Analysis of Bessel van der Kolk's DTD & DSM-5's PTSD

"Exposure to multiple and chronic interpersonal trauma in childhood, typically occurring within the caregiving system – often referred to as complex trauma exposure – is associated with a complex range of symptoms and impairments across several areas of development." (p. 1) "Victims of abuse, neglect, and maltreatment in childhood often develop a wide range of age-dependent psychopathologies with various mental comorbidities. The supporters of a formal DTD diagnosis argue that post-traumatic stress disorder (PTSD) does not cover all consequences of severe and complex traumatization in childhood." (Schmid, Petermann, & Fegeret, 2013, p. 1) DTD "diagnosis is based on the belief that multiple exposures to interpersonal trauma, such as abandonment, physical or sexual assaults or witnessing domestic violence have consistent and predictable consequences that affect many areas of functioning. …DTD is organized around the issue of triggered dysregulation in response to traumatic reminders, stimulus generalization, and the anticipatory organization of behavior to prevent the recurrence of the trauma impact." (Simonelli, p. 8)

Comparison Between van der Kolk's 2005 and van der Kolk et al.'s 2009 Development Trauma Disorder (DTD) Criteria

2005	*2009*
A. Exposure.	A. Exposure. The child or adolescent has experienced or witnessed multiple or prolonged adverse events over at least one year beginning in early childhood or early adolescence, including
• Multiple or chronic exposure to one or more forms of developmentally adverse interpersonal trauma (eg, abandonment, betrayal, physical assaults, sexual assaults, threats to bodily integrity, coercive practices, emotional abuse, witnessing violence and death).	A1. Direct experience or witnessing of repeated and severe episodes of interpersonal violence.
• Subjective experience (eg, rage, betrayal, fear, resignation, defeat, shame).	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. Triggered pattern of repeated dysregulation in response to trauma cues. Dysregulation (high or low) in presence of cues. Changes persist and do not return to baseline; not reduced in intensity by conscious awareness.	B. Affective and Physiological Dysregulation. The child exhibits impaired normative developmental competencies related to arousal regulation, including at least two of the following:

• Affective	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.4. Impaired capacity to describe emotions or bodily states.
• Somatic (eg, physiological, motoric, medical)	B2. Disturbances in regulation in bodily functions (e.g., persistent disturbances in sleeping, eating, and elimination; overreactivity or underreactivity to touch and sounds; disorganization during routine transitions).
	B.3. Diminished awareness/dissociation of sensations, emotions, and bodily states.
• Behavioral (eg, re-enactment, cutting)	C.4. Habitual (intentional or automatic) or reactive self-harm. C.5. Inability to initiate or sustain goal-directed behavior. D.4. Reactive physical or verbal aggression toward peers, caregivers, or other adults
• Cognitive (eg, thinking that it is happening again, confusion, dissociation, depersonalization).	C.1. Preoccupation with threat, or impaired capacity to perceive threat, including misreading of safety and danger cues.
• Relational (eg, clinging, oppositional, distrustful, compliant).	D.1. Intense preoccupationwith safety of the caregiver or other loved ones (including precocious caregiving) or difficulty tolerating reunion with them after separation. D5. 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 regulated empathic arousal as evidenced by lack of empathy for, or intolerance of, expressions of distress in others, or excessive responsiveness to the distress of others.
• Self-attribution (eg, self-hate, blame).	D.2. Persistent negative sense of self, including self-loathing, helplessness, worthlessness, ineffectiveness, or defectiveness.
C. Persistently Altered Attributions and Expectancies	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:

N/A	C.3. Maladaptive attempts at self-soothing (e.g., rocking and other rhythmical movements, compulsive masturbation).
• Negative self-attribution.	N/A
• Distrust of protective caretaker.	D.3. Extreme and persistent distrust, defiance, or lack of reciprocal behavior in close relationships with adults or peers.
• Loss of expectancy of protection by others.	C.2. Impaired capacity for self-protection, including extreme risk taking or thrill seeking.
• Loss of trust in social agencies to protect.	N/A
• Lack of recourse to social justice/retribution.	N/A
• Inevitability of future victimization.	N/A
N/A	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:
N/A	E. Posttraumatic spectrum symptoms. The child exhibits at least one symptom in at least two of the three posttraumatic stress disorder (PTSD) symptom Clusters B, C, and D
N/A	F. Duration of disturbance. Symptoms in DTD Criteria B, C, D, and E last at least 6 months.
D. Functional Impairment	G. Functional impairment. The disturbance causes clinically significant distress or impairment in at two of the following areas of functioning:
• Educational.	Scholastic: Underperformance, nonattendance, disciplinary problems, dropout, 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.	Familial: Conflict, avoidance/passivity, running away, detachment and surrogate replacements, attempts to physically or emotionally hurt family members, nonfulfillment of responsibilities within the family.
• Peer.	Peer group: Isolation, deviant affiliations, persistent physical or emotional conflict, avoidance/passivity, involvement in violence

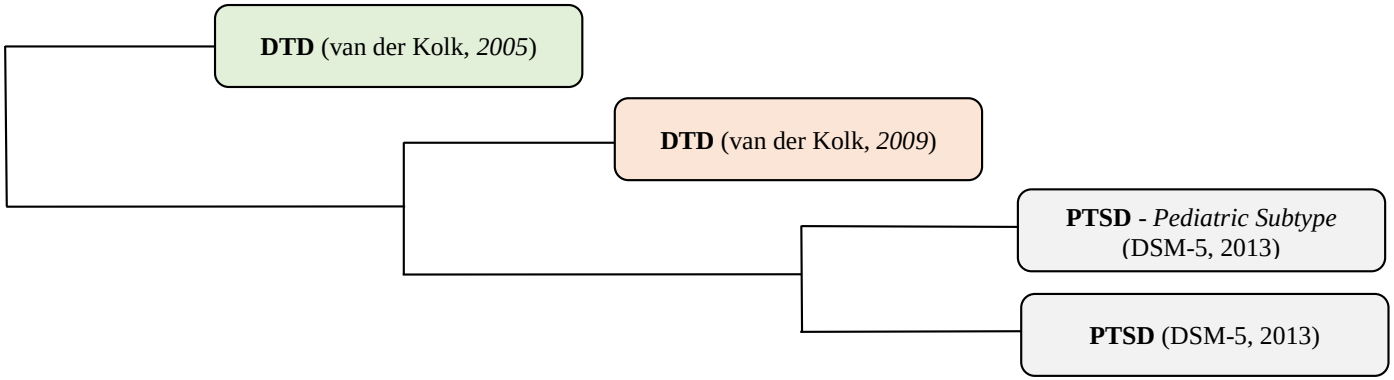
	or unsafe acts, age-inappropriate affiliations or style of interaction.
• Legal.	Legal: Arrests/recidivism, detention, convictions, incarceration, violation of probation or other court orders, increasingly severe offenses, crimes against other persons, disregard or contempt for the law or for conventional moral standards.
• Vocational.	Vocational (for youth involved in seeking or referred for employment, volunteer work, or job training): Disinterest in work/vocation, inability to get or keep jobs, persistent conflict with coworkers or supervisors, underemployment in relation to abilities, failure to achieve expectable advancements
N/A	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; severe headaches (including migraine); or chronic pain or fatigue.

Correlation Coefficient and Coefficient of Determination Between Various Trauma Disorder Diagnostic Criteria

Trauma Diagnoses Type		*r*	r^2	*Strength*
PTSD (DSM-5, 2013)	PTSD - Pediatric Subtype (DSM-5, 2013)	0.93253	86.96%	Very strong (+)
PTSD - Pediatric Subtype (DSM-5, 2013)	DTD (van der Kolk, 2009)	0.02802	0.08%	Very weak (+)
PTSD (DSM-5, 2013)	DTD (van der Kolk, 2009)	0.01420	0.02%	Very weak (+)
DTD (van der Kolk, 2005)	DTD (van der Kolk, 2009)	-0.00311	0.00%	None (0)
PTSD (DSM-5, 2013)	DTD (van der Kolk, 2005)	-0.07690	0.59%	Very weak (-)
PTSD - Pediatric Subtype (DSM-5, 2013)	DTD (van der Kolk, 2005)	-0.08925	0.80%	Very weak (-)

Note. NVivo 12 Plus was used to analyze data. Results are listed in descending order from closest linear correlation to distant linear correlation. r = Pearson correlation coefficient. r^2 = coefficient of determination. Pearson correlation coefficient strengths are based on Evans (1996).

Tree Diagram of Correlation Between Various Trauma Disorder Diagnostic Criteria



Line-by-Line Comparison of Trauma Disorder Diagnostic Criteria

Bessel van der Kolk's (2009) Developmental Trauma Disorder (DTD) - "adverse caregiver attachment coupled with self/relational dysregulation"	*DSM-5's (2013 Posttraumatic Stress Disorder (PTSD) < Age 7 Years (Preschool Subtype) - "traumatic insult to safety coupled with psycho-biological distress"*	*DSM-5's (2013) Posttraumatic Stress Disorder (PTSD) > Age 6 Years - "traumatic insult to safety coupled with psycho-biological distress*	*Analysis from the Current Literature*
			Ford (2015) • "*Polyvictimization* (i.e., exposure to multiple types of *interpersonal* traumatic stressors) has been identified as a unique risk factor for severe psychosocial problems in childhood that are consistent with **DTD** (D'Andrea et al., 2012), and *cumulative* exposure to *multiple* types of traumatic stressors and re-victimization have been linked to **CPTSD** in children and adults (Cloitre et al., 2009; Karam et al., 2014)." (p. 2) • "Respondents rated a combination of *traumatic polyvictimization* and *attachment disruption* as a **DTD** feature that was highly discriminable from

			DSM-IV diagnoses (including **PTSD**) and of distinct clinical utility." (p. 2) • "Construct validity was supported by hierarchical regressions, which showed that, after controlling for DSM-IV and **DSM-5 PTSD**, the scores for **DTD** overall and the three factors were associated with parent-rated measures of dysregulation, alexithymia, and impulse control problems." (p. 2) • "Additional construct validity evidence was provided by logistic regressions showing that **PTSD** was uniquely associated with exposure to *sexual trauma*, *emotional abuse*, and *interpersonal violence*, but **DTD** was uniquely associated with *family or community violence* and *an impaired caregiver*." (p. 2) • "**DTD** criteria had clinical utility and were discriminable from childhood *internalizing*

Commented [JHK1]: Marked dysfunction in emotional awareness, social attachment, and interpersonal relating.

Commented [JHK2]: "Social neglect—that is, the absence of adequate caregiving during childhood—is a diagnostic requirement of both **reactive attachment disorder** and **disinhibited social engagement disorder**." (DSM-5, p. 265)

Commented [JHK3]: "When caregivers are emotionally absent, inconsistent, frustrating, violent, intrusive, or neglectful, children are likely to become intolerably distressed and unlikely to develop a sense that the external environment is able to provide relief." (van der Kolk, 2005, p. 3)

Commented [JHK4]: What about **Reactive Attachment Disorder** as an "internalizing" expression with depressive symptoms and withdrawn behavior?

			(including **PTSD**) and *externalizing* psychiatric diagnoses." (p. 2) **Stolbach, et al. (2013)** • The **DTD** construct differs from other approaches to diagnosis in that it directs clinical attention to both *discrete traumatic stressors* and *individuals' attachment histories*. **Teague (2013)** • "Betrayal trauma theory gives a supportive description and explanation for **DTD** as it relates to trauma exposures and outcomes. … That is, **DTD** can be understood as the experince [sic] of severe betrayals (i.e., multiple sufferings) in a percieved [sic] trusting intimate childhood or adolescent relationship that interferes with functioning." (p. 612) • "Developmental trauma can consist of *single* or *multiple* traumas." **van der Kolk (2005)** • "This proposed diagnosis is organized around the issue of *triggered dysregulation*

Commented [JHK5]: What about **Disinhibited Social Engagement Disorder (DSID)** which is marked by disinhibition and "externalizing" behavior?

Commented [JHK6]: "Serious social neglect is a diagnostic requirement for reactive attachment disorder and is also the only known risk factor for the disorder. However, the majority of severely neglected children do not develop the disorder. Prognosis appears to depend on the quality of the caregiving environment following serious neglect." (DSM-5, p. 267)

			in response to traumatic reminders, stimulus generalization, and the anticipatory organization of behavior to prevent the recurrence of the trauma effects." (p. 6)
A. Exposure: The child or adolescent has *experienced* or *witnessed* multiple or *prolonged adverse* events *beginning in early childhood or early adolescence*, including	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:	A. Exposure to actual or threatened *death, serious injury, or sexual violence* in one (or more) of the following ways: **Note:** The following criteria apply to adults, adolescents, and children *older than 6 years*.	**Bishop, Rosenstein, Bakelaar & Seedat (2014)** • Found posttraumatic stress disorder age of *onset* at 6 years. [Rodriguez et al. (1996) found the *age of onset* of sexual abuse in individuals with posttraumatic stress disorder to be around 6 years; Ackerman, Newton, McPherson, Jones, & Dykmanby (1998) found the *age of onset* of childhood sexual abuse to be approximately 7 years]
A.1. Direct experience or witnessing of *repeated and severe* episodes of *interpersonal* violence.	A.1. Directly experiencing the traumatic event(s). A.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,	A.1. Same as Preschool Subtype A.2. Same as Preschool Subtype	**Ford (2015)** • Children exposed to *developmentally adverse interpersonal traumatic stressors* (e.g., maltreatment, prolonged family or community violence, torture, exploitation, and genocide) - *especially in formative*

	television, movies, or pictures.		*periods* (e.g., early childhood and adolescence) - <u>are at risk for PTSD</u>. **van der Kolk (2005)** • "Forms of childhood trauma exposure — such as *psychological or emotional abuse and traumatic loss* — have been demonstrated to be associated with **PTSD** symptoms and self-regulatory impairments in children and into adulthood." (p. 6)
N/A	A.3. Learning that the traumatic event(s) occurred to a parent or caregiving figure.	A.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.	**Ford (2015)** • "Traumatic loss (separation from a caregiver) was associated with both DTD and PTSD." (p. 2)
N/A	N/A	A.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	**van der Kolk (2005)** • "…*classification* of traumatic events may need to be <u>defined more broadly</u>." (p. 6)

		exposure through electronic media, television, movies, or pictures, unless this exposure is work related.	
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.	N/A	N/A	
B. *Affective and Physiological Dysregulation*. The child exhibits impaired normative developmental competencies related to arousal regulation, including at least two of the following:	E. 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:	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:	
B.1. Inability to modulate, tolerate, or recover from *extreme* affect states (e.g., fear, *anger*, shame), including prolonged and extreme tantrums or *immobilization*.	C.3. Substantially increased frequency of *negative* emotional states (e.g., fear, *guilt*, *sadness*, shame, *confusion*). E.1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or	D.4. Persistent *negative emotional* state (e.g., fear, *horror*, anger, *guilt*, or shame). E.1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.	

Commented [JHK7]: Reactive Attachment Disorder Diagnostic Criteria? C.2.: "*Repeated changes of primary caregivers* that limit opportunities to form stable attachments (e.g., frequent changes in foster care)."

Commented [JHK8]: Reactive Attachment Disorder Diagnostic Criteria?
C.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."
C.3.: "Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios)."

Commented [JHK9]: This "lumps" two non-directly related, and discriminant trauma exposure sources.

Commented [JHK10]: Reactive Attachment Disorder: "In addition, their *emotion regulation capacity is compromised*, and they display episodes of negative emotions of *fear, sadness, or irritability* that are not readily explained." (DSM-5, p. 266)

Commented [JHK11]: Immobilization is the opposite of prolonged and extreme tantrums – thus creating conflicting "lumped" diagnostic criteria.

	objects (including extreme temper tantrums).		
B2. Disturbances in regulation in bodily functions (e.g., persistent disturbances in sleeping, eating, and elimination; overreactivity or underreactivity to touch and sounds; disorganization during routine transitions).	E.2. Hypervigilance. E.3. Exaggerated startle response. E.5. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).	E.3. Same as Preschool Subtype E.4. Same as Preschool Subtype E.6. Same as Preschool Subtype	
B.3. Diminished awareness/dissociation of sensations, emotions, and bodily states.	B.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.	D.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).	**van der Kolk (2005)** • "Chronically traumatized children tend to suffer from distinct alterations in states of consciousness, including amnesia, hypermnesia, dissociation, depersonalization and derealization." (p. 4)
B.4. *Impaired* capacity to *describe* emotions or bodily states.	C.6. Persistent *reduction* in *expression* of positive emotions.	D.4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).	**van der Kolk (2005)** • "The children often are literally are "out of touch" with their feelings, and often have no language to describe internal states." (p. 4)
C. *Attentional and behavioral dysregulation*. The child exhibits impaired normative developmental competencies related to sustained attention,	N/A	C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s)	

Commented [JHK12]: Reactive Attachment Disorder: "As such, children with reactive attachment disorder show *diminished or absent expression of positive emotions* during routine interactions with caregivers." (DSM-5, p. 266)

learning, or coping with stress, including *at least three* of the following:		occurred, as evidenced by one or both of the following:	
C.1. *Preoccupation* with threat, or impaired capacity to perceive threat, including *misreading* of safety and danger cues.	N/A	N/A	
C.2. Impaired capacity for self-protection, including *extreme* risk taking or thrill seeking.	N/A	E.2. *Reckless* or self-destructive behavior.	
C.3. *Maladaptive* attempts at self-soothing (e.g., rocking and other rhythmical movements, compulsive masturbation).	B.5. *Marked* physiological reactions to reminders of the traumatic event(s).	B.5. Same as Preschool Subtype	
C.4. Habitual (intentional or automatic) or *reactive* self-harm.		E.2. *Reckless* or self-destructive behavior.	
C.5. Inability to initiate or sustain *goal-directed* behavior.	C.4. Markedly diminished interest or participation in significant activities, including constriction of play. C.5. *Socially* withdrawn behavior.	D.5. Markedly diminished interest or participation in significant activities. D.6. Feelings of detachment or estrangement from others.	
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. *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:	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:	

Commented [JHK13]: How does this differ from **DTD** C.4. Criterion

Commented [JHK14]: How does this differ from **DTD** C.2 Criterion?

D.1. *Intense preoccupation* with safety of the caregiver or other loved ones (including precocious caregiving) or *difficulty tolerating reunion* with them after separation.	N/A	N/A	
D.2. Persistent negative sense of self, including self-loathing, helplessness, worthlessness, ineffectiveness, or defectiveness.	N/A	D.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"). D.3. Persistent, distorted cognitions about the *cause or consequences* of the traumatic event(s) that lead the individual to *blame* himself/herself or others.	
D.3. Extreme and persistent distrust, defiance, or lack of reciprocal *behavior* in close relationships with *adults or peers*.	N/A	D.6. *Feelings* of detachment or estrangement from *others*.	
D.4. Reactive physical or verbal aggression toward peers, caregivers, or other adults	D.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).	E.1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.	

Commented [JHK15]: Separation Anxiety Disorder: "They worry about the well-being or death of attachment figures, particularly when separated from them, and they need to know the whereabouts of their attachment figures and want to stay in touch with them." (DSM-5, p. 191)

Commented [JHK16]: Reactive Attachment Disorder: "the child shows a pattern of…highly *ambivalent* responses (e.g., *…resistance to comfort, or a mixture of approach and avoidance*)" [DSM-IV-TR, pp.127-128]. "Thus, the disorder is associated with the absence of expected comfort seeking and response to comforting behaviors." (DSM-5, p. 266)

Commented [JHK17]: Repeat from **DTD** B.1. Criterion

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.	N/A	N/A	
D.6. Impaired capacity to regulated empathic arousal as evidenced by lack of empathy for, or intolerance of, expressions of distress in others, or excessive responsiveness to the distress of others.	B.4. Intense or prolonged *psychological* distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).	B.4. Same as Preschool Subtype	**van der Kolk (2005)** • "Subsequently, when exposed to reminders of a trauma (eg, sensations, physiological states, images, sounds, situations), they tend to behave as if they were traumatized all over again — as a catastrophe." (pp. 3-4)
E. *Posttraumatic spectrum symptoms.* The child exhibits at *least one symptom* in at least two of the three posttraumatic stress disorder ([**DSM-IV-TR] PTSD**) symptom Clusters B (*the traumatic event is persistently reexperienced*), C *(persistent avoidance of stimuli associated with the trauma and numbing of general response*), and D *(persistent symptoms of increased arousal*)	B. Presence of *one (or more)* of the following *intrusion symptoms* associated with the traumatic event(s), beginning after the traumatic event(s) occurred: B.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.	B. Presence of *one (or more)* of the following *intrusion symptoms* associated with the traumatic event(s), beginning after the traumatic event(s) occurred: B.1. [Same as Preschool Subtype] **Note**: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.	**van der Kolk (2005)** • "Traumatized children…tend to communicate the nature of their traumatic past by repeating it in the form of interpersonal enactments, both in their play and in their fantasy lives. **van der Kolk (2005)** • "Chronically traumatized children tend to suffer from distinct *alterations in states of consciousness*,

Commented [JHK18]: **Disinhibited Social Engagement Disorder**: "Young children with the disorder fail to show reticence to approach, engage with, and even accompany adults. In preschool children, verbal and social intrusiveness appear most prominent, often accompanied by attention-seeking behavior. Verbal and physical overfamiliarity continue through middle childhood, accompanied by inauthentic expressions of emotion. (DSM-5, p. 270)

Commented [JHK19]: Ambivalent attachment style?

Commented [JHK20]: So why is DTD not a subtype of PTSD? For example: **Posttraumatic Stress Disorder, Developmental Type**. Considering that DTD is "anchored" in the core symptoms of PTSD (i.e., intrusion, avoidance, and arousal) and only differs because of the exposure source, the argument that DTD is "very distinct" from PTSD is very weak.

	B.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. 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).	B.2. [Same as Preschool Subtype] **Note**: In children, there may be frightening dreams without recognizable content. C. Same as Preschool Subtype C.1. Same as Preschool Subtype C.2. Same as Preschool Subtype	including…nightmares of specific events." (p. 4)

	E.4. Problems with concentration.	E.5. Same as Preschool Subtype	**van der Kolk (2005)** • "Chronically traumatized children tend to suffer from distinct *alterations in states of consciousness*, including…difficulties in attention regulation." (p. 4)
F. Duration of disturbance**.** Symptoms in DTD Criteria B, C, D, and E last *at least 6 months*.	E. The duration of the disturbance is *more than 1 month*.	F. Duration of the disturbance (*Criteria B, C, D, and E*) is more than 1 month.	
G. Functional impairment. The disturbance causes clinically significant distress or impairment in *at [sic] two of the following areas* of functioning:	F. The disturbance causes clinically significant distress or impairment in…	G. The disturbance causes clinically significant distress or impairment in…functioning.	**van der Kolk (2005)** • "Developmental trauma sets the stage for unfocused responses to subsequent stress leading to dramatic increases in the use of medical, correctional, social and mental health services." (p. 3) • "Numerous studies of traumatized children find problems with unmodulated aggression and impulse control, attentional and dissociative problems, and difficulty negotiating relationships with caregivers, peers, and, later in life, intimate partners." (p. 5)
Scholastic: Underperformance, nonattendance, disciplinary	…with school behavior	…or other important areas of functioning	

problems, dropout, 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, nonfulfillment of responsibilities within the family.	… in relationships with parents, siblings,…or other caregivers	…or other important areas of functioning	
Vocational (for youth involved in seeking or referred for employment, volunteer work, or job training): Disinterest in work/vocation, inability to get or keep jobs, persistent conflict with coworkers or supervisors, underemployment in relation to abilities, failure to achieve expectable advancements	N/A	occupational	
Health: Physical illness or problems that cannot be fully accounted for; physical injury or degeneration, involving the digestive, neurological (including conversion symptoms and analgesia),	N/A	…or other important areas of functioning	

sexual, immune, cardiopulmonary, proprioceptive, or sensory systems; severe headaches (including migraine); or chronic pain or fatigue.			
N/A	…peers	…social	
N/A	G. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition.	H. Same as Preschool Subtype	
N/A	*Specify* whether: **With dissociative symptoms**: The individual's symptoms meet the criteria for posttraumatic stress disorder, and 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).	Same as Preschool Subtype	

	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). **Note**: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts) or another medical condition (e.g., complex partial seizures).		
N/A	*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).	Same as Preschool Subtype	**Bishop, Rosenstein, Bakelaar & Seedat (2014)** • "Parents' emotional expression toward their children can have *long-lasting effects and contribute* to posttraumatic stress disorder and social anxiety disorder in later life." (p. 10)

Possible Reasons Developmental Trauma Disorder (DTD) Was Not Included in the DSM-5

- *Scarcity of Comprehensive Research*
  - "There is a paucity of studies on the age of onset of emotional developmental trauma (EDT) in people with PTSD and social anxiety disorder, underscoring the need for more investigation in this area to better inform the nature and timing of interventions." (Bishop, Rosenstein, Bakelaar & Seedat, 2014, p. 10)
  - Only one international study has attempted to apply the proposed DTD criteria: Klasen, F., Gehrke, J., Metzner, F. Blotevogel, M., and Okello, J. (September 2013). Complex trauma symptoms in former Ugandan child soldiers. *Journal of Aggression, Maltreatment & Trauma, 22*:7, 698-713, DOI: 10.1080/10926771.2013.814741
  - The first field test to apply the proposed DTD criteria to archival data [not real-time] of a sample of children in the United States: Stolbach, B.C., Minshew, R., Rompala, V., Dominguez, R.Z., Gazibara,T., and Finke, R. (July 2013). Complex trauma exposure and symptoms in Urban traumatized children: A preliminary test of proposed criteria for developmental trauma disorder. *Journal of Traumatic Stress, 26*: 483-491. doi:10.1002/jts.21826
- *Ford (2015)*
  - "The construct validity and diagnostic integrity of [complex] CPTSD have been challenged as not being grounded in ''a clear definition of the disorder, reliable and valid assessment measures, support for convergent and discriminant validity, and incremental validity with respect to implications for treatment planning and outcome'" (Resick et al., 2012, p. 241), (pp. 1-2).
  - "Research, therefore, is needed to test and refine the operational definition of the CPTSD features both as embedded in and distinct from other PTSD symptoms with adults who have experienced severe childhood traumatization - and to determine the construct validity of CPTSD in relation to personality disorders that involve similar features (Dorrepaal, Thomaes, Smit, et al., 2014; Ford & Courtois, 2014) - both embedded in and apart from the other features of ICD-11 and DSM-5 PTSD" (p. 2).
  - "Therefore, further tests of the construct validity of DTD and its relationship to polyvictimization are a research priority" (p. 2)
  - "However, varied definitions have been used to operationalize and inform assessments of these constructs representing the burden of traumatic exposure (Grasso, Greene, & Ford, 2013). Research is needed to develop and validate unified definitions and assessments of childhood polyvictimization and cumulative traumatic exposure" (p. 2).
  - Childhood traumas ([major altering life] MAL event, physical, sexual, emotional, and total) are not significantly different in individuals with PTSD and …severe early developmental trauma. (Bishop, Rosenstein, Bakelaar & Seedat, 2014)
- *Rahim (2014)*
  - "…the proposed criteria for DTD do not specifically mention attachment…" (p. 549)

- *Schmid et al., (2013)*
  - "A main argument against inclusion of formal DTD criteria into existing diagnostic systems is that emphasis on the etiology of the disorder might force current diagnostic systems to deviate from their purely descriptive nature. Furthermore, comorbidities and biological aspects of the disorder may be underdiagnosed using the DTD criteria." (p. 1)
  - "Many symptoms of borderline personality disorder or attachment disorder [with disinhibition] are included in the list of DTD symptoms, thus impeding the distinction between these disorders." (p. 7)
  - "DTD diagnosis favors a psychosocial explanation for the etiology of the disorders and neglects the biological explanations of the biopsychosocial model to understand the development of mental disorders." (p. 7)
  - "Diagnosing DTD implies that emotional dysregulation is caused by traumatic experiences but ignores the fact that the reverse relationship also exists." (p. 8)
  - "Although the proposed diagnostic criteria are meant to take the age and developmental status of the patient into account, symptoms are not sufficiently stipulated age-sensitive." (p. 8)
  - "For inexperienced professionals the concentration on trauma-related symptoms in the diagnostic process may result in a pressure to detect traumatic life events." (p.8)
- *Stolbach et al. (2013)*
  - "Because the proposed DTD criteria represent a new diagnostic entity, screening mechanisms and standardized measures for DTD have not yet been developed." (p. 484)
  - "More research is needed to answer these questions to further refine and validate the DTD construct." (p. 487)

Developmental Trauma Disorder (DTD) Diagnostic Options Using DSM-5

1. *Posttraumatic Stress Disorder, Preschool Subtype (before age 6 years)*

   Rationale:
   - The prevalence of PTSD may vary across *development*; children and adolescents, *including preschool children*, generally have displayed lower prevalence following exposure to serious traumatic events; however, t*his may be because previous criteria were insufficiently developmentally informed* (Scheeringa et al. 2011). Young children are more likely to express reexperiencing symptoms through play that refers directly or symbolically to the trauma.
   - "Based on an exhaustive research review, the PTSD diagnostic criteria in the DSM-5 were substantially expanded to include symptoms consistent with each CPTSD domain." (p. 2)
   - "Two decades ago, complex PTSD (CPTSD) was defined as a syndrome involving pathological dissociation, emotion dysregulation, somatization, and altered core schemas of self, relationships, and sustaining beliefs (morality and spirituality) in the aftermath of traumatic victimization (Herman, 1992). …Thus, the complex PTSD definition proposed for the ICD-11 is largely incorporated into DSM-5 PTSD." (Ford, 2015, p. 1)
   - Early developmental trauma (EDT) or childhood trauma may loosely be defined as any traumatic experience that occurs before 18 years of age. (Bernstein (1998)

2. *Other Specified Trauma- and Stressor-Related Disorder (Developmental Trauma Disorder)*

   "This category applies to presentations in which symptoms characteristic of a trauma- and stressor-related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the trauma- and stressor-related disorders diagnostic class. The other specified trauma- and stressor-related disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific trauma- and stressor-related disorder. This is done by recording 'other specified trauma- and stressor-related disorder' followed by the specific reason (e.g., 'persistent complex bereavement disorder')." (DSM-5, p. 289)

3. *Other Specified Mental Disorder (Developmental Trauma Disorder)*

   "This category applies to presentations in which symptoms characteristic of a mental disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any specific mental disorder. The other specified mental disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific mental disorder. This is done by recording 'other specified mental disorder' followed by the specific reason." (DSM-5, p. 708)

4. *Other Conditions That May Be a Focus of Clinical Attention With DTD (DSM-5, pp. 715-727)*
    - Relational Problems
        - Problems Related to Family Upbringing
            - Parent-Child Relational Problem
            - Upbringing Away From Parents
            - Child Affected by Parental Relationship Distress
        - Other Problems Related to Primary Support Group
            - Disruption of Family by Separation or Divorce
            - High Expressed Emotion Level Within Family
    - Abuse and Neglect
        - Child Maltreatment and Neglect Problems
            - Child Physical Abuse, Confirmed
            - Other Circumstances Related to Child Physical Abuse
                - Encounter for mental health services for victim of child abuse by parent
                - Encounter for mental health services for victim of nonparental child abuse
                - Personal history (past history) of physical abuse in childhood
            - Child Sexual Abuse, Confirmed
            - Other Circumstances Related to Child Sexual Abuse
                - Encounter for mental health services for victim of child sexual abuse by parent
                - Encounter for mental health services for victim of nonparental child sexual abuse
                - Personal history (past history) of sexual abuse in childhood
        - Child Neglect
            - Child Neglect, Confirmed
            - Other Circumstances Related to Child Neglect
                - Encounter for mental health services for victim of child neglect by parent
                - Encounter for mental health services for victim of nonparental child neglect
                - Personal history (past history) of neglect in childhood
        - Child Psychological Abuse
            - Child Psychological Abuse, Confirmed
                - Encounter for mental health services for victim of child psychological abuse by parent
                - Encounter for mental health services for victim of nonparental child psychological abuse
                - Personal history (past history) of psychological abuse in childhood

- Educational and Occupational Problems
  - Educational Problems
    - Academic or Educational Problem
- Housing and Economic Problems
  - Housing Problems
    - Homelessness
    - Inadequate Housing
  - Economic Problems
    - Lack of Adequate Food or Safe Drinking Water
    - Extreme Poverty
    - Low Income
    - Insufficient Social Insurance or Welfare Support
- Other Problems Related to the Social Environment
  - Social Exclusion or Rejection
  - Target of (Perceived) Adverse Discrimination or Persecution
- Problems Related to Crime or Interaction With the Legal System
  - Victim of Crime
- Other Circumstances of Personal History
  - Other Personal History of Psychological Trauma
  - Personal History of Self-Harm

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