- · So how can ACE cause physical problems later in life?
- Where do we hold our stress?
- https://www.youtube.com/watch?y=ccKFkcfXx-c

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#### Attachment or Relational Issues

Klds ability to process frauma and adversity is directly related to the quality of their attachment relationships.

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- Secure Attachment both contains and opens up a child's world.
- · Allows children safety to explore their world (agency)
- Provides healthy model of self and others (trust)
   Teaches child how to communicate, and how to read communication from others
- Teaches children how to understand, tolerate, and cope with emotional experience
   Provides structure and limits
- Teaches that relationships are predictable, safe, trustworthy, and allows them to anticipate future responsiveness with relationships

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#### Attachment or Relational Issues

· When we are scared, hurt or distressed as a child, what do we do?

- This gives us an instinctive built-in GPS on how we deal with danger or adversity for the rest of our lives. (9/11 example) (Also talk about restraint and re-traumatization here. If possible allow child to self-regulate).
- · What happens when home and parental figures are not safe?
- · We learn that relationships are unpredictable, dangerous, chaolic
- · We learn that relationships are unsafe and often traumatic
- · We anticipate future harm
- · We become Hypervigilant and/or shut down relationships

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#### Attachment Styles

- Secure: develops when caregiver is regularly attuned, nurturing, and acts as a secure base. Approximately 55% of normetive population.
- Avoidant: develops when caregiver is chronically rejecting or withdrawn. Child learns to minimize or cut off emotions. Approximately 20-25% of normative population.
- Anxious-Ambivalent: develops when caregiver is inconsistent. Caregiver maybe distent, intrusive, neglectful. Child often misaturnes emotions, and both seeks and resists contact. Approximately 10-15% of normative population.

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#### Attachment Styles

 Disorganized: develops when parent is either frightening or frightened. Child shows contradictory behaviors with no particular organized pattern of attachment. Child is left with no organized strategy for meaning-making. May often appear frozen or dazed. Approximately 10-15% of normative population, Biggest pradictor of BPD.

- Attachment relationships are formative because they facilitate the development of the brain's self-regulatory mechanism, which in turn allow the individual to perform effective in society.
- What problems could attachment issues cause? Broad spectrum of Attachment Disorders that are often caused by Trauma, but there are many other problems too.

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#### Attachment Issues

- Still face experiment
- · Child's safety zone

Most of us will repeat out attachment relationship that we had with our parents over and over throughout our lives.

- Avoidant Style most likely to choose isolation in spite of innelliness.
- There is an Attachment-Oriented Treatment Model, especially effective in working with couples. At this point, not adapted for use with juveniles. However, the Residential Treatment Curriculum is made to address many of the problems we see in attachment issues and disorders.

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### Self-blame, self-harm, self-esteem

- These are the issues where talk therapy, such as Psychoanalysis and CBT, are very effective.
- One tool that is often effective during these sessions, especially if the traumalic incident happened in childhood, is to remind the child of how old they were. For example, can a 7 year old really be guilty of.......
- Must establish safety and stabilization, as well as a safetherapeutic relationship before diving into these issues.
- Self-esteem can often benefit from pro-social activities and reactivating curiosity and/or finding new pleasure activities.
- · Self-harm replacement strategies.

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#### Aggression and Self-Destructive Behavior

Often these will be alleviated by addressing self-regulation, and affect/emotional issues.

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- Attachment problems often lead to problems with frustration tolerance. (RTC)
- if these problems persist, showing they are not a by-product of the other issues, then one should employ an anger management solution, such as ART.
- CBT can address the thinking errors that often lead to risk-taking behaviors as well.

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#### **DTD Treatment**

- · Trauma Identity Continuum:
- No Self-Damaged Self-Wictim—Survivor—Person
  Conversation: How would you describe each of these stages? What kind of behaviors or symptoms would you expect to see in each phase?
  Phases of intervention

- 1. Stabilization
   2. Deconditioning of Traumatic Memories and Responses
- Recommends
   R

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#### Phase 1: Stabilization

- Safety
- Objective (physical, environmental)
   Therapeutic (trust, alliance, boundaries)
- Affect Management
- · Identification and labeling of feelings/sometic states
- Emotional Regulation
- Distress Tolerance

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#### Phase 2: Deconditioning

- Exposure
- Desensitization
- Processing
   May include correction/review of faulty beliefs
- Meaning-Making (Part 1)
   Restricturing of treuma-related schemas.
- Remembrance and Mourning the Traumatic Loss

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#### Phase 3: Reconnection

- · Social Reconnection
- · Temporal Reconnection (in the present moment)

- Restitutive Experiences
- Compatency Building
   Pleasure
- Mastery
- Meaning-Making (Part 2)
   Development of present and future oriented schemes of self.
   others, and world.

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#### Other Important Trauma Information

Complex Trauma: When kids are abused from an early age, especially by parental figures, or they are faced with multiple traumas or repeated traumas, they often suffer from complex trauma or developmental trauma disorder. These youth will suffer many more symptoms than youth with PTSD. They will suffer with cognitive deficits, developmental delays, problems with self-regulation, attachment disorders or related relational problems, somatic problems (especially increased illness), problems with affect and emotions, low self-esteem, aggression and self-destructive behavior, and often self-blame. Since many of these are not covered by the DSM-V definition of PTSD, these kids get comorbid diagnoses that result in overtreatment or undertreatment of their condition.

Trauma often can lead to changes in the reward center of the brain. This sometimes leads to pain being pleasure and vice-versa in traumatized individuals.

Ivan Pavlov (Pavlov's dogs): "Trauma is the loss of the instinct of purpose."

Bessell van der Kolk: "Trauma is an illness of not feeling fully alive in the present."

Talk Therapy: Helpful if trauma was rooted in shame and/or secrecy. If not, making these kids tell their stories over and over again is probably doing more harm than good.

Pay attention to body posture!!!

\*\*\*How kids process trauma depends on the quality of their attachment relationships\*\*\* (Anna Freud, Oliver Sax: importance of parental response, support, and belief)

Do not restrict movement unless absolutely necessary. When we are traumatized or triggered, the frontal lobe shuts down and the limbic system takes over, so our instinct is to move, usually towards home. When our movements are restricted, it is much more traumatizing than when we can move and self-regulate. How many of your kids were traumatized at home where they could not run away? This leads to helplessness and a very high traumatization rate. If trauma happened somewhere else where kids could run away toward a safe home, less chance-of trauma disorder.

Self-regulation therapies: Yoga, Thai Chi, drum circles, usually involve rhythmic movements and breathing.

Dopamine blockers: used to treat limbic system and help with self-regulation. However, these are a disaster for learning and lead to educational issues and cognitive deficits.

#### **Treatment Approaches for Developmental Trauma Disorder**

Exposure Therapy Cognitive Behavioral Therapy Group Therapy **Internal Family Systems** ARC Therapy (Attachment, Regulation, Competencies) SMART (Sensory Motor Arousal Regulation Treatment) Art Therapy Music Therapy Yoga, Thai Chi, Martial Arts, Drum Circles EMDR (Eye Movement Desensitization Reprocessing) Multi-Modal Therapy Psychoeducation Family Based Therapy (especially addressing Attachment Issues) Relaxation Techniques Journaling Medications Dialectical Behavior Therapy

Psychoanalysis

#### PTSD 10 Ways to Build Resilience

- 1. Make connections.
  - Accept help and support.
  - Find a support group.
- 2. Avoid seeing crises as insurmountable problems.
- 3. Accept that change is a part of living.
- 4. Move toward your goals. Do something regularly.
- 5. Take decisive actions.
- 6. Look for opportunities for self-discovery.
  - Reflect on what you can learn about yourself.
- 7. Nurture a positive view of yourself. Be confident in your problem solving ability or get help in problem solving.
- 8. Keep things in perspective. Avoid blowing the event out of perspective.
- 9. Maintain a hopeful outlook. Visualize what you want.
- 10. Take care of yourself.
  - Exercise regularly.
  - Engage in enjoyable activities.

## Universal Precautions for PTSD

- · Do approach all as if they have PTSD
- Do enhance the sense of safety
- Do enhance the sense of security
- Do enhance the sense of competency
- Do enhance self-esteem
- · Do use a calm and deliberate voice
- Do orient to the here and now .
- Do offer support and empathy
- · Do model responsible behavior
- Do encourage participation in PTSD treatment
- Do get permission before touching the client
- Do have an awareness of body space
- · Do make the client aware if you are approaching from behind
- Do use a calm voice and avoid yelling
- · Do manage the intensity when discussing trauma
- · Do understand the trauma is very real to them
- · Do understand that the client may feel tremendous shame, blame, or guilt
- · Do have an awareness of their triggers of trauma
- Do value your ability to help!

#### DSM-5 ® TRAUMA— AND STRESSOR-RELATED DISORDERS/ POSTTRAUMATIC STRESS DISORDER

#### DIAGNOSTIC CRITERIA

- A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
  - 1. Directly experienced 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 traumatic event(s) (e.g., first reresponders collecting human remains; police officers repeatedly exposed to details of child abuse):
- B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event (s), beginning after the traumatic event(s) occurred:
  - 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 of the traumatic events(s) are expressed.
  - 2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event (s).

Note: In children, there may be frightening dreams without recognizable content.

3. Dissociative reactions (e.g. flashbacks) in which the individual feels or acts as if the traumatic event (s) were recurring. (Such reaction may occur on a continuum, with the most extreme expression being a complete loss of surroundings of present surroundings.)

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 aspects of the traumatic event (s).

5. Marked physiological reactions to internal or external cures that symbolize or resemble an aspect of the traumatic event (s).

#### DSM-5 ® TRAUMA— AND STRESSOR-RELATED DISORDERS/ POSTTRAUMATIC STRESS DISORDER CONTINUED

- 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 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 the dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
  - 2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
  - 3. Persistent, distorted cognitions about the cause or consequences of the traumatic of the traumatic event (s) that lead the individual to blame himself/herself, or others.
  - 4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
  - 5. Markedly diminished interest or participation in significant activities.
  - 6. Feelings of detachment or estrangement from others.
  - 7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).
- E. Marked alterations in arousal and reactivity associated with the traumatic event (s) occurred, beginning or worsening after the traumatic event (s) occurred, as evidenced by two (or more) of the following:
  - 1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
  - 2. Reckless or self-destructive behavior.
  - 3. Hypervigilance.
  - 4. Exaggerated startle response.
  - 5. Problems with concentration.
  - 6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

#### DSM-5 ® TRAUMA— AND STRESSOR-RELATED DISORDERS/ POSTTRAUMATIC STRESS DISORDER CONTINUED

- F. Duration of the disturbances (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 substance (e.g., medication, alcohol) or other medical condition.

#### Specify whether:

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

- 1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental process or body (e.g., felling as thought 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 in and unreal, dreamlike, distant, or distorted).

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

#### Specify if:

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

#### DSM-5 ® Trauma— and stressor-related disorders/ 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 re witnessed only in the electronic media, television, movies, or pictures.
- 3. Learning that the traumatic event (s) occurred to a parent or caregiving figure.
- B. Presence if one (or more) of the following intrusion symptoms associated with the traumatic event (s), beginning after the traumatic event (s) occurred.
  - Recurrent, involuntary, and intrusive distressing memories of the traumatic event (s).
     Note: Spontaneous and intrusive memories may not necessarily appear distressing and may be expressed as play reenactment.
  - 2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event (s).
    - Note: It may not be possible to ascertain that the frightening content is related to the traumatic event (s).
  - 3. Dissociative reactions 9e.g., flashbacks) in which the child feels or acts as of 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 reenactments may occur in play.
  - 4. Intense or prolonged psychological distress t exposure to internal or external cures that symbolize or resemble an aspect of the traumatic event (s).
  - 5. Marked physiological reactions to the remainders of the traumatic event (s).
- C. One (or more) of the following symptoms, representing either persistent avoidance of stimuli associated s 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).

## DSM-5 ® TRAUMA— AND STRESSOR-RELATED DISORDERS/ POSTTRAUMATIC STRESS DISORDER FOR CHILDREN 6 YEARS AND YOUNGER CONTINUED

#### **NEGATIVE ALTERATIONS IN COGNITIONS**

- 3. Substantially increased frequency of negative emotional states (e.g., fear, guilt, sadness, shame confusion).
- 4. Markedly diminished interest or participation in significant activities, including constriction of play.
- 5. Socially withdrawn behavior.
- 6. Persistent reduction in expression of positive emotions.
- D. Alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
  - 1. Irritable behavior and angry outbursts with little or no provocation) typically expressed as verbal or physical aggression toward people or objects (including extreme temper tantrums).
  - 2. Hypervigilance.
  - 3. Exaggerated startle response.
  - 4. Problems with concentration.
  - 5. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).
- B. The duration of the disturbance is more than 1 month.
- F. The disturbance causes clinically significant distress or impairment in relationships with parents, siblings, peers, or other caregivers or with school behavior.
- G. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or other medical condition.

#### Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress dis order, 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 process or body (e.g., felling as thought 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 in and unreal, dreamlike, distant, or distorted).

## DSM-5 ® TRAUMA— AND STRESSOR-RELATED DISORDERS/ POSTTRAUMATIC STRESS DISORDER FOR CHILDREN 6 YEARS AND YOUNGER CONTINUED

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

Specify if:

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

## DTD Training Evaluation

Agency:	Wo	ork Experience:				
Please circle the numbe						
ion:	r that best describes your o	<b>pin-</b> Lacking		Adequate		Excellent
My level of knowledge before the training:	and skill in this topic area	1	2	3	4	5
My level of knowledge	and skill now is:	1	2	3	4	5
Regarding the Trainin	g:					
The organization and th	e pace were:	1	2	3	4	5
The variety and interest	of the presentation were:	1	2	3	4	5
The materials provided	:	1	2	3	4	5
The amount of job spec	rific practical information wa	as: 1	2	3	4	5
The balance of lecture	and discussion was:	1	2	3	4	5
The trainers ability to	:					
Cover objectives was:		1	2	3	4	5
Illustrate and clarify po	oints:	1	2	3	4	5
Encourage participation	n and questions was:	1	2	3	4 -	5
Respond to questions v	was:	1	2	3	4	5
The overall usefulnes	s of this training:	1	2	3	4	5

Thank you for taking the time to complete this form! Your feedback will help to improve this training.