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April T. Salvaterra
Clinicians' Diagnostic
Evaluation of Chronic
Childhood Trauma: An
Examination of the Clinical
Utility of Developmental
Trauma Disorder

ABSTRACT

In this study licensed mental health clinicians working with traumatized children and adolescents participated in a mixed method web survey examining professional opinions on the provisional Developmental Trauma Disorder diagnosis submitted for inclusion in the DSM-V. It was found that 88.3% of participating clinicians agreed that the diagnostic criteria for Developmental Trauma Disorder adequately described the symptomatology displayed by their clients with histories of complex trauma. Eighty-six percent of clinicians reported that they would assign their clients a diagnosis of DTD were it available in the current DSM-IV, and 75.5% of those clinicians said they would use DTD in place of one or more of the client's current diagnoses. Interestingly it was also found that symptoms described exclusively by DTD were among the most commonly reported symptoms for chronically traumatized clients. Affect dysregulation, impulsivity, anxious mood, lack of focus and attention, social and relational impairments, physical aggression, and hyperarousal and hypervigilance are all crucial aspects of DTD's diagnostic criteria and were most frequently observed in the traumatized client sample. The results of this study imply that DTD may in fact describe the symptomatology presented by chronically traumatized children and adolescents and may serve as a potentially useful assessment tool in the field of childhood trauma. The

inclusion of Developmental Trauma Disorder in the DSM-V is supported by this study's clinical sample and has the potential to lead to more effective treatment interventions and outcomes with this population.

CLINICIANS' DIAGNOSTIC EVALUATION OF CHRONIC CHILDHOOD
TRAUMA: AN EXAMINATION OF THE CLINICAL UTILITY OF
DEVELOPMENTAL TRAUMA DISORDER

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work

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2010

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To my sister Emily, your strength of spirit and dedication are truly inspiring.

Finally, I dedicate this paper to the young boys of Griffith Hall at the Andrus Children's Center in Yonkers, NY. You have taught me more about empathy, resilience, and love than you will ever know. You are the faces behind the statistics and the living evidence that awareness, compassion, and hope stand strong in the face of tragedy.

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CHAPTER I

INTRODUCTION

Since the inclusion of Post Traumatic Stress Disorder in the Diagnostic and Statistical Manual-III in 1980, conceptualization of PTSD has progressed significantly. While researchers have primarily focused their attention on the adult's reaction to trauma, few studies have been conducted on how children respond to chronic trauma exposure at varying developmental stages. The only current diagnosis in use at this time for childhood trauma is the designed-for-adults PTSD, as we have yet to see a childhood trauma diagnosis officially approved by the American Psychiatric Association. The exposure criteria for PTSD includes having “experienced, witnessed, or have been confronted with an event or events that involved actual or threatened death or serious injury, or threat to physical integrity of self or others” (American Psychiatric Association, 2000). This definition does encompass many of the most stressful and overwhelming human experiences one can endure, but it does not address many of the terrifying experiences faced by children raised in abusive and neglectful homes (Bloome, 2002).

Several studies have shown that traumatized children present different symptomatology than adults, particularly after exposure to chronic, early onset, and/or interpersonal trauma (Najjar, Weller, Weisbrot, & Weller, 2008; D'Andrea, Spinazzola, van der Kolk, 2009; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005; Terr, 1990; Pynoos, Fairbank, Briggs-King,

Steinberg, Layne, Stolbach, et al., 2008; Kinniburgh, Blaustein, & Spinazzola, 2005; D'Andrea, Spinazzola, & van der Kolk, 2009; Briere & Spinazzola, 2005). Those children and adolescents exposed to chronic maltreatment and repeated traumatization may have pervasive impairments in the development of the mind and brain (Margolin & Vickerman, 2007). Furthermore, those who are victimized at the hands of caregivers tend to suffer insecure attachments and have vast impairments in affect regulation (Margolin & Vickerman, 2007).

Bessel van der Kolk (2005) and the Complex Trauma Taskforce of the National Child Traumatic Stress Network have submitted a developmentally appropriate diagnosis, Developmental Trauma Disorder, (DTD), for inclusion in the DSM-V, which accounts for developmental age and exposure chronicity. The current study surveyed clinicians on their opinion of DTD's clinical utility as it pertains to the children and adolescents they see in their practice. Clinicians were given the formal criterion for DTD submitted to the APA and were asked whether they think the diagnostic criterion for DTD adequately describe the symptomatology displayed by their chronically traumatized child and adolescent clients. Clinicians were also asked whether they would employ the DTD diagnosis were it available in the current DSM-IV and if they would use it in place of any of the client's current diagnoses. Finally, clinicians were given the opportunity to supply any additional comments regarding their professional opinion of the DTD diagnosis.

CHAPTER II

LITERATURE REVIEW

Childhood trauma is one of the greatest adversities facing our nation's children today. Each year over 3 million children are reported to authorities for abuse and neglect charges, with approximately 1 million cases substantiated. A remarkable number of children are familiar with their abusers as 80% of those responsible for childhood trauma are the children's own parents (van der Kolk, 2005). The National Institute of Justice also approximates that the combined cost of childhood abuse, including mental health care, social services, medical care, and police services is \$4,379 per incident of child abuse, making it one of the greatest public health concerns in the country (Anda et al., 2006). Additionally, thousands of children undergo traumatic medical and surgical procedures, and are victims of natural disasters, accidents, and community violence (Agency for Children and Families, 2003).

The researchers in the Adverse Childhood Experiences (ACE) study (Felitti, Anda, & Nordenberg, 1998), a large study of 17,337 adults, looked at the effects of adverse childhood experiences on adult health decades later. The study found that childhood trauma is immensely more common than recognized or acknowledged. Eleven percent of adults in the study reported having been emotionally abused as a child, 18.8% reported being exposed to family mental illness, 19.9 % reported sexual abuse, 23.5% reported being exposed to family alcohol abuse, and 30.1% reported physical abuse. Twelve and a half percent of

adults also reported witnessing their mothers being battered; and 4.9% reported family drug abuse. These traumas were shown to have a powerful correlation to adult health even 50 years later: as ACE scores rise, so does the prevalence of smoking, intravenous drug use, obesity, chronic obstructive pulmonary disease, heart disease, cancer, stroke, diabetes, skeletal fractures, depression, sexual promiscuity, sexually transmitted diseases, physical inactivity, and attempted suicide (Felitti, Anda, Norderberg, et. al, 1998).

These figures coincide with results from other studies that have found between 17 and 33% of women in the general public report histories of sexual and/or physical abuse during childhood (Finkelhor, Hotaling, Lewis, & Smith, 1990; Kessler et al., 1995). In mental health settings these percentages rise to 35 to 50% (Cloitre, Cohen, Han & Edelman, 2001). Half as many women report instances of adult rape as do women who report histories of childhood sexual abuse with approximately 10% of women in the general population reporting adult rape (Breslau, Davis, Andreski, Peterson, & Schultz, 1997; Kesler et al, 1995). Sixty-one percent of all rapes occur before the victim turns 18, and 29% of forcible rapes occur before the age of 11 (Acierno, Resnick, Kilpatrick, Saunders, & Best, 1999). Epidemiological research has also found that childhood abuse is the most common cause of traumatization in women, whereas men are more frequently traumatized by assault, war, accidents, and natural disasters throughout the span of their lifetime (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995).

Even with the large percentage of adults reporting histories of childhood abuse and the 1 million substantiated cases of child abuse each year, PTSD is not the most common diagnosis given to abused children. Separation Anxiety

Disorder, Oppositional Defiant Disorder, and phobic disorders are all more common than PTSD; with ADHD quite common for children with trauma histories as well (van der Kolk, Pynoos, et al., 2009; Putnam, 2003). These findings are also supported by the DSM-IV field trial that suggests trauma has its most pervasive impact in the first decade of life and becomes more like “pure” PTSD with age (van der Kolk et. al, 2005). Still the prevalence of PTSD diagnoses in adolescents ages 16 to 22 years old in the general population is only 3% in females and 1% in males (Najjar, Weller, Weisbrot, & Weller, 2008) even though reports of childhood abuse are much higher.

It is important to note that not all children exposed to trauma will develop pathological responses; however, the shortage in trauma related diagnoses for children with trauma histories may be a large indicator that the current DSM-IV (APA, 2000) does not supply a diagnosis that adequately captures the clinical presentation of childhood trauma. For instance, of those children in treatment for trauma related psychopathology with the National Child Traumatic Stress Network, less than a quarter meet criteria for PTSD (Pynoos et al., 2008). Additionally, in the absence of a developmentally sensitive trauma-specific diagnosis for children, it is not unusual for such children to be diagnosed with three to eight Axis I and Axis II disorders (Putnam, 2008).

The only trauma related diagnosis in the DSM –IV used for both children and adults is Post Traumatic Stress Disorder, which was created in response to the large number of Vietnam veterans returning home with psychiatric problems. In the late 1970’s, only a small sum of research had been written on “traumatic neuroses.” Therefore, the DSM committee had to rely on clinical descriptions of

trauma reactions observed in primarily male combat veterans for developing the criteria of the original PTSD diagnosis (Shatan, Smith, & Haley, 1977). The three main symptom clusters developed for the DSM-III in 1980, re-experience, avoidance, and hyperarousal, are virtually unchanged in the current DSM-IV (2000) implying that today's traumatized children are still measured against criteria developed around the experience of male combat veterans over 30 years ago.

Recent trends in mental health practice have begun to view trauma as a more subjective experience in which the details of the event are not as important as the reaction of the victim (Bloom, 2003). Lenore Terr (1990), a child psychiatrist who did one of the first longitudinal studies on traumatized children, described trauma as a sudden, unexpected, overwhelming, intense emotional blow, or series of blows, that assaults the individual from outside. These traumatic events happen externally but are quickly incorporated into the mind.

Exposure criteria for PTSD in the current DSM-IV is written as “experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or threat to physical integrity of self or others” (p. 467, American Psychiatric Association, 2000). This definition includes many of the most stressful and overwhelming human experiences one can endure but does not address the complicated and continual traumas related to interpersonal childhood abuse, particularly those abuses that occur at the hands of a caregiver (van der Kolk, 2005; D’Andrea, Spinazzola, & van der Kolk, 2009; van der Kolk et al, 2009). Isolated traumatic incidents, even in children

and adolescents, tend to produce discrete conditioned behavioral responses similar to those seen in adults with PTSD. This differs however, from children exposed to “complex trauma” which is “multiple and/or chronic and prolonged developmentally adverse traumatic events, most often of an interpersonal nature and early-life onset” (van der Kolk, 2007, p.227).

Children with histories of complex trauma may have pervasive impairments in the development of the mind and brain, including deficits in the ability to integrate sensory, emotional, and cognitive information in an organized whole. Additionally, complex trauma that occurs at the hands of caregivers tends to lead to insecure attachments and has vast impairments on affect regulation, interpersonal relational development, impulse control, and can lead to attentional and dissociative problems (Margolin & Vickerman, 2007; van der Kolk, 2007).

Although the current DSM-IV does not have a specific diagnosis dedicated to the distinct symptomatology seen in child victims of trauma, it does allocate a section in the PTSD chapter to associated symptoms often seen in children. This cluster of symptoms is referred to as DESNOS or Disorder of Extreme Stress Not Otherwise Specified (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005; Briere & Spinazzola, 2005). These symptoms are seen most frequently in children with complex trauma and present as impairments in six clusters:

Altered Self-Capacities

These impairments are usually seen when trauma results in disrupted attachment and include dysfunction in areas of identity, affect regulation, and

interpersonal relatedness. These impairments in turn often lead to maladaptive thinking and behavior patterns including suicidal ideation, impulse control, and substance abuse.

Cognitive Disturbance

This impairment is seen in the form of low self-esteem, self blame, helplessness, hopelessness, expectations of rejection and loss, and an overestimation of the amount of danger in the world.

Mood Disturbance

This cluster involves symptoms or disorder involving anxiety, depression, anger, and aggression.

Overdeveloped Avoidance Responses

These symptoms are most common with traumas that occur early in life and are sustained over time. Such responses include dissociation, substance abuse, and tension reducing behaviors such as compulsive sexual behavior, bingeing and purging, self-mutilation and suicidality.

Somatoform Distress

This cluster refers to symptoms of bodily distress or dysfunction that stem from psychological distress. When trauma distress cannot be processed or expressed verbally it often manifests itself in bodily experiences of pain, discomfort, and illness.

Posttraumatic Stress

This cluster includes symptoms seen in classic PTSD such as intrusive thoughts or reexperiences in the form of flashback or nightmares, avoidance of

traumatic triggers, emotional numbing, hypervigilance, and increased startle response (Briere & Spinazzola, 2005).

The current PTSD diagnosis in the DSM-IV does not capture the multiplicity of adverse child exposures over important developmental periods in childhood. Bessel van der Kolk and the Complex Trauma Taskforce of the National Child Traumatic Stress Network have attempted to conceptualize a clearer picture of how complex trauma affects developing children and have incorporated the clusters of impairment described by DESNOS in their new diagnosis (D’Andrea, Spinazzola, & van der Kolk, 2009). Developmental Trauma Disorder, or DTD, is a provisional diagnosis submitted for inclusion in the DSM-V. 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” (van der Kolk, 2005, p. 405).

Developmental Trauma Disorder was conceived on the idea that exposure to chronic interpersonal trauma results in a set of coherent symptoms which have specificity and are not accounted for by any DSM –IV diagnosis. These symptoms build on those described in DESNOS and include dysregulation of affect and behavior, disturbances of attention and consciousness, distortions in attributions, and interpersonal difficulties (D’andrea, Spinazzola, van der Kolk, 2009; Kinniburgh, Blaustein, & Spinazzola, 2005).

Historically, studies have found that children exposed to maltreatment and interpersonal violence have exhibited symptoms consistent with those

described by Developmental Trauma Disorder. An early study on maltreatment by Bradley (1986) found maltreated children presented with decreased cognitive functioning, poor social functioning, and oppositional behaviors. Teisl and Cicchetti (2008) found children with a history of physical abuse displayed lower cognitive processing, affect regulation, and aggressive cue interpretation compared to non-abused peers. Bailey, Moran, & Penderson (2007) found struggles with self-regulation, interpersonal relationships, attributions, and cognition in a sample of at-risk youth. The maltreated group of this sample showed an increase in self-harming behaviors, interpersonal conflict, identity confusion, and dissociation. Another study found that just witnessing domestic trauma was significantly related to negative world views, affect regulation, externalizing behaviors and aggression, and social problems (Kitzman, Gaylord, Holt, & Kenny, 2003). Additionally, Spinazzola et al. (2005) found that affect dysregulation, inattention, poor self-image, and decreased impulse control were present in more than half his sample of maltreated children, implying that these symptoms are often co-occurring. This data combines to suggest that there is a grouping of symptoms commonly seen in abused children that are not currently covered by any existing diagnosis.

Studies on the brain development and central nervous system functioning of both abused children and adult survivors of childhood trauma have produced findings consistent with the symptomatology found in the studies above. Tulper and De Bellis (2006) found increased hippocampal volume was associated with interpersonal trauma and that the range of increase was associated with the age

of trauma and externalizing behaviors. Another study found that cortisol, a stress hormone associated with traumatic events, can lead to hippocampal atrophy and that elevations in cortisol levels related to childhood interpersonal trauma predicted hippocampal volume reduction over time (Weems & Carrion, 2007). De Bellis (2002) also found a difference in the decreased volume in the corpus callosum, prefrontal cortices, temporal lobe, and an increase volume in the superior temporal gyrus in traumatized children with a diagnosis of PTSD as opposed to those maltreated children without PTSD. Duration and age of trauma were also significantly positively related with brain volumes.

DTD's developmentally sensitive criteria address the full spectrum of individual and relational functioning overlooked by PTSD and by doing so account for much of the symptomatology covered by co-morbid and excessive diagnoses. Several diagnoses are commonly used to describe the specific set of symptoms displayed by chronically traumatized children, specifically PTSD, ADHD, Oppositional Defiant Disorder, Reactive Attachment Disorder, and Bipolar Disorder. PTSD is the most similar to DTD as DTD incorporates classic trauma symptoms of re-experience, avoidance and hypervigilance but DTD quickly differentiates itself as a childhood trauma diagnosis by requiring an absence or disruption of protective caregiving which is not seen in PTSD (D'Andrea, Spinazzola, & van der Kolk; van der Kolk et al, 2009). DTD goes further to distinguish the difference between hypervigilance and impulsivity by describing impulsivity as a means to self-soothe, affect dysregulation unrelated to hyperarousal, interpersonal difficulties as a consequence of long standing

insecure attachment, and a distorted perception of others rather than impairments in social functioning (D'Andrea, Spinazzola, & van der Kolk., 2009).

DTD also shares overlaps with ADHD, as deficits in attention, consciousness, and cognition are key symptoms in both. In DTD inattention, hyperactivity, and decreases in cognition are the result of emotional distress, which is not the case in ADHD. The chronic dissociation seen in DTD is similar to inattention in ADHD but the sense of depersonalization and derealization seen in dissociation differ from focus and attention problems often seen in school settings. Additionally, DTD and ADHD appear to share risky, impulsive, and dysregulated behavior but the traumatized child in DTD engages in these behaviors due to affective instability and attempts to self soothe. Furthermore, a child with pure ADHD tends to exhibit symptoms consistently in a range of environments whereas a child with DTD presents fluctuations between impulsive and hyperaroused behavior with withdrawn and flat affect (D'Andrea et al., 2009). In short, the major differentiating factor between ADHD and DTD is the traumatized child's use of maladaptive coping skills, skills often misconstrued when not viewed through a trauma-focused lens. Sadly, this lens is rarely applied in practice, as diagnoses of ADHD are far more frequent for survivors of childhood interpersonal trauma than PTSD (D'Andrea et al., 2009; Endo et al., 2006; Briscoe-Smith & Hinshaw, 2006).

Oppositional Defiant Disorder shares overlaps with DTD in symptom areas of temper loss, defiance, and argumentative and annoyed behavior and mood. However, ODD symptoms of blaming, intentionally annoying others, and

spiteful and vindictive behaviors is not incorporated in DTD. DTD describes a wide range of emotional dysregulation beyond the anger and resentment seen in ODD and includes behavioral problems related to self-harm, self-blame, and insecurity (van der Kolk et al, 2009).

Reactive Attachment Disorder and DTD are similar in that they both arise from severe disruptions in protective caregiving. RAD is characterized by social inhibition and disinhibition, which look much like DTD's symptoms of disengagement and distrust as well as behavioral and relational dysregulation. RAD also neglects to account for the effects of interpersonal violence, affect dysregulation, behavioral aggression, self-harm and self-soothing, and a persistent negative view of self (van der Kolk et al, 2009).

Bipolar Disorder and DTD share some overlap as both diagnoses describe impulsivity, affect dysregulation and breaks with reality. However, again as with ADHD, Bipolar Disorder's impulsivity is not viewed as a means of self-soothing and tension reduction as it is in DTD. Abused children are also much more labile than those with classic Bipolar Disorder whose cycles in mood are slower than the moment to moment shifts experienced by children with DTD. Additionally, children with Bipolar Disorder often experience grandiosity during manic states, whereas the impulsive and hyperaroused traumatized children described by DTD tend to have little self-esteem and often view themselves as damaged (D'Andrea et al., 2009).

Neglecting to view maltreated children through a trauma-focused lens often results in the misuse of non-trauma related diagnoses. It can be

hypothesized then that these abused children would show resistance to non-trauma-focused treatments. Several studies have been conducted to examine this issue. Pavuluri (2006) looked at the responses to lithium in a sample of children diagnosed with Bipolar Disorder finding that a history of physical or sexual abuse predicted a non-response to the drug. Another study found that abused adolescents did worse than non-abused adolescents in non-trauma-focused substance abuse treatment (Grella & Joshi, 2003). These effects are likely to last into adulthood as Ford and colleagues (2007) found that DTD symptoms predicted poor substance abuse treatment outcomes in adults.

Fortunately, research has also shown that maltreated children, even those without a trauma-related diagnosis, have better results when treated with trauma informed interventions (Copping, 2001; Greenwald & Rule, 2002; Becker-Weidman, 2006; Dozer et al, 2006; D'Andrea et al., 2009). Copping and colleagues (2001) found that child survivors of interpersonal childhood trauma showed improvements in DTD symptoms after they received treatment focused on trauma and attachment. Another study found that a sample of boys with diagnoses of Conduct Disorder showed symptom improvement after implementing trauma-focused EMDR while those given standard care showed negligible improvement (Greenwald & Rule, 2002). A study of 64 children with Reactive Attachment Disorder showed that 100% of the sample had histories of severe, interpersonal childhood trauma and that DTD symptoms improved with attachment focused dyadic therapy with caregivers (Becker-Weidman, 2006). Dozier et al (2006) found that an intervention targeted at attachment and

emotional regulation showed improvement in cortisol levels and behavior in a sample of abused toddlers.

Extensive descriptive literature on Developmental Trauma Disorder is readily available and most researchers agree that the current adult PTSD diagnosis is not suitable for children with complex trauma (van der Kolk, 2005; Najjar, Weller, Weisbrot, & Weller, 2008; D'Andrea, Spinazzola, & van der Kolk, 2009). Surprisingly there has been very little research on the applicability of Developmental Trauma Disorder to abused children currently receiving treatment. The current study fills that gap by examining clinicians' professional opinions of the provisional DTD criteria including whether or not they feel it is an appropriate depiction of the symptomatology presented by their traumatized child clients.

CHAPTER III

METHODOLOGY

This study is an examination of clinicians' opinions on the clinical utility of the proposed diagnostic criteria for Developmental Trauma Disorder. Licensed mental health clinicians reported information on child and adolescent clients in a mixed method web survey.

Sample

To participate in the survey, participants were required to meet certain eligibility criteria. Eligible clinicians must have been capable of assigning mental health diagnoses to their clients, worked with the traumatized child or adolescent in a mental health treatment setting within the past year, had access to a computer with email, and were fluent in English. This population included social workers, Master's level counselors, psychologists, psychiatrists, marriage and family therapists, and psychiatric nurse practitioners. Participating clinicians had to be licensed, although there were no restrictions on number of years of licensure. Clinicians were sampled across a variety of mental health treatment settings including outpatient, residential, school, day treatment, private practice, hospital, inpatient, and juvenile detention centers.

Eligible participants worked with traumatized children and/or adolescents ages 5 to 18 and were asked to provide blinded information on a sample of those clients. Although the study specified an age range of 5 to 18, ultimately, information regarding clients ages 3 to 21 was included based on a post-hoc decision to expand the age range of the client sample. It has been argued that

age restrictions on DTD are arbitrary as clients do not develop into or out of this diagnosis upon reaching certain ages, and, therefore, close outliers were accepted into the study. One outlier, a 42-year-old client, was omitted. This decision will be further discussed in the discussion section.

Data Collection & Analysis

Participants were recruited utilizing a snowball method. An email was sent to contacts within the field explaining the rationale for the study, the inclusion and exclusion criteria for participation, and a link to the web-based survey (see Appendix B). Participants were then asked to forward the recruitment email to colleagues and friends who met the inclusion criteria and to post the email on any related listservs. This study was also posted to relevant listservs including those found through YahooGroups related to Behavior Analysis and Disruptive Disorders, Psychodynamic Research, Society for Personality Assessment, Clinical Social Work, Social Work Underground, Family Therapists in Washington DC, Private Practice Social Work, Domestic Violence Treatment, and Juvenile Justice.

Participants in this study were directed to a web survey through SurveyMonkey.com comprised of 23 multiple choice and open-ended questions. After eligibility was verified informed consent was obtained by having participants read a detailed informed consent letter (see Appendix C). Those participants that consented were directed to check a button labeled “I Agree” and to print a copy of the letter for their records.

After participants answered questions regarding personal demographics they were provided with a copy of the official proposed diagnostic criteria for Developmental Trauma Disorder submitted to the American Psychiatric Association for inclusion in the DSM-V and were asked to review it (see Appendix D). Participants were then asked to choose the last two child or adolescent clients they worked with that met the exposure criteria (criterion A) for DTD stated as,

“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” (van der Kolk, et al., p.6)

Participants were asked a series of ten questions for each of the selected client including demographic information on age, gender, race, treatment setting, current diagnosis (es), symptomatology, and trauma history (see Appendix E). Participants were also asked if in their professional opinion they believed the criteria described by the given DTD diagnosis adequately applied to their chosen client, if they would assign a diagnosis of DTD to this client were it available in the current DSM-IV, and if they would assign it in place of any of the client’s current diagnosis(es). If they answered yes, they were then asked to indicate which diagnoses they would replace. Finally, participants were given a space

where they could add any additional comments regarding DTD and its applicability to their clinical practice.

Data was collected and compiled through SurveyMonkey.com and analyzed using Microsoft Excel. Counts and percentages, including averages and standard deviations where appropriate, were calculated for each question. Qualitative data was coded for positive and negative attitudes, including clinician's opinions on DTD's usefulness in their practice, its inclusion in the DSM-V, its ability to lead to better treatment of traumatized children and adolescents, its ability to replace supplementary diagnoses, its improved description of trauma symptomatology, adjustments needed in criterion, and the need for future research.

CHAPTER IV

FINDINGS

In this study 221 mental health clinicians attempted to participate in the study's web survey, of which, 162 were eligible. Ninety-two participants completed the survey; however, 7 were omitted for providing incomplete data.

Participating clinicians (N=85) came from a variety of mental health fields with 47 social workers (LCSW), 11 Master's level counselors (LPC), 14 psychologists (PhD/PsyD), 6 psychiatrists (MD), 3 PhD-level social workers (PhD), 2 marriage and family therapists (LMFT), 1 psychiatric nurse practitioner (CNP) and 1 unknown. Participant years of licensure ranged from 1 to 47, with a mean of 12 years (S.D. = 10). Fifty-four participants worked in outpatient settings, 20 in residential settings, 18 in school settings, 8 in day treatment settings, 8 in private practice settings, 6 in hospital settings, 3 in inpatient settings, and 3 in juvenile detention centers. Many participants worked in more than one treatment setting with 66.6% in outpatient, 24.7% in residential, 22.2% in school settings, 9.9% day treatment, 9.9% in private practice, 7.4% in hospital settings, 3.7% in inpatient settings, and 3.7% in juvenile detention centers.

Clients (N=163) ranged in age from 3 to 21 years old with a mean of 12.1 years (S.D. = 4.1 years). Females comprised 55% of clients (n=90) and males 45% (n=73). Forty-eight percent of clients identified as White, 36% African American, 16% Hispanic, 2.5% Asian, 2.5% American Indian, 0.6% Pacific Islander, and 5.5% as other. Ninety-three clients (57%) were treated in outpatient settings, 32 (19.6%) in residential programs, 30 (18.4%) in school settings, 12

(7.4%) in day treatment programs, 2 (1.2%) in inpatient settings, 2 (1.2%) in hospital settings, and 9 (5.5%) in other settings such as private practice and juvenile detention centers.

Clinicians reported on the given diagnoses for their chronically traumatized clients (see Figure 1). Clients were assigned anywhere from 1 to 8 diagnoses each with a mean of 3 diagnoses per client (S.D. = 1.5) The most commonly reported diagnosis for the client population was PTSD with 45.3% of clients diagnosed. The second most common diagnosis was ADD/HD with 30.8% of clients diagnosed, followed by Anxiety and Depressive Disorders with 20.7% each, Oppositional Defiant Disorder (17.0%), Disruptive Behavior Disorder (14.5%), Bipolar and Learning Disorders (12.6% each), Conduct Disorder (11.9%), and Reactive Attachment Disorder (11.3%).

Participants were also asked to report their clients' symptomatology (see Figure 2). In support of previous studies, symptoms associated with ADD/HD rather than PTSD were among the highest reported with 73.6% of traumatized clients displaying affect dysregulation, 66.3% displaying impulsivity, 60.7% displaying anxious mood, 58.3% displaying a lack of focus and attention, 46.6% displaying hyperarousal, and 32.5% displaying hyperactivity. Other highly reported symptoms included social impairments (58.9%), relational impairments (57.1%), physical aggression (47.9%), hypervigilance (43.6%), verbal aggression (41.7%), and impairments in daily living (31.3%).

To gather information on the nature of the trauma experienced by those in the sample, events involved in the clients' trauma history were also reported (see

Figure 3). These findings indicated that 71.3% of clients suffered from emotional abuse, 59.4% had involvement with foster care or the department of social services, 58.8% of clients suffered from an impaired caregiver, 58.8% experienced neglect, and 56.3% of clients experienced a change of guardianship. Over half (51.9%) of clients also suffered physical abuse, 44.4% suffered sexual abuse, and 41.9% witnessed or suffered domestic violence. Additionally, clients experienced anywhere from 1 to 13 different forms of trauma. On average clients' trauma histories included 6 categories of traumatic events (S.D. = 2.7).

When asked whether they believed the proposed DTD diagnostic criteria adequately applied to their chosen clients, a vast majority of participants reported "yes." Clinicians reported that 144 of the 163 (88.3%) clients fit the full criteria for DTD (see Figure 4). Additionally, 86% of clinicians (N=85) said they would utilize a DTD diagnosis for their client if it were available in the current DSM-IV (see Figure 5).

Most importantly, when a clinician reported they would use a DTD diagnosis for their client, they reported they would use it in place of one or more of the client's current diagnoses 75.5% of the time (see Figure 6). Of the 414 diagnoses assigned to the study's 163 traumatized clients, Developmental Trauma Disorder replaced 157 diagnoses, ranging from 1 to 5 diagnoses per client. Thus, 37.9% of diagnoses were replaced by DTD, with a mean of 1.5 diagnoses per client (S.D. = 0.8).

The most frequently replaced diagnosis was PTSD with 44 of the 72 PTSD diagnoses replaced by Developmental Trauma Disorder (61.1%) (see

Figure 7). Additionally, 83.3% of Adjustment Disorder diagnoses were replaced by DTD. Over half the given Intermittent Explosive Disorders (62.5%) were replaced, along with 52.5% of Conduct Disorder diagnoses, 51.5% of Anxiety Disorder, and 50% each of Dissociative Disorders and Dysthymic diagnoses. Forty-eight percent of assigned Oppositional Defiant Disorder diagnoses, 44% of Reactive Attachment Disorder, 43.5% of Disruptive Behavior Disorder, 30% of Bipolar Disorder, and 26.5% of ADD/HD diagnoses were also replaced by the DTD diagnosis.

Finally clinicians were asked to provide any additional qualitative data on their opinion of Developmental Trauma Disorder's clinical usefulness in their practice. Thirty-three clinicians provided comments, 91% of which reflected positive attitudes towards DTD and its use in their practice. Only 1 participant (3.3%) reflected a negative view of DTD's clinical usefulness. Furthermore, 42.4% of respondents specifically referred to DTD's usefulness in their practice, 30.3% reported that they thought DTD provided a more accurate depiction of trauma symptomatology and sequelae than the current PTSD diagnosis, 24.2% of respondents reported that they believe DTD will replace the use of superfluous and erroneous diagnoses, 12.1% specifically reported they believe DTD should be included in the DSM-IV, and 9.1% reported they believe DTD will lead to improved trauma focused treatment of traumatized clients.

“This diagnosis has long been needed; the DSM IV categories, especially PTSD, have not covered the childhood etiology and profound effects we see in so many kids/adolescents, and we need this specificity to guide our treatment efforts”

“This diagnosis paints a clearer picture of the multitude of symptoms children have presented in my practice that don't totally fit all the criteria for the multiple diagnosis they receive, such as PTSD, Depression, Anxiety, ADHD, RAD. I have seen so many children being diagnosed with ADHD and placed on medications when they have a traumatic history as though it is not being considered at all as contributing to their focusing, attention, and hyperarousal symptoms”

“This is a long-overdue diagnosis that bundles together what appear to be phenomenologically-consistent symptoms that otherwise get either misconstrued as part of, or misapplied towards, inaccurate diagnoses.”

“Bravo-I think it is overdue. I hope it is implemented in the new DSM V”

Responding clinicians also expressed views on DTD’s limitations with 15.2% reporting diagnostic criterion should be adjusted, and 1 respondent (3.3%) reporting further research on DTD is needed.

“The diagnosis remains to be seen. I believe the studies cited in the reason for the new diagnosis were not adequate to create a new level of DSM diagnosis. I believe that it is worth pursuing and over the next two editions the validity of the construct will either be proven or disproven.”

“I like the DTD diagnosis but believe it is defined too specifically to be truly useful. My experience is that such a diagnosis could be assigned and useful for treatment planning and focus without such stringent criteria.”

CHAPTER V

DISCUSSION

This study found that a large majority of clinicians believe the diagnostic criteria for Developmental Trauma Disorder adequately describe the symptomological presentation of their chronically abused child and adolescent clients. Furthermore, clinicians reported they would utilize a DTD diagnosis were it approved by the American Psychiatric Association and most would use it in place of one or more of the client's current diagnoses.

The results of this study support and expand upon many of the findings from previous studies on chronic childhood abuse. The study's central goal of finding information on clinicians' opinions of DTD, its accuracy of symptomatology, and its usefulness in the field was also successful. Interestingly, it was reported an enormous majority of traumatized clientele (88.3%) met the full criteria for DTD. Of the 163 clients reported on in this study, 144 of them met the criteria for a DTD diagnosis. Additionally, clinicians stated they would assign a diagnosis of DTD for 86% of reported clients were it available in the current DSM-IV. This data suggests the DTD diagnosis may be useful in clinical practice and may have applicability in the field of childhood trauma.

In this study, the most frequently reported symptoms for the chronically traumatized client sample; affect dysregulation, impulsivity, anxious mood, lack of focus and attention, social and relational impairments, physical aggression, and hyperarousal and hypervigilance, were found to coincide with each and

every diagnostic criteria requirement for DTD, implying the diagnosis depicts the accurate sequelae for chronic interpersonal childhood trauma.

Many of these symptoms, specifically those in the areas of affective and physiological dysregulation, attentional and behavioral dysregulation, and self and relational dysregulation, are not included in the contemporary PTSD diagnosis. The lack of these symptom clusters in the current PTSD criteria may explain why so few traumatized children actually qualify for diagnoses of PTSD. The adult PTSD criteria do not describe the actual symptom picture resulting from chronic, interpersonal trauma through out child development. As these symptom clusters are also not described by any other current DSM-IV diagnosis, trauma focused or otherwise, we see why numerous superfluous diagnoses are given to account for unaddressed symptoms (Putnam, 2003; Najjar, Weller, Weisbrot, & Weller, 2008; Pynoos, et al., 2008; van der Kolk, Pynoos, et al., 2009). The high prevalence of these uncharacteristic trauma symptoms found through out this study's sample support the need for a DTD's developmentally sensitive and exposure informed criteria. These results are also supported by prior studies on victims of chronic childhood abuse, which found similar symptomatology (Bradley, 1986; Kitzman, Gaylord, Holt, & Kenny, 2003; Spinazzola, et al, 2005; Bailey, Moran, & Penderson, 2007; Teisl & Cicchetti, 2008).

Clients in this study suffered numerous forms of trauma with an average of 6 different categories of trauma reported. Some clients endured as many as 13 distinct categories of traumatization. Trauma events were also interpersonal in

nature with emotional, physical and sexual abuse, neglect, involvement in foster care or social services, impaired caregiver, and change of guardianship among the most frequently reported trauma events. These results combine to support research that states those clients with histories of chronic, interpersonal trauma tend to display DTD symptomatology where as those children with experiences of discrete trauma tend to display a more classic PTSD presentation (van der Kolk, 2007).

The most frequently reported trauma events for the client sample also support the accuracy of DTD's exposure criteria. Qualifying clients must experience or witness repeated episodes of interpersonal violence as well as experience some rupture in protective caregiving; repeated separation from the primary caregiver; or be exposed to persistent emotional abuse. All of the most frequently reported trauma events in this study refer to at least one requirement of the exposure criteria.

Although diagnoses of Separation Anxiety, ODD, ADD/HD, and phobic disorders are more frequent for the general population of traumatized children, in this study, the most commonly given diagnosis for the client sample was PTSD. As contributing clinicians in this study participated voluntarily, it can be assumed they had an interest in issues of childhood trauma and possibly Developmental Trauma Disorder. It is possible that these clinicians are more informed on trauma related material and may put more emphasis on the role of trauma in their clinical practice resulting in more trauma-centered diagnoses.

Even with the high prevalence of PTSD diagnoses in this sample, clients were still assigned an average of three diagnoses each, with a ceiling of eight. This finding further supports research that has found in the absence of a developmentally appropriate trauma diagnosis clients are often assigned 3 to 8 diagnoses a piece in order to account for additional symptomatology (Putnam, 2008). Even with a possible increased trauma focus among clinicians, it appears additional diagnoses were used to account for unaddressed symptoms and/or comorbid disorders. The implementation of DTD in clinical practice might reduce the use of excessive diagnosing as it was found that anywhere from 1 to 5 diagnoses per client were replaced by a diagnosis of DTD. A large majority (75.5%) of clinicians who stated they would assign DTD to their clients reported they would also use it in place of one or more previously given diagnoses.

The application of DTD in practice may give clinicians a more precise tool for describing the experience of one of our most vulnerable populations, and in doing so may free them from the burden of excessive and stigmatizing disorders. The diagnosis most frequently replaced by DTD was PTSD, which is unsurprising as it was also the most frequent previously assigned diagnosis. The other diagnoses most often replaced by DTD were found to be some of the most stigmatizing and victim blaming diagnoses in use; Intermittent Explosive Disorder, Conduct Disorder, Oppositional Defiant Disorder, Reactive Attachment Disorder, and Disruptive Behavior Disorder were among the other diagnoses most frequently replaced by DTD. These disorders depict disturbing behavior and relational impairments while removing the child from the context

of trauma. Without a diagnosis that highlights the environment in which such behaviors and impairments were developed, the child becomes viewed as intrinsically disturbed and ill. The use of these diagnoses gives clinicians little incentive to use trauma-focused treatments and eventually the role of trauma in the child's development and presentation is forgotten all together. The use of DTD in place of such diagnoses keeps trauma in the spotlight, highlights the developmental context, removes blame from the victim, and insists on the use of trauma informed treatments.

ADD/HD and Bipolar Disorder were also commonly replaced diagnoses. The use of DTD in place of these diagnoses, as well as others, has the potential to spare traumatized children from erroneous and unnecessary psychiatric treatment. Past research has shown that trauma histories are often a predictor for non-response to lithium in children and adolescents with a diagnosis of Bipolar Disorder; the use of DTD in place of Bipolar Disorder could save thousands of children from unwarranted and risky lithium prescriptions (Pavuluri, 2006). The implementation of DTD in place of ADHD for traumatized children also has the potential to save enormous numbers of children from needless stimulant prescriptions and possible stigmatization by school personnel, which has the potential to further adversely affect an already traumatized child.

Qualitative opinions of DTD and its introduction into the field were found to be overwhelmingly positive in nature. Clinicians request and support its inclusion in the DSM-V and in general view it as a much needed diagnosis that

will lead to more precise evaluation, less erroneous diagnosing, trauma-focused treatment, and better treatment outcomes.

“The symptoms offered are appropriate to child and adolescent levels of development -- so often a shortcoming of DSM IV”

“I am pulling for DTD to make it into DSM-V, the children/parents and therapists treating these kids need a more clear way of conceptualizing these clinical issues.”

“I love van der kolk and DTD for many reasons. It takes into account the attachment system and better accounts for the hyperarousal and affect dysregulation we see in children repeatedly exposed to family violence or neighborhood violence that do not meet criteria A. for PTSD. I do not like (the) disruptive behavior diagnosis or oppositional defiant (disorder) because that just classifies the kid as having behaviors that grown-ups find annoying when really the prefrontal cortex of the child has gone off-line and the child is coping the best they can given faulty hardwiring caused by repeated exposure to traumatic material.”

There were several common criticisms of DTD as well, particularly, its diagnostic criteria, with several respondents reporting they believe DTD criteria is “too cumbersome” to be helpful

“I am not sure that " repeated", "prolonged" or "multiple" exposures to traumatic incidents is accurate. In some cases, particularly physical or sexual abuse you may find that only one incident is severe enough to trigger symptoms consistent with Developmental Trauma Disorder”

“As is true of any 'new' diagnosis in the DSM its major utility is to promote research to validate its existence, and to refine the most specific diagnostic criteria. As it stands now the criteria are too cumbersome and I think that clinicians will tend to ignore thoroughness. On the other hand, I support the inclusion as the research is so far sound and I think it is about time that these kids stop getting labeled as 'bipolar' et al.”

This study is unique in that it is the first study designed to examine clinicians' views of the proposed DTD diagnosis. It is the first to directly ask clinicians whether they will utilize this diagnosis in practice and whether they believe it has legitimacy as a diagnostic construct. It is also the first study to examine the effect of DTD's implementation in practice on the use of supplementary diagnosing. The questioning of clinicians is most valuable as they are the professionals who will be entrusted to implement this tool in practice. It is the clinicians' discretion and evaluation that ultimately decide the clinical utility of any diagnostic instrument. No matter how valid or reliable a test or construct is determined to be, if the clinician does not apply it in practice, then it can have no efficacy. This study has determined that the majority of clinicians surveyed do in fact view DTD's criteria as an adequate depiction of the symptomatology presented by their chronically traumatized clients and that they would implement it in their practices were it approved by the American Psychiatric Association.

The questions used in this study are a unique strength as they were designed to assess the clinical utility of DTD, an aspect of diagnosis that has not yet been addressed by research. Clinical utility is described as the ease and efficiency of the use of an assessment as well as the meaningfulness and relevance of the information it provides (Polgar & Barlow, 2005). As a large majority of the client sample met the criteria for DTD, it can be inferred that DTD does indeed have meaningfulness and relevance in the field of childhood trauma as it adequately describes a symptom set observed by clinicians. The

large percentage of clinicians who reported they would utilize DTD in their practice, both independently and in place of supplementary diagnoses, indicates the diagnosis' potential usefulness and efficiency in describing a condition unaddressed by any other diagnosis. In short these findings suggest that DTD serves a meaningful purpose in the field of childhood trauma and is likely to be put to use should it be included in the DSM-V.

The sample size obtained in this study is an additional strength as it represents a fair number of mental health clinicians and traumatized clients. Clinicians from every mental health background with a wide range of experience and expertise reported on clients with just as much diversity. Racially diverse clients, from a wide range of treatment settings, and an assortment of trauma histories produced a sample representative of today's chronically traumatized child population.

Clients ranged in age from 3 to 21 years of age, providing information on victims at all developmental stages. Although initial requirements asked that clinicians report on clients' ages 5 to 18, a post-hoc decision to include close outliers was made. It has been argued by D'Andrea, Spinazzola, & van der Kolk (2009) that age restrictions implemented on DTD diagnoses are arbitrary, as it cannot be proven that children develop into or out of this condition upon reaching certain ages or developmental stages. Qualitative input from participating clinicians supported this argument as well.

“Why not include children younger than 5? I work with (the) 0 to 6 population and many of my clients fit this criteria.”

Several participants reported observing DTD symptoms in traumatized children as young as three and contended they would assign a DTD diagnosis for these children in their personal practices. One participant reported observing DTD symptoms in a 42-year-old female client with a history of chronic interpersonal trauma and ruptures in protective caregiving and commented,

“This diagnosis is not only useful and valid for children/adolescents but should be extended to the situation of adults who have similar histories, since PTSD as a diagnosis does not fully capture the pervasive developmental experience of many clients.”

Although this client was not included in the study’s sample (her age was far beyond the given limitations), it is conceivable that adults would maintain symptomatology and relational patterns from severe childhood trauma. Many Axis II disorders are conceptualized as long lasting consequences of childhood abuse and it is possible that DTD’s criteria may be applicable to adults as well. This query creates an area for further study.

This study also has several limitations, particularly a general participant bias. As this research was conducted through a voluntary web survey it can be presumed that participants had a greater interest and/or knowledge of childhood trauma and Developmental Trauma Disorder than the general clinical population. This bias may account for some of the high approval levels found throughout the results and therefore creates certain limitations on generalizability. The clinician sample was also unevenly distributed with social workers making up a very large portion of participants. Further studies would benefit from a sample evenly dispersed across mental health providers.

An aspect of clinical utility excluded from examination in this study is the ease and efficiency of the actual diagnostic criteria for DTD. There were not specific questions included in the survey to measure or obtain opinions on the ease of the criteria although several participants did include this area in their comments. Several respondents referred specifically to DTD's criteria labeling it "excessive" and "cumbersome". Many eligible participants also opted to end the survey upon reaching the screen with the diagnosis, implying it may have been too long or complicated to grasp. Further studies would benefit from examining specifically the ease and efficiency of DTD's diagnostic criteria and this study's incapacity to do so is a limitation of its measure on clinical utility.

Also, as this is the first study to assess issues related to the clinical utility of the DTD diagnosis, these findings are only preliminary. Although the results are compelling, future research should be conducted to replicate and extend the results of the current study.

The implication of this research is that Developmental Trauma Disorder may have clinical utility. Clinicians have reported that DTD adequately depicts the symptomatology presented by their clients with complex trauma and that they will utilize this diagnosis in practice. DTD also fills an imperative gap between available diagnostic assessments and the actual sequelae experienced by victims of chronic, interpersonal, childhood trauma. With a central focus on trauma and environmental factors, DTD has the potential to release children and adolescents from the stigmatizing effects of behavior oriented diagnoses.

Disorders such as Oppositional Defiant, Disruptive Behavior, ADD/HD, RAD,

and Bipolar Disorder frequently end up blaming the victim for problematic behavior and relational impairments. Victims are viewed as intentionally defiant and disruptive while actual ill attempts to cope and self-soothe are disregarded. The implementation of DTD in clinical practice could educate mental health providers, pediatricians, teachers, parents, and childcare providers on the actual etiology of pathological responses, creating the community of care and empathy our abused children desperately need and deserve.

The use of DTD in clinical practice has enormous implications for treatment interventions and outcomes. The diagnosis' central focus on trauma as the origin of pathology insists on the use of trauma-focused interventions. Prior studies have shown that clients with trauma histories fair worse in non-trauma based interventions while clients with histories of abuse and mistreatment, regardless of diagnosis, fair better when treated with trauma-focused treatments (Copping, 2001; Greewnwald & Rule, 2002; Grella & Joshi, 2003; Pavuluri, 2006; Becker-Weidman, 2006; Dozer et al, 2006; Ford, et al., 2007; D'Andrea et al., 2009). With the outstanding number of child abuse reports each year and the ensuing financial strain childhood interpersonal trauma places on our nation's medical, mental, social, and protective services, DTD's potential to increase focus on etiology, precision of assessment, and effectiveness of treatment stands to save tax payers vast sums of money (Anda, et al, 2006; van der Kolk, 2005).

As it stands now, Developmental Trauma Disorder has been submitted by the Complex Trauma Taskforce of the National Child Traumatic Stress Network to the American Psychiatric Association for consideration in the DSM-V. The

APA reports the DSM-V is scheduled to be released in May, 2013 however, no decision on the actual inclusion of the diagnosis has been made.

Developmental Trauma Disorder attempts to fill a gap in contemporary diagnostic assessment by offering a trauma-focused, developmentally sensitive diagnosis. The measure claims to capture the complete sequelae of chronic, interpersonal, childhood trauma unaddressed by any existing diagnosis. The majority of clinicians surveyed in this study agreed that DTD adequately depicts the symptomatology observed in their chronically traumatized clients and that they would utilize this diagnosis in practice. DTD also stands to replace the use of inaccurate and often victim-blaming diagnoses that have been commonly used to accommodate symptoms unaddressed by the current PTSD diagnosis. The results of this study offer preliminary support for the inclusion of DTD in the DSM-V as it was found DTD may have clinical utility and usefulness in the field of childhood trauma. If approved by the American Psychiatric Association and included in the DSM-V, Developmental Trauma Disorder has the potential to increase the accuracy and effectiveness of the care of some of our most vulnerable populations, while continuing to educate our nation's mental health providers on the pervasive effects of interpersonal, childhood trauma.

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Figure 1.

Existing Client Diagnosis

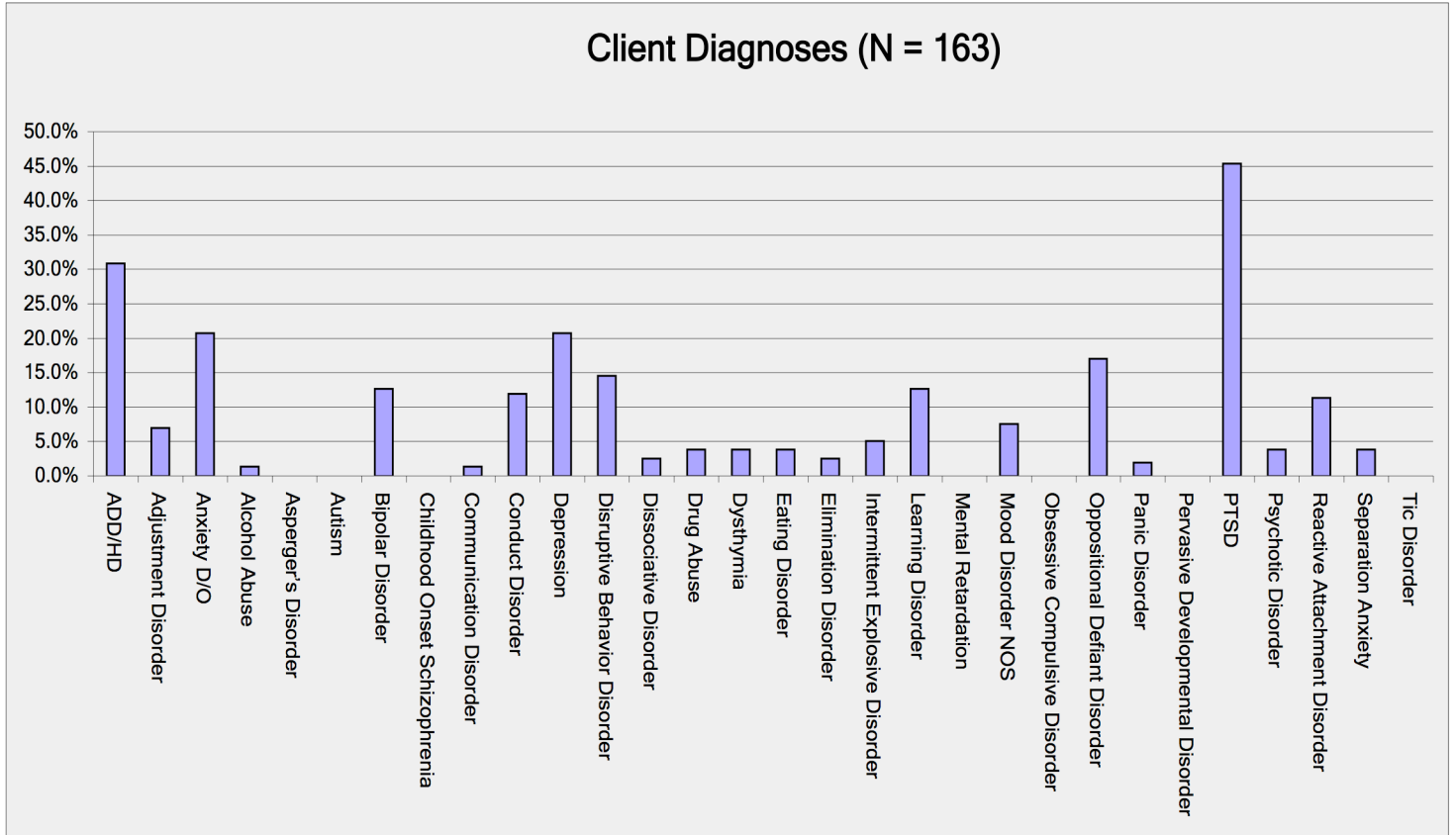


Figure 2.

Client Symptoms

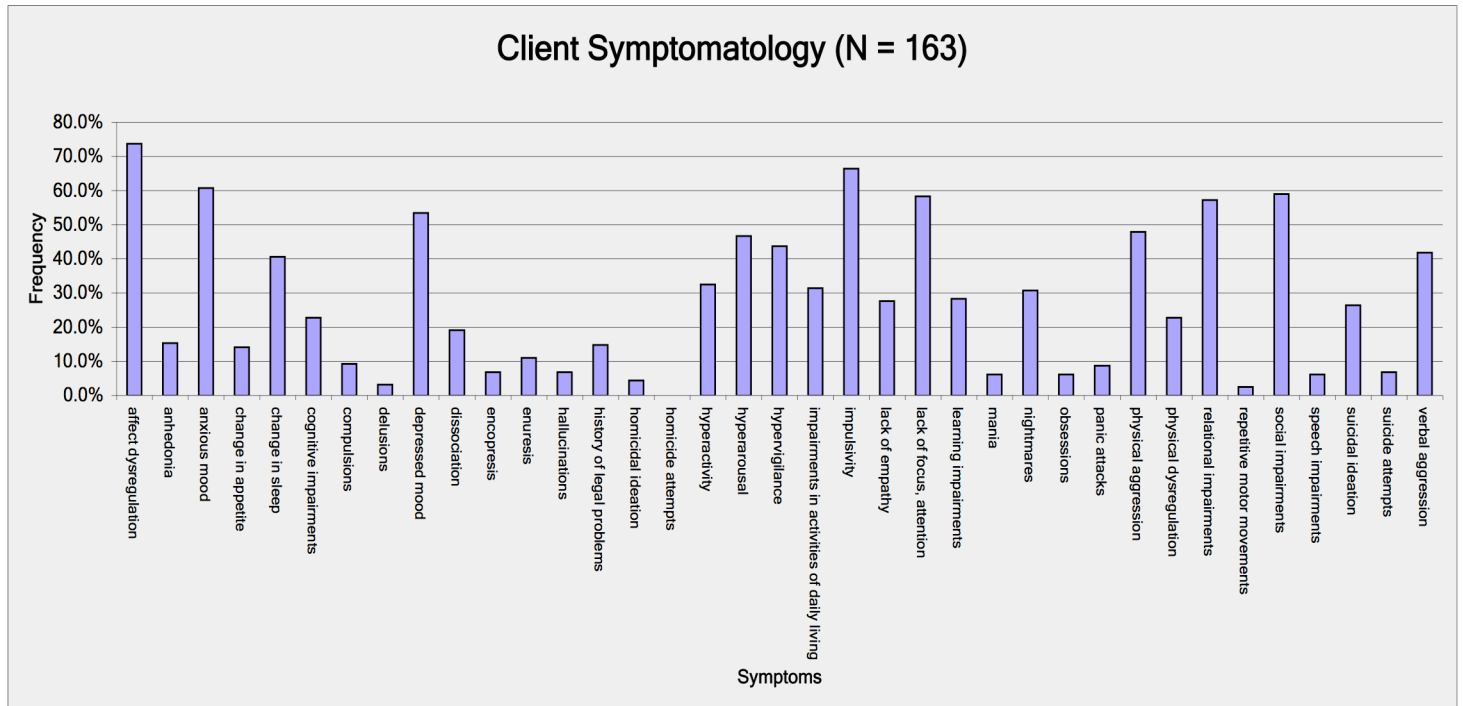


Figure 3.

Events in Client Trauma History

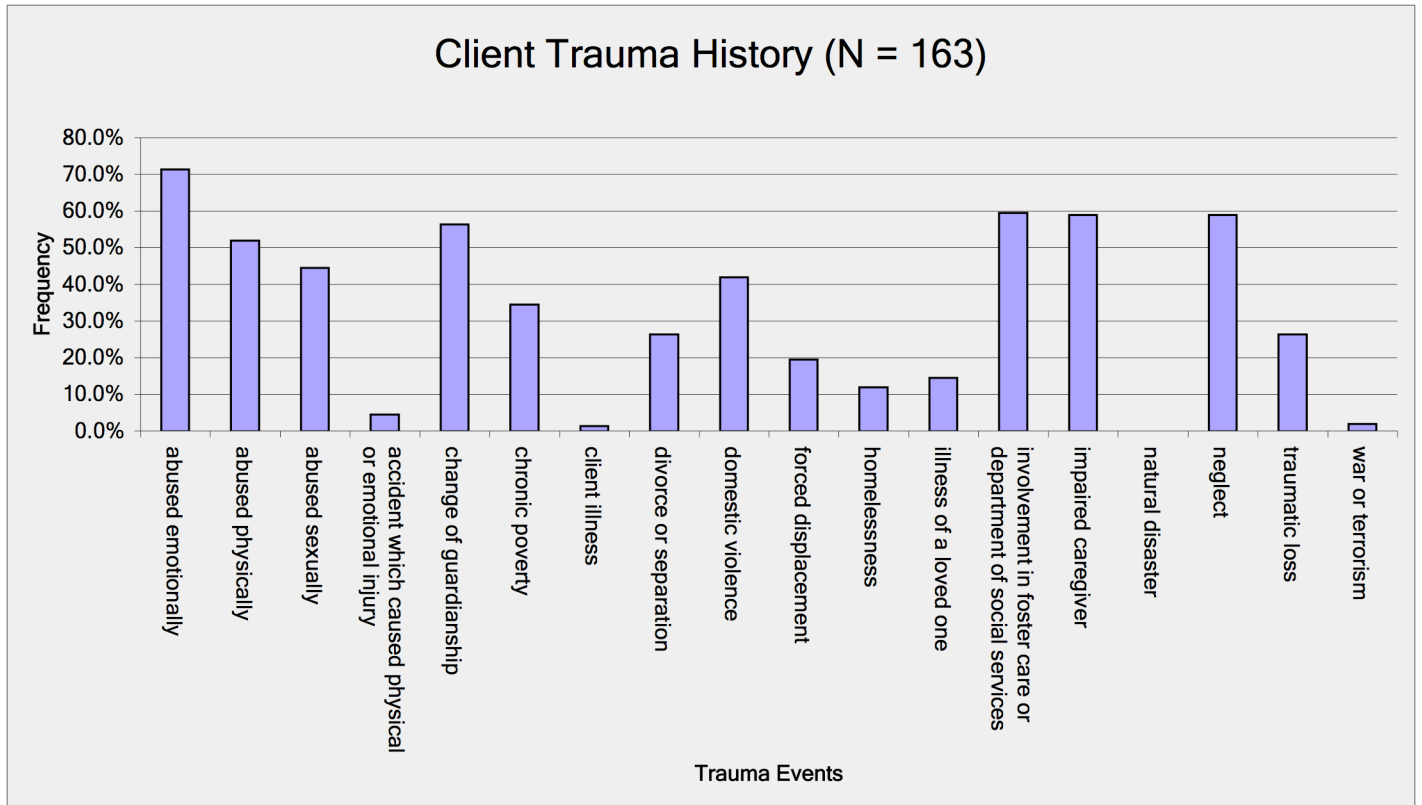


Figure 4.

Developmental Trauma Disorder Applicability

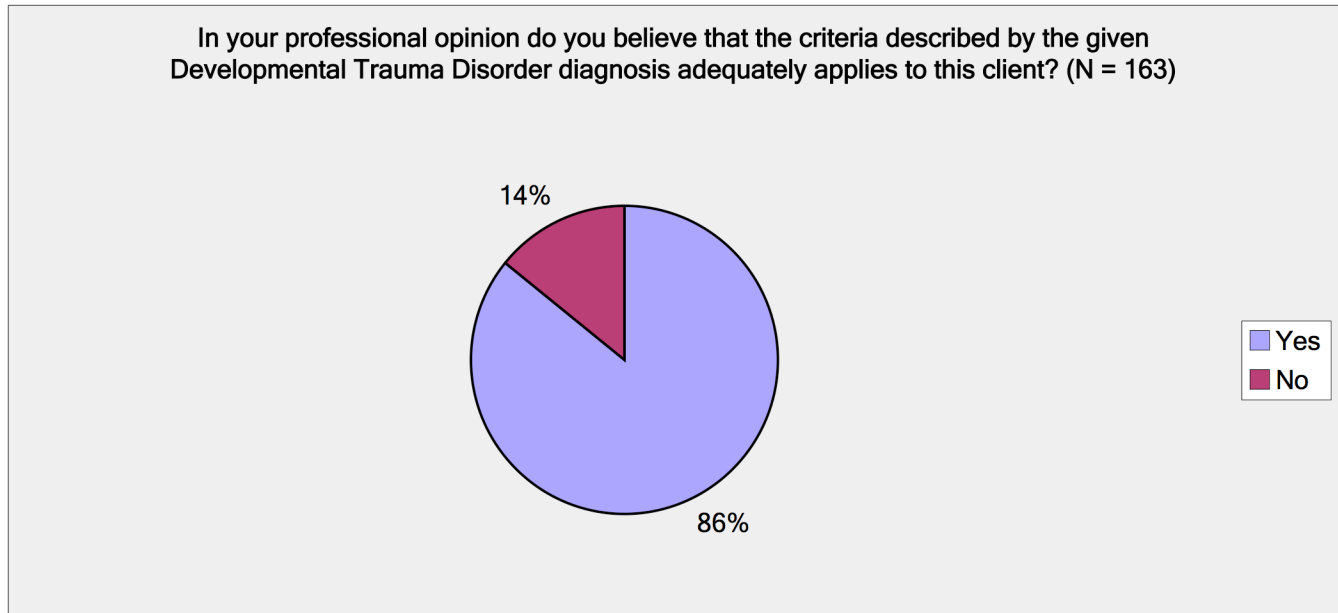


Figure 5.

Clinical Use of Developmental Trauma Disorder

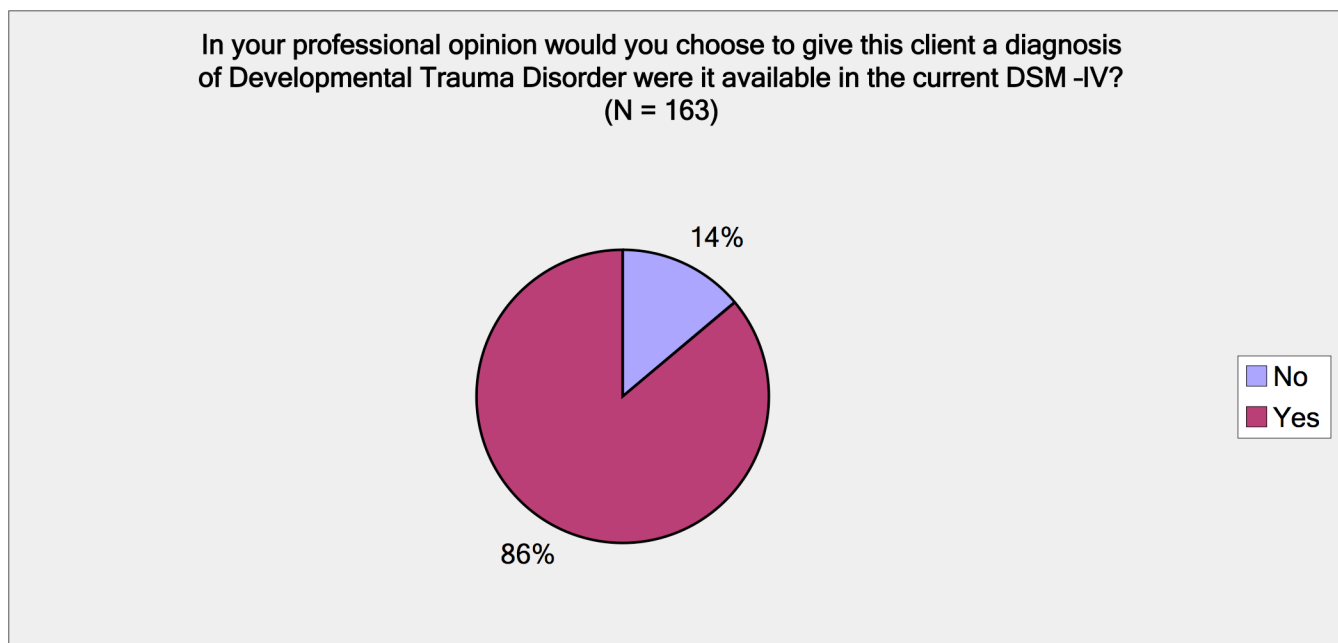
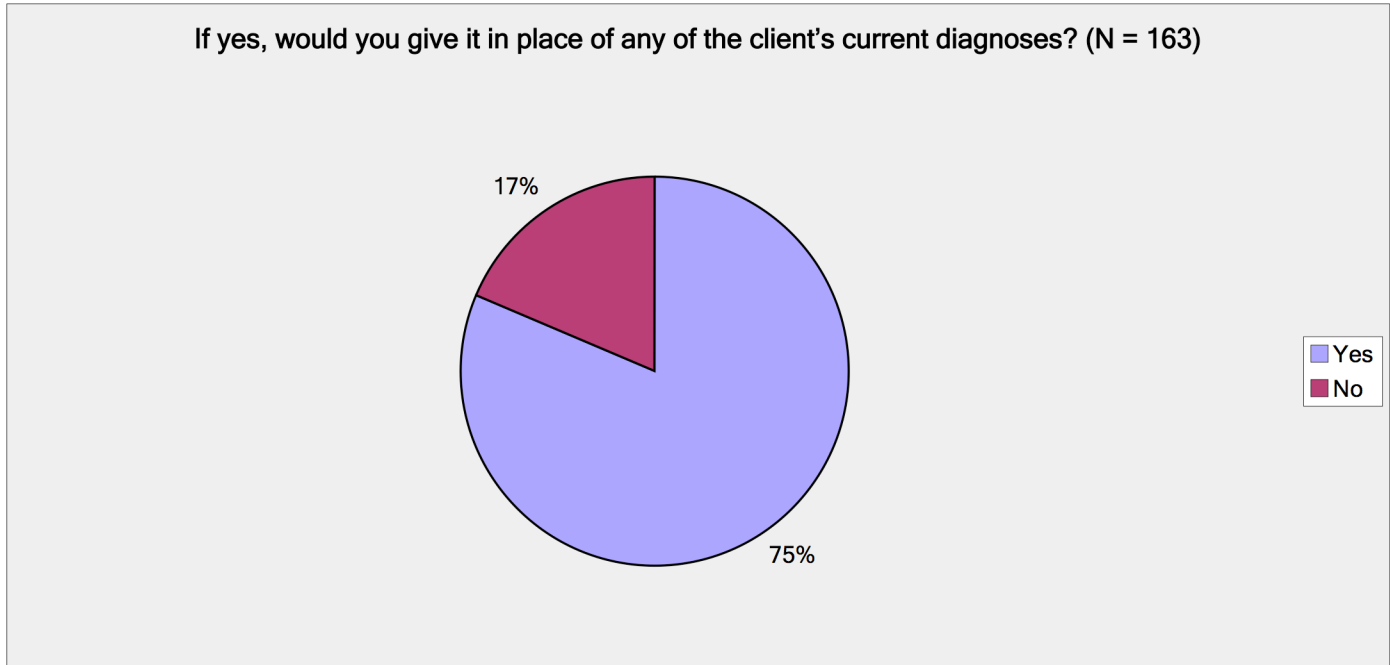


Figure 6.

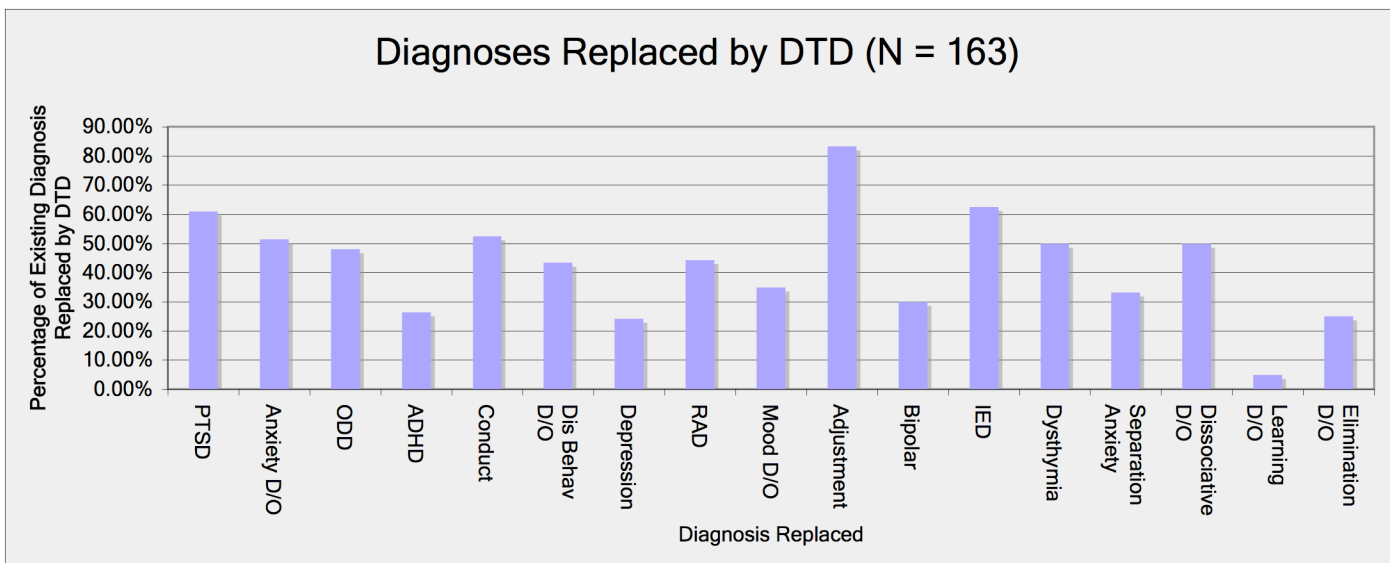
The Use of Developmental Trauma Disorder in Place of Existing Diagnoses



Note* 8% of participants did not respond to this question

Figure 7.

Existing Diagnoses Replaced by Developmental Trauma Disorder



APPENDIX A

HSR Approval Letter

February 15, 2010

April Salvaterra

Dear April,

Your revised materials have been reviewed. You have done an excellent job of simplifying your study and making it much more manageable for you and for your participants. You have also completed the revisions and corrections we suggested. We are glad to give final approval to your study. However, there are just three very small but important things we would like you to do. First in the **Purpose** section of the Application, you never say this is for your thesis and for possible publication and presentation. Secondly, you never mention that this is for your thesis in your Consent. Finally, in your recruitment materials, the heading at the top of the page looks like this is a study that the Institution is doing. Please revise the title at the top.

Before you begin recruitment, please correct those three pages and send them to Laurie Wyman (lwyman@smith.edu) for your permanent file.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

This is a very interesting and timely study as the whole process of reviewing the new DSM classification is just getting underway. Good luck with your project.

Sincerely,
Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Jill Clemence, Research Advisor

APPENDIX B

Recruitment E-mail

Research on Developmental Trauma Disorder!

Looking for Licensed Mental Health Clinicians
to Participate in a Short On-Line Survey!

Hello,

My name is April Salvaterra, and I am a graduate student at the Smith College School for Social Work. I am looking for licensed mental health clinicians to participate in a short on-line survey examining the clinical utility of Bessel van der Kolk et al.'s Developmental Trauma Disorder diagnosis submitted for inclusion in the upcoming DSM-V. With over 3 million reports of child abuse occurring in the U.S. each year, research on this innovative childhood trauma diagnosis is more pertinent now than ever. To access the survey please click on the link <http://www.surveymonkey.com/s/developmentaltrauma>.

Participation in this web-based survey is entirely voluntary and anonymous and will only take 20-25 minutes to complete. You may skip any question or terminate the survey at any time but, unfortunately, due to the anonymous nature of this study, withdrawal after submission of the survey will not be possible.

I want to thank you in advance for your contribution to this study and ask that you please **send this email to any and all licensed mental health clinicians** working with traumatized children and/or adolescents you may know of. Posting this survey on any **related listservs** would also be greatly appreciated. Feel free to contact me at the email below if you have any questions.

Thank you for your time and your contribution,
April Salvaterra

APPENDIX C

Informed Consent Letter

Dear Potential Research Participant:

My name is April Salvaterra, and I am a graduate student at the Smith College School for Social Work. For completion of my Master's thesis I am conducting a mixed method study to examine clinicians' opinions on the clinical utility of the Developmental Trauma Disorder diagnosis submitted for inclusion in the Diagnostic and Statistical Manual V. I am interested in whether clinicians believe Developmental Trauma Disorder is a clinically useful diagnosis for children and adolescents with complex trauma histories they have treated within the past year. My research is informed by the work of Bessel van der Kolk and the Complex Trauma taskforce of the National Child Traumatic Stress Network. This study is being conducted as part of the requirements for the Master of Social Work degree at Smith College School for Social Work and may be used in future presentations and publications.

I will provide you with a copy of the official diagnostic criteria for Developmental Trauma Disorder submitted to the American Psychiatric Association for consideration in the DSM-V. I will ask you to provide demographic information about yourself, such as your degree, license, treatment setting, and years in the field. I will also ask for demographics pertaining to your chosen clients such as age, gender, race, treatment setting, current diagnosis, current symptomatology, and trauma history. Finally, I will question if you believe a Developmental Trauma Disorder diagnosis is appropriate for your clients and whether you would employ this diagnosis rather than any of the child's current diagnoses. Your information will be collected anonymously through a web-based survey and will be kept confidential; no identifying information will be requested.

Benefits of this study include contribution to the exploration of the clinical utility of Developmental Trauma Disorder, increased awareness and knowledge of a proposed comprehensive diagnosis for child survivors of complex trauma, and contribution to the field of mental health. The potential risk of participating in this study is loss of time and productivity. This survey will take approximately 15-20 minutes to complete.

Strict confidentiality will be maintained, as consistent with federal regulations and the mandates of the social work profession. All information will be collected anonymously. All data will be kept in a secure file for a minimum of three years, after which it will be destroyed.

Participation in this project is entirely voluntary, and you may refuse to answer any question or terminate the survey at any point during participation in the project as long as you have not yet submitted your responses. In order to terminate the survey early simply leave the site. Withdrawal from this study after submission of the survey will not be possible due to the anonymous nature of the study as particular submissions will be impossible to identify. If you have any concerns about your rights or about any aspect of the study, I encourage you to call me or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

Thank you for your time,
April Salvaterra

Resources

http://www.traumacenter.org/research/research_landing.php

http://www.ncctsn.org/nccts/nav.do?pid=hom_main

APPENDIX D

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.

b. The traumatic event is persistently reexperienced in one (or more) of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
2. Recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

c. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

- Efforts to avoid thoughts, feelings, or conversations associated with the trauma
- Efforts to avoid activities, places, or people that arouse recollections of the trauma
- Inability to recall an important aspect of the trauma
- Markedly diminished interest or participation in significant activities
- Feeling of detachment or estrangement from others
- Restricted range of affect (e.g., unable to have loving feelings)
- Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

d. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- Difficulty falling or staying asleep
- Irritability or outbursts of anger
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response

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 least two of the following areas of functioning:

- G. 1. **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.
- G. 2. **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.
- G. 3. **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.
- G. 4. **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.
- G. 5. **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.
- G. 6. **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 co-workers or supervisors, under-employment in relation to abilities, failure to achieve expectable advancements.

APPENDIX E

Web Survey

Section I:

Directions: Please answer the following questions regarding your clinical experience.

1. What is your degree and license?
2. How many years have you been licensed in the field?
3. What is the treatment setting in which you work? (check all that apply)
 - out-patient
 - residential
 - day treatment
 - in-patient
 - school setting
 - hospital setting
 - other

Section II:

Directions: Please read the following proposed criteria for DEVELOPMENTAL TRAUMA DISORDER for inclusion in the DSM-V from van der Kolk, B.A. et al. (2009). [retrieved from www.traumacenter.org]

You will then be asked several questions about how you feel this diagnosis might be used in your current practice. **You may want to print out a copy of these criteria for your use as you answer the questions that follow.**

(See Appendix D).

QUESTIONS

Directions: In the next section, I will ask you to think of the last two children or adolescents you have worked with in the past year that have complex trauma histories as defined by the following DTD criteria:

Category 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*

Please provide the requested information below regarding each child or adolescent that comes to mind.

Client #1

1. What is the client's current age?

2. What is the client's current gender?

- Male
- Female
- Other

3. What is the client's race? (Select as many as apply)

- African American
- Hispanic
- Asian
- American Indian
- Pacific Islander
- White
- Other

4. What is the treatment setting in which you are/were treating this client?

- Out-patient
- Residential
- Day treatment
- In-patient
- School setting
- Hospital setting
- Other

5. What is/are the client's current diagnosis/es (Please check all that apply)

- ADD/HD
- Anxiety D/O
- Alcohol Abuse
- Asperger's Disorder
- Autism
- Bipolar Disorder
- Childhood Onset Schizophrenia
- Communication Disorder
- Conduct Disorder
- Depression
- Disruptive Behavior Disorder
- Dissociative Disorder
- Drug Abuse
- Dysthymia
- Eating Disorder
- Elimination Disorder
- Intermittent Explosive Disorder
- Learning D/O
- Mental Retardation
- Mood Disorder NOS
- Obsessive Compulsive Disorder
- Oppositional Defiant Disorder
- Panic Disorder
- Pervasive Developmental Disorder

- PTSD
- Psychotic Disorder
- Reactive Attachment Disorder
- Separation Anxiety
- Tic Disorder
- Other: Please Specify _____

6. What are the client's current symptoms? (Please check all that apply)

- affect dysregulation
- anhedonia
- anxious mood
- change in appetite
- change in sleep
- cognitive impairments
- compulsions
- delusions
- depressed mood
- dissociation
- encopresis
- enuresis
- hallucinations
- history of legal problems
- homicidal ideation
- homicide attempts
- hyperactivity
- hyperarousal
- hypervigilance
- impairments in activities of daily living
- impulsivity
- lack of empathy
- lack of focus, attention
- learning impairments
- mania
- nightmares
- obsessions
- panic attacks
- physical aggression
- physical dysregulation
- relational impairments
- repetitive motor movements
- social impairments
- speech impairments
- suicidal ideation
- suicide attempts
- verbal aggression
- Other: Please Specify _____

7. Which events were involved in the client's trauma history? (Please check all that apply)

- abused emotionally
- abused physically
- abused sexually
- accident which caused physical or emotional injury
- change of guardianship
- chronic poverty
- client illness
- divorce or separation
- domestic violence
- forced displacement
- homelessness
- illness of a loved one
- involvement in foster care or department of social services
- impaired caregiver
- natural disaster
- neglect
- traumatic loss
- war or terrorism
- Other: Please Specify _____

8. In your professional opinion do you believe that the criteria described by the given Developmental Trauma Disorder diagnosis adequately applies to this client?

- Yes
- No, If not, why?

9. In your professional opinion would you choose to give this client a diagnosis of Developmental Trauma Disorder were it available in the current DSM-IV?

- No
- Yes

10. If yes, would you give it in place of any of the client's current diagnoses?

- Yes
- No
- If yes, which one(s)?

Client #2

1. What is the client's current age?

2. What is the client's current gender?

- Male
- Female
- Other

3. What is the client's race? (Select as many as apply)

- African American
- Hispanic
- Asian
- American Indian
- Pacific Islander
- White
- Other

4. What is the treatment setting in which you are/were treating this client?

- Out-patient
- Residential
- Day treatment
- In-patient
- School setting
- Hospital setting
- Other

5. What is/are the client's current diagnosis/es (Please check all that apply)

- ADD/HD
- Anxiety D/O
- Alcohol Abuse
- Asperger's Disorder
- Autism
- Bipolar Disorder
- Childhood Onset Schizophrenia
- Communication Disorder
- Conduct Disorder
- Depression
- Disruptive Behavior Disorder
- Dissociative Disorder
- Drug Abuse
- Dysthymia
- Eating Disorder
- Elimination Disorder
- Intermittent Explosive Disorder
- Learning D/O
- Mental Retardation
- Mood Disorder NOS
- Obsessive Compulsive Disorder
- Oppositional Defiant Disorder
- Panic Disorder
- Pervasive Developmental Disorder
- PTSD
- Psychotic Disorder
- Reactive Attachment Disorder
- Separation Anxiety
- Tic Disorder

- Other: Please Specify _____

6. What are the client's current symptoms? (Please check all that apply)

- affect dysregulation
- anhedonia
- anxious mood
- change in appetite
- change in sleep
- cognitive impairments
- compulsions
- delusions
- depressed mood
- dissociation
- encopresis
- enuresis
- hallucinations
- history of legal problems
- homicidal ideation
- homicide attempts
- hyperactivity
- hyperarousal
- hypervigilance
- impairments in activities of daily living
- impulsivity
- lack of empathy
- lack of focus, attention
- learning impairments
- mania
- nightmares
- obsessions
- panic attacks
- physical aggression
- physical dysregulation
- relational impairments
- repetitive motor movements
- social impairments
- speech impairments
- suicidal ideation
- suicide attempts
- verbal aggression
- Other: Please Specify _____

7. Which events were involved in the client's trauma history? (Please check all that apply)

- abused emotionally
- abused physically
- abused sexually
- accident which caused physical or emotional injury
- change of guardianship

- chronic poverty
- client illness
- divorce or separation
- domestic violence
- forced displacement
- homelessness
- illness of a loved one
- involvement in foster care or department of social services
- impaired caregiver
- natural disaster
- neglect
- traumatic loss
- war or terrorism
- Other: Please Specify _____

8. In your professional opinion do you believe that the criteria described by the given Developmental Trauma Disorder diagnosis adequately applies to this client?

- Yes
 - No, If not, why?
-

9. In your professional opinion would you choose to give this client a diagnosis of Developmental Trauma Disorder were it available in the current DSM –IV?

- No
- Yes

10. If yes, would you give it in place of any of the client’s current diagnoses?

- Yes
 - No
 - If yes, which one(s)?
-

Section III:

Directions: Please provide any additional comments below regarding your opinion on the clinical usefulness of DTD in your practice.