Developmental Trauma Disorder: Towards a rational, empirically based diagnosis for traumatized children for the DSM 5

Bessel A. van der Kolk MD
Trauma Center, Boston MA
National Child Traumatic Stress Network
Boston University School of Medicine
BvdK: “What if anything about treatment has been helpful, or harmful.”

“Treatment is a penalty to control my behavior.
“I was being medicated for something that happened to me.
“They gave me fake diagnoses and labels that turned us into zombies.
“I could not function in school or be motivated for anything because of the medications.
“These diagnoses follow you for the rest of your life.
“We had no voice – we had to scream and act to be seen and heard
“Medications cannot compensate for lack of love.
Incest in the United States one out of 1.1 million women

‘There is little agreement about the role of father-daughter incest as a source of serious subsequent psychopathology. The father-daughter liaison satisfies instinctual drives in a setting where mutual alliance with an omnipotent adult condones the transgression. .. The act offers an opportunity to test in reality an infantile fantasy whose consequences are found to be gratifying and pleasurable.

....... such incestuous activity diminishes the subject’s chance of psychosis and allows for a better adjustment to the external world.

....... the vast majority of them were none the worse for the experience.'
Trauma and early attachment patterns determine brain development
Stimulation of reward system in human brain: decreasing distress

- Sweet, salty, fatty foods
- Positive Human Interactions
- Drugs of abuse: Cocaine, heroin, stimulants
- Sensations of Pleasure, calm and safety: Release of hormones that regulate stress
- EtOH: Decrease physiological distress

From Bruce Perry
Reward systems in the brain are based on rhythmical interactions and attunement
What cannot be communicated to the (m)other cannot be communicated to the self.

Bowlby (1991)
The Internal Working Model

- That which becomes off-limits in the communication with the caregiver eventually becomes off-limits for inner experience.
- Defensive exclusion of physical self-experience to deal with alarm and fear of relational loss becomes encapsulated in the individual's defensive structure:
- …. and are manifested in patterns of attachment (Bowlby, 1980).
Adverse Childhood Experiences Study (ACE)

Vincent Felitti & Robert Anda

Kaiser Permanente & Center for Disease Control
# Adverse Childhood Experiences Are Very Common

## Percent reporting types of ACEs:

### Household exposures:

<table>
<thead>
<tr>
<th>Experience</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol abuse</td>
<td>23.5%</td>
</tr>
<tr>
<td>Mental illness</td>
<td>18.8%</td>
</tr>
<tr>
<td>Battered mother</td>
<td>12.5%</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>4.9%</td>
</tr>
<tr>
<td>Criminal behavior</td>
<td>3.4%</td>
</tr>
</tbody>
</table>

### Childhood Abuse:

<table>
<thead>
<tr>
<th>Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological</td>
<td>11.0%</td>
</tr>
<tr>
<td>Physical</td>
<td>30.1%</td>
</tr>
<tr>
<td>Sexual</td>
<td>19.9%</td>
</tr>
</tbody>
</table>
Effects of Child Maltreatment on Health

Prevalence of Health Risks per # of Adverse Childhood Experiences

- Current smoker
- Severe Obesity
- Two or more wks. of depressed mood in last yr.
- Ever attempted suicide

- 0 ACE
- 1 ACE
- 2 ACE's
- 3 ACE's
- 4 or more ACE's

Effects of Child Maltreatment on Health

Prevalence of Health Risks per # of Adverse Childhood Experiences

- Considers self an alcoholic: 3, 10, 11, 16
- Ever used illicit drugs: 0, 1, 2, 28
- Ever injected drugs: 0, 1, 1, 2, 3
- Had 50 or more intercourse partners: 3, 5, 6, 6, 7
- Ever had a sexually transmitted disease: 6, 9, 10, 13

0 ACE, 1 ACE, 2 ACE's, 3 ACE's, 4 or more ACE's

Effects of Child Maltreatment on Health

Prevalence of Disease per # of Adverse Childhood Experiences

Prevalence (%)

0 ACE 1 ACE 2 ACE's 3 ACE's 4 or more ACE's

<table>
<thead>
<tr>
<th>Disease</th>
<th>0 ACE</th>
<th>1 ACE</th>
<th>2 ACE's</th>
<th>3 ACE's</th>
<th>4 or more ACE's</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ischemic heart disease</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Stroke</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Chronic bronchitis or emphysema</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Diabetes</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Ever had hepatitis or jaundice</td>
<td>6</td>
<td>6</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

Estimates of the Population Attributable Risk* (PAR) of ACEs for Selected Outcomes in Women

<table>
<thead>
<tr>
<th>Mental Health</th>
<th>PAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current depression</td>
<td>54%</td>
</tr>
<tr>
<td>Suicide attempt</td>
<td>58%</td>
</tr>
</tbody>
</table>

**Abuse:**

<table>
<thead>
<tr>
<th>Abuse</th>
<th>PAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholism</td>
<td>65%</td>
</tr>
<tr>
<td>IV drug abuse</td>
<td>78%</td>
</tr>
</tbody>
</table>

**Crime Victim:**

<table>
<thead>
<tr>
<th>Crime Victim</th>
<th>PAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual assault</td>
<td>62%</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>52%</td>
</tr>
</tbody>
</table>

*Based upon the prevalence of one or more ACEs (62%) and the adjusted odds ratio.
# Correlates of Disturbed Attachment vs. Unresolved Trauma

<table>
<thead>
<tr>
<th>Symptom Profile</th>
<th>Disturbed Attachment (Secure vs. Not)</th>
<th>Unresolved Trauma (Ut vs. not)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD Severity</td>
<td>---</td>
<td>.17*</td>
</tr>
<tr>
<td>Affect Dysregulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capacity for NMR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anger Expression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Suicidality and Self Injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disturbances in Relation to Others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perceptions of Belonging/Support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cumulative Revictimization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somatization</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Stovall-McClough & Cloitre (2006) JCCP
## Correlates of Disturbed Attachment vs. Unresolved Trauma

<table>
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<th>Disturbed Attachment (Secure vs. Not)</th>
<th>Unresolved Trauma (Ut vs. not)</th>
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<tbody>
<tr>
<td>PTSD Severity</td>
<td>---</td>
<td>.17*</td>
</tr>
<tr>
<td>Affect Dysregulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capacity for NMR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anger Expression</td>
<td>.24**</td>
<td>---</td>
</tr>
<tr>
<td>Chronic Suicidality and Self Injury</td>
<td>.22*</td>
<td>---</td>
</tr>
<tr>
<td>Disturbances in Relation to Others</td>
<td>.19*</td>
<td>---</td>
</tr>
<tr>
<td>Perceptions of Belonging/Support</td>
<td>.29**</td>
<td>---</td>
</tr>
<tr>
<td>Cumulative Revictimization</td>
<td>.26**</td>
<td>---</td>
</tr>
<tr>
<td>Somatization</td>
<td>.23**</td>
<td>---</td>
</tr>
</tbody>
</table>
# Predictors of Adolescent Dissociative Symptoms (Hierarchical Linear Regression)

<table>
<thead>
<tr>
<th>Step</th>
<th>Factors Evaluated</th>
<th>Δ F</th>
<th>p</th>
<th>Variance Explained</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Demographic Variables</strong></td>
<td>1.34</td>
<td>n.s.</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td>• Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Cumulative Demographic Risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td><strong>Quality of Early Maternal Care</strong></td>
<td>8.30</td>
<td>.00*</td>
<td>39%</td>
</tr>
<tr>
<td></td>
<td>• Verbal Engagement at Home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Emotional/Physical Withdrawal at Home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Disrupted Maternal Communication in the Laboratory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td><strong>Child Behavioral Problems</strong></td>
<td>.01</td>
<td>n.s.</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>• Teacher Report, 7 year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td><strong>Maternal Psychopathology</strong></td>
<td>1.71</td>
<td>n.s.</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td>• Dissociative Symptoms, 19 year</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Putnam et al: Prospective Longitudinal Study of the Effects of Sexual Abuse

- 166 girls aged 6 - 15 years & primary non-abusing caretaker
  - 84 Sexually abused by family member
  - 82 Comparison girls matched on: age, race, SES, & family constellation (1 or 2 parents)

- Abuse Statistics
  - Age onset: 7.9 yr (±3.3)
  - Duration: 26.3 months (±29.6)
  - Physical violence: 51.9% of cases
  - Perpetrators: Biological Father: 23.4%, Father Figure (Stepfather, Live-in boyfriend): 58.4%, Other family
Male peers

- **Non-abused**
- **Abused**

**Putnam Peer graph**

**Biology: alteration in HPA feedback loop:**

- **Testosterone**: 28 (A) 5 (C)
- **Androstendione**: 120 (A) 48 (C)

Increased # pregnancies, drug abuse, sexually provocative
Complex Trauma in the National Child Traumatic Stress Network

Bessel van der Kolk, M.D., Joseph Spinazzola, Ph.D., Julian Ford, Ph.D., Margaret Blaustein, Ph.D., Melissa Brymer, Psy.D., Laura Gardner, BsPH, Susan Silva, Ph.D., Stephanie Smith, Ph.D.
NATIONAL CHILD TRAUMATIC STRESS NETWORK

- 54 Sites across 31 US States & D.C.
- Intervention Development & Evaluation Centers
- Community Treatment & Services Centers
Child Trauma Exposure History

- **Age of Onset**
  - Mean Age: 5.22 years
  - Range: 1 – 10 Years

- Early Exposure: 1/3 of the sample is adolescent and yet all children experienced trauma prior to age 11

- **Number of Types**
  - **Mean:** 3.36
  - **Range:** 1 – 11 types

- **Duration of Trauma**
  - Multiple-event or chronic trauma: 82%
Current Status – Utilization of Core Data Set

As of August 2008:

- Baseline data have been collected for 9,366 youth
- Currently there are 8,120 follow-up records available
- 46 sites have provided data to the Core Data Set
  - Majority using Electronic Data Capture (InForm)
There is little agreement about the role of father-daughter incest as a source of serious subsequent psychopathology. The father-daughter liaison satisfies instinctual drives in a setting where mutual alliance with an omnipotent adult condones the transgression. .. The act offers an opportunity to test in reality an infantile fantasy whose consequences are found to be gratifying and pleasurable.

...... such incestuous activity diminishes the subject’s chance of psychosis and allows for a better adjustment to the external world.

...... the vast majority of them were none the worse for the experience.
### Demographics of Current Core Data Set

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age at Baseline (Treatment Entry)</strong></td>
<td>Mean = 10.29; Range = 0-21</td>
<td></td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td>White</td>
<td>44.7%</td>
</tr>
<tr>
<td></td>
<td>African American</td>
<td>31.5%</td>
</tr>
<tr>
<td><strong>Ethnicity (Hispanic/Latino)</strong></td>
<td></td>
<td>24.4%</td>
</tr>
<tr>
<td><strong>Sex (female)</strong></td>
<td></td>
<td>52.1%</td>
</tr>
<tr>
<td><strong>Custody</strong></td>
<td>Parent(s)</td>
<td>45.8%</td>
</tr>
<tr>
<td></td>
<td>Other Relatives</td>
<td>12.5%</td>
</tr>
<tr>
<td></td>
<td>State</td>
<td>11.2%</td>
</tr>
<tr>
<td><strong>Insurance Coverage</strong></td>
<td>Any insurance</td>
<td>69%</td>
</tr>
<tr>
<td></td>
<td>Public</td>
<td>58.9% of insured</td>
</tr>
</tbody>
</table>
**MEDICAID POPULATION, MASSACHUSETTS N = 384,046**

<table>
<thead>
<tr>
<th>PTSD</th>
<th>Depression</th>
<th>Panic</th>
<th>Bipolar</th>
<th>DID</th>
</tr>
</thead>
<tbody>
<tr>
<td>22,802</td>
<td>22,897</td>
<td>13,281</td>
<td>1,463</td>
<td>1,228</td>
</tr>
</tbody>
</table>

PTSD + Depression 2,986
PTSD + Panic 1,277
PTSD + Bipolar 217
PTSD/DID 669

Total PTSD 27,950 = 7% of total Medicaid population

Macy et al, 1997
<table>
<thead>
<tr>
<th>DayRx</th>
<th>IP Days</th>
<th>IP Admits</th>
<th>24hr</th>
<th>Crisis</th>
<th>ARTP</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD</td>
<td>8,536</td>
<td>622</td>
<td>38</td>
<td>962</td>
<td>9,360</td>
</tr>
<tr>
<td>DID</td>
<td>7,598</td>
<td>926</td>
<td>45</td>
<td>219</td>
<td>59</td>
</tr>
<tr>
<td>BIPOL</td>
<td>869</td>
<td>72</td>
<td>34</td>
<td>153</td>
<td>100</td>
</tr>
</tbody>
</table>

\[
\text{MEDICAID POPULATION, MASSACHUSETTS N} = 384,046
\]

\[
8,536 \times \$550 = \$47,000,000
\]
Most Commonly Reported Traumas

![Bar chart showing the most commonly reported traumas]

- Loss
- Domestic Violence (DV)
- Emotional Abuse
- Sexual Abuse
- Neglect
- Physical Abuse
- Illness/Medical
- Serious Injury/Accident
- Natural Disaster
- Kidnapping
- Community Violence
- School Violence
- Sexual Assault/Rape
Prevalence of Multiple Traumas

- Percent Single Trauma: 13.9%
- Percent Multiple Traumas: 71.6%
Met Full Criteria for PTSD

73.5% No
24.5% Yes
Adverse Childhood Experiences Study (ACES)*

Felitti et al. 1998;
Percentage of Children Experiencing Cumulative Traumas

![Bar chart showing the percentage of children experiencing cumulative traumas.](chart_image)
Developmental Trauma Disorder (DTD) Case Study

Study Principal Investigators: Julian Ford, Ph.D., Joseph Spinazzola, Ph.D., Bradley Stolbach, Ph.D. & Bessel A. van der Kolk, M.D.

Project conceived, designed and peer-reviewed by the Developmental Trauma Taskforce, a joint committee of the International Society for Traumatic Stress Studies (ISTSS) and the National Child Traumatic Stress Network (NCTSN), Bessel A. van der Kolk, Chair.

Financial support for this project supported by SAMHSA-CMHS NCTSI National Center & Community Practice Site Grants

Preliminary analyses and slide preparation by Rachel Dekel, Ph.D. & Joseph Spinazzola, Ph.D.

Mid-Study Status Update

Presented to Illinois Child Trauma Coalition

February 2008
Study Design

- Representative case vignettes from national expert sites serving children impacted by complex adaptation to serial or repeated trauma exposure.
  - Target Recruitment: 100 cases (5-10 cases across 10-15 network sites & their affiliates)

- Study Components:
  - Structured narrative case vignette
  - Trauma History Profile (Pynoos et al., Core Dataset, NCTSN)
  - Detailed Symptom Checklist (80 items)
    - Entire set of 17 DSM-IV symptoms of PTSD
    - Symptoms of potential relevance to DTD Diagnosis identified by expert panel of DTD Taskforce
    - Representative symptoms of all other child-relevant DSM-IV disorders
    - Five unassigned items for clinician determination as needed
Case Selection: Inclusion Criteria

- Aged 3 - 18
- Presenting at trauma clinics for evaluation or treatment services
- Histories of serial or repeated interpersonal trauma, maltreatment and/or neglect.
- Clinician selection based on perceived representation of range and diversity of complexly traumatized youth (e.g., varying age, gender, race, ethnicity, trauma exposure, and impairment profile)
Study Analyses

- Data Analyses:
  - Step 1: Descriptive analyses (e.g., general and stratified exposure/symptom frequencies and identification of most significant presenting problems (underway)
  - Step 2: Data Reduction/Classification (e.g., Cluster or Factor Analysis*)
  - Step 3: Narrative Analyses (e.g., Clinical Interpretation; Qualitative Data Coding/Analyses)
  - Step 4: Compilation of annotated case book including quantitative results and analyses/interpretation of illustrative narrative vignettes
## Distribution of Cases as of January 24, 2008

<table>
<thead>
<tr>
<th>Center</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicago</td>
<td>11</td>
</tr>
<tr>
<td>Boston</td>
<td>8</td>
</tr>
<tr>
<td>New Orleans</td>
<td>7</td>
</tr>
<tr>
<td>Michigan</td>
<td>6</td>
</tr>
<tr>
<td>Alaska</td>
<td>3</td>
</tr>
<tr>
<td>Connecticut</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>37</strong></td>
</tr>
</tbody>
</table>
## Sample: Children’s Gender by Age

<table>
<thead>
<tr>
<th></th>
<th>0-4</th>
<th>5-12</th>
<th>13-18</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Male</strong></td>
<td>1</td>
<td>10</td>
<td>3</td>
<td>14 (38%)</td>
</tr>
<tr>
<td><strong>Female</strong></td>
<td>5</td>
<td>10</td>
<td>8</td>
<td>23 (62%)</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>19</td>
<td>21</td>
<td>37 (100%)</td>
</tr>
</tbody>
</table>
Sample: Children’s Distribution of Race and ethnicity

<table>
<thead>
<tr>
<th>Race</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>African-American</td>
<td>56</td>
</tr>
<tr>
<td>White</td>
<td>29</td>
</tr>
<tr>
<td>Native American</td>
<td>6</td>
</tr>
<tr>
<td>Mixed</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>

23% of the children are Latino
Frequencies of Trauma Exposure

- Physical maltreatment: 59
- Loss: 65
- Traumatic violence: 68
- Domestic violence: 70
- Emotional abuse: 81
- Neglect: 89
- Impaired caregiver

The National Child Traumatic Stress Network
Frequencies of Trauma Exposure

- War and terror: 30
- Kidnapping: 25
- Interpersonal violence: 22
- School violence: 19
- Medical trauma: 19
- Physical assault: 17
- Forcible displacement: 14
- Sexual assault: 11
- School violence: 11
- Interpersonal violence: 11
- Natural Disaster: 5
- Serious injury: 2
- Community violence: 2
- Sexual maltreatment: 0
- Forced displacement: 0
- Medical trauma: 0
- Physical assault: 0
- Sexual assault: 0
- School violence: 0
- Interpersonal violence: 0
- Natural Disaster: 0
- Serious injury: 0
- Community violence: 0
- Sexual maltreatment: 0
Proposal to include Developmental Trauma Disorder in the DSM V

Bessel A. van der Kolk MD
Dante Cicchetti PhD
Marylene Cloitre PhD
Wendy D’Andrea PhD
Julian Ford PhD
Alicia Lieberman MD
Frank Putnam MD
Glenn Saxe MD
Joseph Spinazzola PhD
Bradley Stolbach PhD
Martin Teicher MD PhD

Robert Pynoos PD
The goal of introducing the diagnosis of Developmental Trauma Disorder is to capture the reality of the clinical presentations of children and adolescents exposed to chronic interpersonal trauma and thereby guide clinicians to develop and utilize effective interventions and for researchers to study the neurobiology and transmission of chronic interpersonal violence.

Whether or not they exhibit symptoms of PTSD, children who have developed in the context of ongoing danger, maltreatment, and inadequate caregiving systems are ill-served by the current diagnostic system, as it frequently leads to no diagnosis, multiple unrelated diagnoses, an emphasis on behavioral control without recognition of interpersonal trauma and lack of safety in the etiology of symptoms.
The introduction of PTSD in the psychiatric classification system in 1980 has led to extensive scientific studies of that diagnosis.

However, over the past 25 years there has been a relatively independent and parallel emergence of

I. The field of Developmental Psychopathology (e.g. Maughan & Cicchetti, 2002; Putnam, Trickett, Yehuda, & McFarlane, 1997), which has documented the effects of interpersonal trauma and disruption of caregiving systems on the development of affect regulation, attention, cognition, perception, and interpersonal relationships.

II. The other significant development has been the increasing documentation of the effects of adverse early life experiences on brain development (e.g. De Bellis et al., 2002; Teicher et al., 2003), neuroendocrinology (e.g. Hart, Gunnar, & Cicchetti, 1995;) and immunology (e.g. Putnam et al., 1997; Wilson et al, 1999).
A survey of 1,699 children receiving trauma-focused treatment across 25 network sites of the National Child Traumatic Stress Network (Spinazzola et al, 2005) showed that the vast majority (78%) was exposed to multiple and/or prolonged interpersonal trauma, with a modal 3 trauma exposure types;

Less than ¼ met diagnostic criteria for PTSD. Fewer than 10% were exposed to serious accidents or medical illness.

Most children exhibited posttraumatic sequelae not captured by PTSD: at least 50% had significant disturbances in affect regulation; attention & concentration; negative self-image; impulse control; aggression & risk taking.
Whether or not they have symptoms of PTSD children who have developed in the context of ongoing danger, maltreatment, and inadequate caregiving systems are ill-served by the current diagnostic system.

It frequently leads to no diagnosis, multiple unrelated diagnoses, an emphasis on behavioral control without recognition of interpersonal trauma and lack of safety in the etiology of symptoms, and a lack of attention to ameliorating the developmental disruptions that underlie the symptoms.
CONSENSUS PROPOSED CRITERIA FOR DEVELOPMENTAL TRAUMA DISORDER

A. Exposure. The child or adolescent has experienced or witnessed multiple or prolonged adverse events over a period of at least one year beginning in childhood or early adolescence, including:

A. 1. Direct experience or witnessing of repeated and severe episodes of interpersonal violence; and

A. 2. Significant disruptions of protective caregiving as the result of repeated changes in primary caregiver; repeated separation from the primary caregiver; or exposure to severe and persistent emotional abuse
B. Affective and Physiological Dysregulation. The child exhibits impaired normative developmental competencies related to arousal regulation, including at least two of the following:

B. 1. Inability to modulate, tolerate, or recover from extreme affect states (e.g., fear, anger, shame), including prolonged and extreme tantrums, or immobilization

B. 2. Disturbances in regulation in bodily functions (e.g. persistent disturbances in sleeping, eating, and elimination; over-reactivity or under-reactivity to touch and sounds; disorganization during routine transitions)

B. 3. Diminished awareness/dissociation of sensations, emotions and bodily states

B. 4. Impaired capacity to describe emotions or bodily states
C. Attentional and Behavioral Dysregulation: The child exhibits impaired normative developmental competencies related to sustained attention, learning, or coping with stress, including at least three of the following:

C. 1. Preoccupation with threat, or impaired capacity to perceive threat, including misreading of safety and danger cues

C. 2. Impaired capacity for self-protection, including extreme risk-taking or thrill-seeking

C. 3. Maladaptive attempts at self-soothing (e.g., rocking and other rhythmical movements, compulsive masturbation)

C. 4. Habitual (intentional or automatic) or reactive self-harm

C. 5. Inability to initiate or sustain goal-directed behavior
D. Self and Relational Dysregulation. The child exhibits impaired normative developmental competencies in their sense of personal identity and involvement in relationships, including at least three of the following:

D. 1. Intense preoccupation with safety of the caregiver or other loved ones (including precocious caregiving) or difficulty tolerating reunion with them after separation

D. 2. Persistent negative sense of self, including self-loathing, helplessness, worthlessness, ineffectiveness, or defectiveness

D. 3. Extreme and persistent distrust, defiance or lack of reciprocal behavior in close relationships with adults or peers

D. 4. Reactive physical or verbal aggression toward peers, caregivers, or other adults

D. 5. Inappropriate (excessive or promiscuous) attempts to get intimate contact (including but not limited to sexual or physical intimacy) or excessive reliance on peers or adults for safety and reassurance

D. 6. Impaired capacity to regulate empathic arousal as evidenced by lack of empathy for, or intolerance of, expressions of distress of others, or excessive responsiveness to the distress of others
E. Posttraumatic Spectrum Symptoms. The child exhibits at least one symptom in at least two of the three PTSD symptom clusters B, C, & D.

F. Duration of disturbance (symptoms in DTD Criteria B, C, D, and E) at least 6 months.

G. Functional Impairment. The disturbance causes clinically significant distress or impairment in at two of the following areas of functioning:

- Scholastic: under-performance, non-attendance, disciplinary problems, drop-out, failure to complete degree/credential(s), conflict with school personnel, learning disabilities or intellectual impairment that cannot be accounted for by neurological or other factors.

- Familial: conflict, avoidance/passivity, running away, detachment and surrogate replacements, attempts to physically or emotionally hurt family members, non-fulfillment of responsibilities within the family.

- Peer Group: isolation, deviant affiliations, persistent physical or emotional conflict, avoidance/passivity, involvement in violence or unsafe acts, age-inappropriate affiliations or style of interaction.

- Legal: arrests/recidivism, detention, convictions, incarceration, violation of probation or other court orders, increasingly severe offenses, crimes against other persons, disregard or contempt for the law or for conventional moral standards.

- Health: physical illness or problems that cannot be fully accounted for physical injury or degeneration, involving the digestive, neurological (including conversion symptoms and analgesia), sexual, immune, cardiopulmonary, proprioceptive, or sensory systems, or severe headaches (including migraine) or chronic pain or fatigue.
<table>
<thead>
<tr>
<th>Dataset</th>
<th>Contributors</th>
<th>N</th>
<th>Sample Source</th>
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<tr>
<td>NCTSN Survey</td>
<td>Spinazzola, J., Ford, J.D., Zucker, M., van der Kolk, B.A., Silva, S., Smith, S.F., and Blaustein, M.</td>
<td>1699</td>
<td>Clients at NCTSN sites</td>
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<tr>
<td>NCTSN Core Data Set</td>
<td>Pynoos, R.S., Ostrowski, S., Fairbank, J.A., Briggs-King, E.C., Steinberg, A., Layne, C., and Stolbach, B.</td>
<td>4435</td>
<td>Clients at NCTSN sites</td>
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<td>CANS Dataset</td>
<td>McClelland, G., Fehrenbach, T., Griffin, E., Burkman, K., and Kiesel, C.</td>
<td>7668</td>
<td>All Illinois Foster Care system</td>
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<td>CCTC Dataset</td>
<td>Stolbach, B.C., Dominguez, R.Z., and Rompala, V.</td>
<td>172</td>
<td>All PTSD criterion A-exposed; none have risk to self or others</td>
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<td>Western Michigan Dataset</td>
<td>Richardson, M., Henry, J., Black-Pond, C., and Sloane, M.</td>
<td>209</td>
<td>Foster care</td>
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<td>NSA re-analysis</td>
<td>Ford, J. D., Elhai, J. D., Connor, D. F., and Frueh, B. C.</td>
<td>4023</td>
<td>National random</td>
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<td>Juvenile Justice</td>
<td>Ford, J. D., Hawke, J., and Chapman, J.</td>
<td>1825</td>
<td>Juvenile Detention Centers Preschoolers exposed to domestic violence</td>
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<td>Ghosh Ippen and Lieberman</td>
<td>Ghosh Ippen, C.G., Harris, W.W., Van Horn, P.J., and Lieberman, A.F.</td>
<td>89</td>
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Overcoming trauma

1. Effective action
How the brain “gets on with life” 
(LeDoux, 2003)

Threat

Basal Ganglia

LA

CA

AB

CO

ME

Active coping
  • Planning
  • Action

Passive coping
  • Freezing
  • Despondency
Overcoming trauma

1. Effective action
2. Self-regulation
PREDICTORS OF TREATMENT OUTCOME

NMR Change in Phase II

Phase I WAI

Working alliance inventory

PTSD, Post-tx

Cloitre et al, 2003
Overcoming trauma

1. Effective action
2. Self-regulation
3. Accessing the emotional brain
Dorsolateral pre-frontal Cortex – working memory, Plans for action

Amygdala

Medial prefrontal Experience/interoception
For more information

Trauma Center Research Office

http://www.traumacenter.org