

## Appendix B

### Other Traumatic Disorders

#### **Disorders of Extreme Stress Not Otherwise Specified (DESNOS)**

**Disorder of Extreme Stress Not Otherwise Specified (DESNOS)** refers to a condition resulting from interpersonal victimization and exposure to multiple traumas or to stressful events of a prolonged duration. When an individual is repeatedly exposed to traumatic stress, disruptions can occur in brain functions and structures, endocrinological function, immunological function, and central and autonomic nervous system arousal. These biological disruptions interact with psychological, emotional, spiritual, and cognitive processes and a variety of disturbances that are different from the symptoms that characterize PTSD.

In order for an individual to be diagnosed with DESNOS, six areas of functioning must be affected.

*(The following is adapted from Directions in Psychiatry, Volume 21, Lesson 25, "Complex Trauma and Disorders of Extreme Stress [DESNOS] Diagnosis, Part One: Assessment 2001.")*

#### **1. Alterations in the regulation of affective impulses:**

Individuals who meet criteria for DESNOS have difficulty managing their emotional experiences. They tend to overreact to minor stresses, become easily overwhelmed, appear to have extreme reactions to neutral or mild stimuli, have trouble calming themselves, and may use extreme, self-destructive measures, such as self-injury, drug use, eating disorders, or compulsive sexual activity, in attempts to manage their emotions. Very often they have a great deal of trouble either expressing or controlling their anger. They are often preoccupied with suicide or sex, and they may engage in extremely risky behavior.

#### **2. Alterations in attention or consciousness:**

Children and adolescents frequently learn to cope with traumatic experiences by dissociating, or separating these experiences from their "everyday" level of consciousness. Healthy individuals remember an event as a coherent whole, with most parts of the experience connected. When an individual dissociates, however, this association does not happen. He or she cannot reconcile traumatic experiences with their sense of who they are and how they perceive the world. Those traumatic experiences are split off from the day-to-day consciousness. Usually the experiences are perceptual or sensory, and the individual has difficulty explaining the sensations. In fact, chronically traumatized patients often dissociate to the point where they do not have a sense of what it feels like to be in their bodies.

**3. Alterations in self-perception:**

Children with DESNOS often develop negative views of themselves as being helpless, damaged, and undesirable to others. This is due to the way all young children see the world – they see themselves as the center of the universe. So if something “bad” happens, they believe they have “caused” their own mistreatment.

In addition, chronically traumatized individuals often feel that no one can understand their experience; or they may drastically minimize their own experiences, claiming they were not affected by the experience, or that the experience is not related to current problems. For example, individuals with DESNOS may emphatically insist that they were at fault for childhood molestation due to some inherent character flaw or “badness” that their abuser detected in them, and on which the abuser acted.

**4. Alterations in relationships to others:**

Adults who were abused as a child often have trouble trusting other people. They may follow a pattern of becoming a victim repeatedly as an adult, or by abusing others.

Such individuals often do not see the danger signs of inappropriate behavior on the part of another person. For example, a non-traumatized person will typically be wary of overly friendly approaches by a new acquaintance or a virtual friend, but a traumatized person may not. Nor are they able to see the warning signs in “minor” incidents, as in the case of the woman who repeatedly returns to an abusive partner until the violence escalates to the point where she is killed. Revictimization is often accepted as a matter of course in a relationship.

**5. Somatization or medical problems:**

Many people who suffer from DESNOS have physical complaints that simply can't be explained. There is a great deal of evidence that trauma has a biological effect on the body. Chronic exposure to trauma compromises the stress response, so the individual lacks the normal stress-response hormones.

As we have seen, trauma also impacts the limbic system, and its role in evaluating the emotional significance of stimuli, the hippocampus, the nervous system, and various other organs and systems. Nevertheless, typical complaints include Irritable Bowel Syndrome, chronic pelvic pain and headaches – all symptoms for which there is no obvious physical cause. It may be that for individuals who cannot verbalize their traumatic experiences, physical symptoms provide a symbolic way of communicating emotional pain.

**6. Alterations in systems of meaning:**

Individuals with DESNOS often feel that life has no purpose. They may question past religious or ethical beliefs, or feel that any spiritual force is insensitive to human suffering. Or, they may adopt a fatalistic approach to life, believing that life is pointless because they can't make any positive changes. These individuals may lack the capacity to see options, make choices, or take initiative in their life.

**7. Alterations in perception of the perpetrator:**

This functional area addresses the complex relational attachment systems that follow the crime or abuse, and the lack of appropriate response by primary caretakers or others in positions of authority. The individual with DESNOS may adopt distorted beliefs about the perpetrator, or become preoccupied with hurting the perpetrator.

**Developmental Trauma Disorder**

Some researchers and clinicians have suggested that PTSD may not be as useful a category for diagnosis and treatment of children as a proposed category of developmental trauma disorder, or DTD. A DTD diagnosis requires a history of exposure early in life to adverse interpersonal trauma such as sexual abuse, physical abuse, violence, traumatic losses of others, or significant disruption or betrayal of the child's relationships with primary caregivers.

Van der Kolk and Pynoos, among others, have written a concept paper finalized 2/2/09 entitled *Proposal to Include a Developmental Trauma Disorder Diagnosis for Children and Adolescents in DSM-V*. Topics include:

- A goal of introducing the diagnosis is to have a way to describe clinical presentations of children and adolescents exposed to chronic interpersonal trauma.
- Increasing documentation on effects of interpersonal trauma and disruption of caregiving systems on development of affect regulation, attention, cognition, perception, interpersonal relationships.
- Increasing documentation of adverse early life experiences on brain development, neuroendocrinology, and immunology.
- Traumatic stress in childhood in the majority of cases does not occur in isolation and is co-occurring with chronic victimization and adverse experiences.
- Many children do not receive a trauma-related diagnosis because they did not meet the specific DSM-IV criteria and, hence, inappropriate or no treatment; in addition, many children have complex trauma-related clinical presentations and the pervasive developmental impairments such as impaired emotional and behavioral regulation capacities and attachment-related problems.

Although there are many overlaps with PTSD and DESSOS symptoms, DTD does have new aspects to the diagnosis.

- **Exposure.** The child or adolescent has experienced or witnessed multiple or prolonged adverse events over a period of at least 1 year beginning in childhood or early adolescence, including:
  - ♦ Direct experience or witnessing of repeated and severe episodes of interpersonal violence.
  - ♦ Significant disruptions of protective caregiving as the result of repeated changes in, or separation from, the primary caregiver; or exposure to severe and persistent emotional abuse.
  
- **Affective and physiological dysregulation.** The child exhibits impaired developmental competencies related to arousal regulation, including at least two of the following symptoms:
  - ♦ Inability to modulate affect including affective shifts, inability to calm down after strong affective experiences, hyper-responsiveness to low-grade affective stimuli, inability to self-soothe, problems managing anger, internalized negative effects.
  - ♦ Disturbances in regulation of bodily functions and significant physiological manifestations of stress including sleep disturbances and sleep difficulties, problems with eating and digestion, and hyper-reactivity to physical stimuli; also have oversensitivity to touch and sounds, and problems in fine motor development as well as disorganization during transitions.
  - ♦ Diminished awareness/dissociation of sensations, emotions and bodily states such as depersonalization, lack of awareness of external environment, affective numbing, physical analgesia, difficulty knowing emotions, and increased dissociation of painful/negative effects.
  - ♦ Impaired capacity to describe emotions or bodily states including labeling of emotions, describing internal emotional states, problems communicating needs of hunger and elimination, as well as difficulty communicating wishes and desires.
  
- **Attentional and behavioral dysregulation.** The child exhibits problems related to sustaining attention, learning, or coping with stress, and at least three of the following symptoms:
  - ♦ Preoccupation with threat, impaired capacity to perceive threat, misreading of safety and danger cues, persistent social fears, narrowed focus of attention to an increased focus on a threat, and shifts in awareness of environment in response to threat.
  - ♦ Impaired capacity for self-protection, including extreme risk-taking or thrill-seeking such as fire setting, sexual risk-taking, impulse control problems,

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- problems with judgment, problems understanding rules and anticipating consequences; difficulties with abilities to plan and anticipate; over- or under-estimation of risk.
- ◆ Maladaptive attempts at self-soothing such as chronic masturbation, rocking, self-harm, repetitive self-stimulating behaviors; more substance abuse problems; sexualized behaviors.
  - ◆ Habitual or reactive self-harm including cutting, hitting the self, picking one's skin, head banging, burning oneself (three times as many self-mutilation problems and four times more likely to exhibit self-injurious behavior); higher levels of suicide risk.
  - ◆ Inability to initiate or sustain goal-directed behaviors with lack of curiosity, problems planning or completing tasks; problems with planning, anticipating, and organizing behavior to achieve rewards in the environment.
- **Self and relational dysregulation.** The child lacks a sense of personal identity, has problems with interpersonal relationships, and exhibits at least three of the following symptoms:
    - ◆ Intense preoccupation with safety of caregiver or loved ones; difficulty tolerating separations and reunions; greater attachment problems.
    - ◆ Persistent negative sense of self including self-loathing, helplessness, worthlessness, ineffectiveness, defectiveness; low feelings of self-esteem, self-confidence, self-worth; distorted cognitions of self including negative self-image and appraisal; feelings of guilt or shame, or of being damaged or defective.
    - ◆ Extreme and persistent distrust, defiance, lack of reciprocal behavior in close relationships; exhibition of oppositional behavior; difficulty understanding and reactive physical or verbal aggression toward peers, caregivers, and other adults with volatile interpersonal relationships.
    - ◆ Reactive physical or verbal aggression toward peers, caregivers, or other adults.
    - ◆ Inappropriate attempts to get intimate contact or excessive reliance on peers or adults for safety and reassurance including inappropriate physical boundaries, sexual behavior problems, interpersonal boundary issues, excessive self-disclosure.
    - ◆ Impaired capacity to regulate empathic arousal with lack of empathy for or intolerance of distress of others or excess responsiveness to distress of others; greater detachment or estrangement from others, problems taking perspective of others and attuning to others' emotional states.
  - **Posttraumatic spectrum symptoms.** The child exhibits at least one of a number of PTSD symptoms.

- **Duration of disturbance** of at least 6 months.
- **Functional impairment.** The child shows significant distress in at least two of the following areas:
  - ♦ Scholastic: under-performance, non-attendance, disciplinary problems, conflict with school personnel, or learning disabilities or intellectual impairment that are not neurological.
  - ♦ Familial: conflict, avoidance/passivity, running away, detachment and surrogate replacements, and attempts to physically or emotionally hurt family members.
  - ♦ Peer group: isolation, deviant affiliations, persistent physical or emotional conflict, violence or unsafe acts, or participating in actions that are not age-appropriate.
  - ♦ Legal: arrests and recidivism, detention, conviction and incarceration. The individual shows contempt for the law or conventional standards, and offenses are increasingly severe.
  - ♦ Health: physical illness or problems that can't be fully accounted for, physical injury or degeneration involving body systems; severe headaches or chronic pain and fatigue.