



CLINICAL PERSPECTIVES

Commentary: Developmental Trauma Disorder: A Missed Opportunity in DSM V

This is a commentary on the proposal of van der Kolk, et al. (2009) to include the diagnosis of developmental trauma disorder in the DSM V. As is now known, it was not accepted. Importantly, a commentary relating to this must include comments on both *diagnosis* and *trauma* in children. We will first comment on general issues of diagnostic systems in child psychiatry and then, if we are to use DSM V, why there should be a separate category for developmental trauma.

The issue of diagnosis

It was Professor Assen Jablensky (1987, 2001) who reminded us that the very word 'dia-gnosis' is from the Greek 'Gnostic' – meaning 'relating to knowledge' (interestingly, as it related to a 2nd or 3rd century Greek movement created to *challenge the orthodox* of the time). We certainly need that same momentum now in child psychiatry. The professor went onto to define 'disease' as '*that something*' which underlies signs and symptoms...versus 'classification,' which deals in categories and dimensions. He summarized, "Categories can hide the realities of things"...something we see in everyday clinical practice. Relatedly, George Box (a well known figure in the area of diagnostic model building) famously stated that "All models are wrong but some are useful" (Box & Draper, 1987). This remains as true today as ever. DSM constructs were originally formed from fixed or static psychopathology states in adulthood, mostly aimed at studying epidemiology. These were previously referred to as research diagnostic criteria. By definition, these do not capture the: (a) developmental; (b) progressive; (c) strength based; and (d) resilient contexts that children require. We are thus obliged to acquire a new model, based on the arguments of many researchers and clinicians. Diagnosis in children should clearly consider developmental psychopathology, attachment theory, neuropsychology

and plasticity, as well as resiliency factors (Carrey 2008). Furthermore, Carrey and Gregson (2008) critically point out that there is need for a more flexible diagnostic system to consider emerging data from both genetic and environment interactional studies within the framework of attachment, developmental and systems theory.

Complexities of trauma

If we are to still use DSM V, we might go as far to say that if the Editors of DSM V wanted *only one* trauma diagnosis, then arguably it should have been developmental trauma disorder. Through clinical experience, it is known that even a single event of trauma in adulthood can significantly alter the ongoing developmental trajectory of that adult brain and mind, which may impact the individual in various bio-psycho-social-spiritual ways. A developmental approach to understanding disorders of trauma would support the imperative notion that such a diagnosis is complicated, in that there are constant changes with the individual child/youth/adult (genetically and otherwise) that are further complicated by the individual's interaction with his/her environment. Further, a developmental approach would appropriately recognize the interactive effect of such dynamics of familial systems, as well as cultural and societal expectations. In children and youth, the altered trajectory of development from *ongoing trauma* from *caregivers* over *several developmental periods* is simply more profound and evident across a wider spectrum of developmental domains than adults.

The evolution of trauma diagnoses began with 'battle fatigue' springing from the first and second WW veterans and evolved into DSM criteria of post-traumatic stress disorder (PTSD) in DSM II (ICD-8), III (ICD-9), IV and remains little changed in DSM V. The natural prognosis of trauma reveals ongoing disruption over multiple time periods (i.e.

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layered over decades), still revealed in living World War II vets in their nineties. We would suggest that a developmental trauma disorder could be conceived along a 'spectrum diagnosis,' a notion DSM is currently embracing (see autism disorders), but with the domain of trauma encompassing *all* age groups.

We see a clear convergence of events currently upon us as to why this field of trauma in children is an important opportunity *we must properly conceptualize* in order to forward this area of medicine. This confluence includes: (1) adverse childhood experiences (ACE) outcomes as reported by Felitti et al. (2007; 2008), which so clearly identifies the genesis of chronic medical illness; (2) the imprecision of DSM PTSD criteria for developmental trauma (our only present diagnostic option), which captures only a minority of these trauma cases, as low as 5 to 25% on two large data bases... CANS dataset (Illinois DCFS screen of 7,668 foster children) and NCTSN dataset (Pynoos et al. 2008), together totaling over 17,000 children who experienced *multiple forms of trauma*; and, (3) much greater knowledge of the effect upon neurobiology and developmental psychopathology, following chronic interpersonal trauma. In an attempt to forward this 'moment of opportunity', van der Kolk et al. (2009) sent in their proposal to the DSM V editors advocating that developmental trauma disorder be included.

In this proposal, the history of formulating trauma disorders in children is reviewed. In order to address the complicated nature of trauma and its impact on an individual, terms such as developmental PTSD, complex PTSD, disorders of extreme stress, not otherwise specified (DESNOS) and relational trauma have been introduced to try to capture the developmental psychopathology involved. As pointed out in their proposal, the problem is that following chronic trauma, current clinical practice often reveals *no diagnosis, inaccurate diagnosis* (see Letter to the Editor this Journal, Bremness, A., Polzin, W.) *or inadequate diagnosis*...all of which leads to misguided or complete lack of treatment plans. Further, because there is almost always considerable dysregulation of body (sensory and motor), affect (explosive/irritable or frozen/restricted), cognition (altered perceptions of beliefs, auditory and sensory-perceptual flashbacks and dissociation) and behaviour (multiple forms of regression), the diagnoses of bipolar, oppositional defiant disorder/conduct disorder, attention deficit hyperactivity disorder (ADHD) or other anxiety disorders are confusingly made. Many of these disorders are co-morbid with developmental trauma disorder anyway, as they tend to cluster in these complex families. But the importance is that the *developmental trauma disorder would be primary and thus guide the treatment plan*...and further refine the inclusion (or not) of other co-morbid disorders.

It was van der Kolk (2005) who initially proposed developmental trauma disorder to capture the spectrum of dysregulation in children exposed to interpersonal violence

and pathologic care-giving. The National Child Traumatic Stress Network was then formed to gather consensus on the criteria for developmental trauma disorder. Based on these *consensus criteria* it would now be possible to do field trials on the following domains regarding validity and reliability: exposure (two of two criteria); affective and psychological dysregulation (two of four criteria); attentional and behavioral dysregulation (three of five criteria); self and relational dysregulation (three of six criteria); post traumatic spectrum symptoms (two of three from clusters B, C and D); duration of disturbance (at least six months); and, functional impairment (two of the following six...scholastic, family, peers, legal, health and vocational). Structured diagnostic interviews were used. Through this, van der Kolk outlines the dataset of many thousands of children from various longitudinal studies and goes into great detail about each domain and its diagnostic criteria.

On the important discussion of validity and reliability, van der Kolk (2005) points out in this proposal that developmental trauma disorder does fulfill *the DSM definition* of a 'mental disorder' and (although many necessary specific studies have not yet been conducted in this area of developmental trauma disorder) *moves towards validity* when DSM V Spectrum Study Group's validators are applied; namely: *neural substrates* (neuroendocrine, neuroimaging, and EEG abnormalities); *familiarity* (evidence of intergenerational transmission); *epi-genetic risk factors* (G x E); *specific environmental risk factors* (clearly predict developmental trauma disorder); *biomarkers* (changes in stress hormones); *temperamental antecedents* (behavioral inhibition, social avoidance); *symptom similarity* (affective, behavioral, relational and stress response systems); *abnormality of cognitive or emotional processing* (various studies validate this); *course of illness* (chronic deterioration with episodic spikes in severity in children and persistence over the lifespan); *high rates of co-morbidity* (a wide spectrum); and lastly, *treatment response* (poor so far).

van der Kolk (2005) addresses the question of 'sufficient distinction' from other disorders (using the above validators) and contrasts developmental trauma disorder with: classical post-traumatic stress disorder; depression; attention deficit hyperactivity disorder; oppositional defiant disorder; reactive attachment disorder; separation anxiety disorder; bipolar disorder; dissociative disorders (avoids the primacy of depersonalization, derealization and alter personalities); and, personality disorders. He concludes that that developmental trauma disorder is "distinct from these disorders...although often co-existing with many of them." As to the next DSM question of 'sufficiently distinct from normal,' he relates back to the enormous data set from longitudinal studies and concludes developmental trauma disorder has "predictive validity", as exposure criteria clearly predict significant functional impairment. He then addresses 'sufficient clinical utility' (affirmatively as agreed upon by several national, multidisciplinary networks studying

this field); 'non-zero prevalence' (prevalence yet to be field trialed, but large data bases support high prevalence); and, are the 'diagnostic criteria both reliable and easily implemented clinically.' The answer is affirmative to both. As to the final question of 'should there be acceptance into DSM V', he advocated 'yes' but points out the limitations of a relatively young field and lack of studies in several specific areas. This is, of course, the work that remains for the rest of us. The proposal then sites 58 references current to this field to help guide us.

The Clinics of North America in Child Psychiatry (April, 2007), devoted a complete volume to resiliency where the guest editors (Carrey, Ungar) set out the challenge for conceiving diagnosis in child psychiatry in terms of developmental psychopathology, attachment theory and resiliency factors. Utilizing these foundations, all of the following tenets are the basis of arguing strongly for a separate and distinct category in DSM of developmental trauma disorder: (a) traumatization over several developmental periods; (b) traumatization in various ways (physical, mental, sexual and particularly neglect); and, (c) being hurt by the very people charged with loving and protecting them (inadequate, harmful, unsafe and even toxic care-giving, rather than hurt by an anonymous person in a single event, which could suffice for PTSD).

In our Trauma Attachment Group (TAG) Program in Edmonton, Canada, we have clinically incorporated this diagnostic concept for at least a decade and find it very useful, both from a clinical treatment perspective but also as a theoretical model for understanding change and intervention across a developmental, generational, and cultural perspective. The problem is glaring in Canada as elsewhere. In Alberta for example, a total of 145 children 'in care' died between January, 1999 and June, 2013 (Kleiss & Henton, 2013). This included 57 babies (often 'cause unidentified' but one wonders about the concept of 'anaclitic depression' in infants as described by René Spitz) and 51 teens (14 by suicide). In 2011-12 alone there were 8,700 children in care in Alberta. In this population, there were 11 *reported* deaths and many unreported injuries related to suicidal, homicidal and other high risk behavior...and, chronic, untold misery from family, peer, academic and personal *failures*. Much of this, we believe, comes from not understanding and/or adequately identifying (and therefore, not appropriately treating) developmental trauma disorder. This condition is rampant in foster, adopted as well as kinship care populations, and particularly in First Nation populations...as are the accompanying severe attachment disorders and the full array of diverse learning, behavioral, and emotional co-morbidity that invariably come with developmental trauma disorder. Yet there is reason for optimism, as we have found better outcomes than current prognosis predicts. This is especially true if the program remains open to the findings of a rapidly evolving field of bio-psycho-social-spiritual treatments (see the current work of van der Kolk, Bruce Perry, Daniel

Siegel, Diana Fosha, A Becker-Weidman, Judith Herman, Sandra Bloom and many others), is culturally and trauma informed,...and, is granted a consistent multidisciplinary team to actively treat and supportively 'hold' these very complex and challenging cases over years.

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