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Developmental Trauma Disorder

(DTD)

Definititon : DTD is a diagnostic proposal for DSM-5, authored by Bessel van der Kolk and colleagues. The concept of DTD is based on a wide array of research data that comprises tens of thousands of children across multiple research studies. DTD results from growing up in an interpersonal context of ongoing danger, maltreatment, unpredictability, and/or neglect. 80% of all child maltreatment is at the hands of children's own parents. Maltreatment embeds "hidden traumas" in infant - caregiver interactions that are neglectful, intrusive, unpredictable, threatening, aggressive, rejecting, or exploitive. These interactions convey that the world is a dangerous, unreliable, and/or indifferent place that offers little or no safety. Given the highly limited capacities of infants / young children to assess risk, this lack of physical and/or emotional safety quickly rises to the level of a subjective survival threat (annihilation anxiety) even though the objective nature of the event may not actually be at that level. For this reason, such events do not warrant a diagnosis of PTSD because the events are not "imminently life threatening", a criteria for PTSD. However, it is subjective perception, and not objective lethality, that determines trauma. Using PTSD criteria, the element of trauma gets missed, and the erroneous diagnostic process has begun.

Major diagnostic criteria for DTD: There are seven major diagnostic criteria for DTD.

1. **Witnessing or experiencing multiple adverse interpersonal events involving caretaker(s) for at least one year.**
2. **Affective and physiological dysregulation.**
3. **Attentional and behavioral dysregulation.**
4. **Self and relational dysregulation.**
5. **Chronically altered perception and expectations.**
6. **At least two posttraumatic symptoms.**
7. **Functional impairment- at least two of the following areas: academic, family, peers, legal, health.**
8. **Duration of disorder is at least 6 months.**

Developmental impacts of DTD: DTD can have wide ranging impacts on development, which if not addressed, can distort the developmental trajectory for the remainder of the individual's life span.

1. **Somatic effects: Trauma can affect appetite, digestion, excretory functioning, sleep, the immune system, and temperature regulation. The bodily sense of being unsafe tends to be concentrated most powerfully in the upper chest.**
2. **Autoimmune disorders: DTD can generate autoimmune disorders because chronic overreactivity to subjectively perceived threats depletes the immune system (elevated cortisol levels). This too often gets treated purely as a medical problem by a medical system prone to splitting people into discrete symptom clusters without understanding the overriding picture. The result is ineffective medical care. Application of medical intervention may produce short term improvement, but with the traumatic energy in the system continuing to drive the perception of**

threat, the immune system will only wear out again. This can lead to a "medical" conclusion of a chronic physiological condition that may need ongoing medical treatment. As a result, the real solution gets tragically overlooked.

3. **Speech + language: Speech is impaired, and this blocks being able to talk about a traumatic state while in it. Because the language areas in the prefrontal cortex are not well connected to the amygdala, traumatic emotion can't be effectively talked through. Language, as a whole, can't accurately convey internal experience. However, the presence of emotion cannot be disguised out of the voice, as emotion is neurologically transported by the vagus nerve which runs right through the larynx.**
4. **Dissociation: In traumatized states, emotion, sensation, perception and thought are dissociated into separate fragments. This literally blocks understanding of what is happening which disturbs later memory processing. This sets the stage for learning to ignore the body and what is going on within it. DTD children organize themselves around "not experiencing". Because they are simply "not present" a good deal of the time, children with DTD do not reliably take in new information nor do they internalize information accurately across time. This clearly is highly relevant to academic achievement, to learning from past experience, and to future planning skills. These impairments rob these children of important tools everyone uses for self-regulation.**
5. **Sensory systems: DTD can impair processing in one or more sensory systems if those systems were involved in early traumatic interactions. This can look like sensory based learning disabilities, but it isn't. As a result, when LD approaches are applied in school, they often are ineffective. This is because the sensory processing system is compromised by the presence of a traumatic emotional charge embedded within it, like so much static in a radio station signal, rather than the processing system itself being impaired.**
6. **Attentional system: DTD also dysregulates the attentional system. This, of course, looks like AD/HD and gets overwhelmingly labeled and treated as such. Trauma takes executive functioning skills offline as well. The experience of trauma tends to blunt innate curiosity and exploratory impulses.**
7. **Fragmentation / disorganization: We know from object relations theory that whatever is communicated as being off limits to an infant's caretaker is also off limits to the Self. Infants quickly pick up implicitly, what their caretakers do not want to see, will reject, are afraid of, will retaliate against… These elements become "off limits" which lays the groundwork for fragmenting the child's Self construct. This fragmentation of the Self produces a pervasive state of internal disorganization that causes further fragmentation as time moves forward, and so the disorganization is both effect and then cause. This internal disorganization impairs integrative processing such that the integration of sensory, cognitive, emotional, and behavioral experience into a congruent picture does not occur and so children with DTD can appear very different across time and situations. This, in turn causes significant confusion for the adults interacting with these children on an ongoing basis. Given their confusion, the adults are prone to respond inconsistently to the child, thereby validating the child's view of the world as unpredictable. Now the original traumatic context is being replicated in the present in a dizzying escalating spiral that carries profound implications for attachment.**
8. **Fragmentation / emotional awareness: The fragmentation of the Self disconnects children from their own feelings. Consequently, they may not know what they are feeling and may not even realize they are having an emotional experience. This will block developing emotional regulatory skills. Being internally disconnected will also prevent children with DTD from knowing what other people feel, with devastating effects on attachment and empathy skills.**
9. **The human face: As infants cannot escape the emotion on the caregiver's face, they are trapped by what that face conveys. If the caregiver's face conveys**

frightening emotion, the human face itself can become imprinted as a traumatic trigger. Here lies the origins of future avoidance of eye contact and physical closeness to the face which obstructs attachment.

10. **Internal Working Model: Children with DTD assemble an IWM that portrays the world as inevitably bringing hurt and pain, and themselves as "terrible, horrible…" So they come to expect continuing traumatic experiences. Hence, their behavior is aimed at maintaining some sense of safety by reducing external threat and blocking internal experience and fragmentation. Yet, action that originates from themselves they often see as "evil or bad", thereby creating an exquisite dilemma. Unfortunately this is frequently not understood by the adult world, and this survival behavior is given stigmatizing labels such as "oppositional" which reinforces the destructive view of the Self. This actually blocks emotional healing, as healing requires enormous safety to do the integrative work of connecting traumatic memories to other neural networks such that the traumatic material is ultimately integrated into the overall autobiographical narrative.**

Symptomatic presentation of DTD: Given its multiple developmental interferences, DTD manifests in a wide array of symptomatic presentations. A partial list includes dissociation, rejection of help from others, intense levels of affect, oppositionalism, impulsivity, distrust, flashbacks, nightmares, attentional problems, physical aggression, psychosomatic disturbances, medical illnesses, school difficulties, depression, self-hatred, and self-injurious behavior. Dividing these symptoms up amongst multiple diagnoses, vs. seeing them as facets of global internal disorganization, guarantees treatment failure.

Traumatic memory: Trauma is remembered as the discrete sensory components that were part of it. As such, it is embedded in the discrete sensory events without any processing of them vs. normal memory wherein there is active transformation of sensory events into a sensible narrative. Since sequential thinking is not functioning, the memories can't be chronologically ordered. Consequently, the story of the trauma truly gets told at the end of effective therapeutic interventions, for it is then that cognitive functioning can be brought to bear to integrate the prior discrete somatic elements.

Guilt & shame: Trauma victims carry guilt and shame about what they did or didn't do, in response to what was done to them at the time (trauma / shame interface). Trauma victims hate the little child within who complied, and did not fight, the abuser. This lays the foundation for a shame-based identity which reinforces the impact of fragmentation/disorganization on the Self.

DTD vs. Post Traumatic Stress Disorder (PTSD): PTSD stems from discrete, traumatic incidents rather than an ongoing pattern of embedded trauma. It manifests as specific responses to stimuli that are reminders of the traumatic incident. In the absence of traumatic triggers, PTSD symptoms may be minimal to wholly absent. PTSD lacks the pervasive developmental sequelae of DTD. Since PTSD can't account for all the symptoms of DTD, other diagnoses are often added to PTSD to cover the additional symptoms. This produces fragmented diagnostic thinking and the partial diagnosis phenomenon. Once again, it's the Blind Men and the Elephant story. The part is mistaken for the whole, leading to a lack of understanding about the whole (systemic dysregulation resulting from developmental trauma) and a partially effective, clinical response at best.

On the other hand, the "hidden traumas" of DTD do not meet the DSM-4 definition of a "traumatic event" as they are not imminently life threatening. Evidence based treatments for PTSD do not adequately address the pervasive developmental impairments and attachment difficulties that come with DTD.