Developmental Trauma Disorder: A New Paradigm for Trauma-Informed Assessment

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Continuing Medical Education Commercial Disclosure

I, Julian D. Ford, am a consultant to Advanced Trauma Solutions Professionals Inc., Sole Licensee of the University of Connecticut for the TARGET© Curriculum

What is Developmental Trauma?

1. Victimization/Exploitation

2. Core Attachment Insecurity

3. Exceeds the Individual's Adaptive Capacities/Resources

4. Alters the Individual's Development & Self-Regulation

Other Ways to Describe Developmental Trauma

- Complex Trauma
- Adverse Childhood Experiences (ACEs)
- Toxic Stress
- Cumulative Exposure to Trauma
- Polyvictimization
- Betrayal Trauma
- Catastrophic Experience (*ICD*-10 EPCACE)

A Dilemma: How to Describe the Complex Sequelae Developmental Trauma

- Psychotic, Anxiety, Mood, Dissociative, Substance Use, Sleep, Sexuality, Eating, Adjustment Disorders
- PTSD (DSM-5): Negative Cognitions/Mood, Reckless/ Self-Destructive/Aggressive Behavior, Dissociative ST
- Borderline Personality Disorder
- Complex PTSD 1.0: Disorders of Extreme Stress Not Otherwise Specified (DESNOS)
- Complex PTSD 2.0 (ICD-11): Disturbances of Self Organization (Affect, Relational, Self Dysregulation)

A Further Dilemma: How to Describe the Sequelae of Developmental Trauma for the Developing Child/Adolescent?

- Childhood Internalizing Disorders
- Childhood Posttraumatic Stress Disorder (PTSD)
- Childhood Dissociative Disorders
- Childhood Disruptive Behavior Disorders
- Childhood Neurodevelopmental Disorders
- Reactive Attachment Disorder
- DSM-5 Disinhibited Social Engagement Disorder

Developmental Trauma Disorder Field Trial Clinician Survey

S = 303 International, 1018 United States

82% female, 82% White, 7% Hispanic

Median age = 45

34% Psychology, 29% Social Work, 27% Counseling, 13% MFT, 7% Psychiatry, 6% Child Welfare, 6% Educators, 4% Case Managers, 4% Pediatrics

Developmental Trauma Disorder Field Trial Clinician Survey

DTD items most discriminable from PTSD (95% CI ≥ 4.0) N = 227-252

a) **Repeated Caregiver Separation (5.0-5.8)**
b) **Repeated Caregiver Absences (5.0-5.8)**
c) **Excessive Intimacy Seeking (5.0-5.7)**
d) **Impaired Emotional Boundaries (4.8-5.5)**
e) **Expectancy of Irresolvable Loss (4.6-5.4)**
f) **Somatic Dysregulation-Body Function (4.3-5.1)**
g) **Somatic Dysregulation-Pain/Conversion (4.0-4.7)**

Developmental Trauma Disorder Field Trial Clinician Survey

DTD items most discriminable from PTSD (Cont'd) (95% CI ≥ 4.0) N = 227-252

h. **Risky Behavior (4.6-5.3)**

i. **Self-Harm (4.3-5.0)**

j. **Self-Soothing (4.0-4.6)**

k. **Affect Dysregulation-Impaired Mood Repair (4.0-4.7)**

l. **Affect Dysregulation-Numbed Positive Affect (4.2-4.9)**

m. **Affect Dysregulation-Expressive Deficits (4.3-5.0)**

Developmental Trauma Disorder Field Trial Interview Study Phase I

- *N* = 236 ages 7-18 years old; 50% female
  - 30% African American/Biracial, 17% Hispanic, 3% Asian American
- Trauma Histories: 9% No trauma, 11% one type trauma, 38% poly-victim, 62% traumatic loss, 45% family violence, 24.5% neglect, 21% sexual abuse, 21% emotional abuse, 17% community violence

Developmental Trauma Disorder Field Trial Interview Study: Confirmatory Factor Analysis

Model	χ^2	CFI	TLI	BIC	RMSEA	SRMR
1-Factor	147.07*	0.93	0.91	4404.62	0.05 [0.04, 0.07]	0.05
3-Factor	145.79*	0.92	0.91	4395.52	0.05 [0.04, 0.07]	0.05
Hybrid	149.16*	0.92	0.90	4404.35	0.06 [0.04, 0.07]	0.08

Note. CFI, Comparative Fit Index; TLI, Tucker-Lewis Index; BIC, Bayesian Information Criterion; RMSEA, Root Mean Square Error of Approximation, SRMR, Standardized RMR.

Optimal fit indicated by lower χ^2, CFI and TFI $\geq$ .90, RMSEA and SRMR < 0.05, and a 10-point or greater difference in BIC between non-nested models (the latter indicates that the model with the smaller BIC is statistically superior with 150:1 odds) (Kass & Raftery, 1995). * p < .001

Developmental Trauma Disorder Discriminant Validity

DTD was *not* associated with the presence of a *DSM-5* dysregulation disorder on an unadjusted basis (*OR* = 1.74, 95% *CI* = 0.76 – 3.60)

However, PTSD *was* strongly associated with the presence of a *DSM-5* dysregulation disorder both on an unadjusted basis (*OR* = 3.72, 95% *CI* = 1.60 – 8.62) and in a multivariate logistic regression (*OR* = 3.34, 95% *CI* = 1.36 – 8.20) controlling for effects of DTD and demographics

DTD v. PTSD: Shared and Differential Trauma Antecedents

Shared:

- Emotional abuse or neglect, polyvictimization

Unique to DTD:

- Witnessing family or community violence
- Caregiver impairment or separation

- Unique to PTSD:
- Physical violence victimization

DTD vs. PTSD Comorbidity

Shared:

- Affective, Psychotic, Anxiety Disorders

Unique to DTD:

- Panic Disorder, Disruptive Behavior Disorders

Unique to PTSD:

- Obsessive Compulsive Disorder

Developmental Trauma Disorder Field Trial Interview Study Phase II

N = 271 ages 8-18 years old (*Mdn*=11.5)

- 47% female
- 50% White, 29% African American/Biracial, 17% Hispanic, 1% Asian American, 10% Other
- Trauma History: 4.5% No trauma, 4.5% one type trauma, 17% poly-victim, 80% separation/loss, 32.5% family violence, 19% neglect, 21% sexual, 20% emotional abuse, 18% community violence

Developmental Trauma Disorder Field Trial ReplicationStudy: Confirmatory Factor Analysis

Model	χ^2	CFI	TLI	BIC	RMSEA	SRMR
1-Factor	198.81*	0.88	0.87	366.87	0.07 [0.05, 0.08]	0.06
3-Factor	**172.30***	**0.91**	**0.89**	**357.17**	**0.06 [0.05, 0.07]**	**0.05**
Hybrid	179.56*	0.90	0.87	381.23	**0.06 [0.05, 0.07]**	**0.05**

Note. CFI, Comparative Fit Index; TLI, Tucker-Lewis Index; BIC, Bayesian Information Criterion; RMSEA, Root Mean Square Error of Approximation, SRMR, Standardized RMR.

Optimal fit indicated by lower χ^2, CFI and TFI $\geq$ .90, RMSEA and SRMR < 0.05, and a 10-point or greater difference in BIC between non-nested models (the latter indicates that the model with the smaller BIC is statistically superior with 150:1 odds) (Kass & Raftery, 1995). * p < .001

DTD v. PTSD: Shared and Differential Childhood Trauma/Adversity Antecedents

Shared

- Family Violence, Community Violence, Neglect, Polyvictimization

Unique to DTD

- Emotional Abuse, Traumatic Separation

Unique to PTSD

- Non-Interpersonal, Interpersonal Violence, and Sexual Trauma, Caregiver Impairment

DTD v. PTSD: Shared & Distinct Psychiatric Comorbidities

Shared

- Bipolar, Psychotic, Panic, Phobic, Attention Deficit, Conduct, Separation Anxiety Disorders

Unique to DTD

- ODD, OCD, Major Depression

Unique to PTSD

- [None]

Developmental Trauma Disorder

Criterion A.

Developmental Trauma Exposure

A. 1. Severe violence or victimization

AND

A. 2. Disruption of primary attachment bonds

Developmental Trauma Disorder

Criterion B.

Affective/Physiological Dysregulation

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

B. 2. Inability to modulate/recover from extreme bodily states: aversion to (a) touch, (b) sound; (c) unexplained bodily problems

Developmental Trauma Disorder

Criterion B.

Affective/Physiological Dysregulation

B. 3. Diminished awareness/dissociation of emotional or bodily feelings

B. 4. Impaired capacity to describe emotions (alexithymia) or bodily states

Developmental Trauma Disorder

Criterion C.

Attentional/Behavioral Dysregulation

C. 1. Attention-bias toward or away from potential threats

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

Developmental Trauma Disorder

Criterion C.

Attentional/Behavioral Dysregulation

C. 3. Maladaptive self-soothing

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

C. 5 Inability to initiate or sustain goal-directed behavior

Developmental Trauma Disorder

Criterion D.
Self and Relational Dysregulation

D. 1. Persistent extreme negative self-perception—self-loathing or viewing self as damaged/defective

D. 2. Attachment insecurity: attempt to care for caregivers, or difficulty tolerating reunion after separation from primary caregiver(s)

Developmental Trauma Disorder

Criterion D.

Self and Relational Dysregulation

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

D. 4. Reactive physical/verbal aggression

Developmental Trauma Disorder

Criterion D.

Self and Relational Dysregulation

D. 5. Psychological boundary deficits (excessive seeking of intimate contact or reliance on peers/adults for safety/reassurance)

D. 6. Dysregulated empathic arousal (intolerant/indifferent or overly reactive to others' distress

Summary of Field Trial Results

DTD is distinct from PTSD

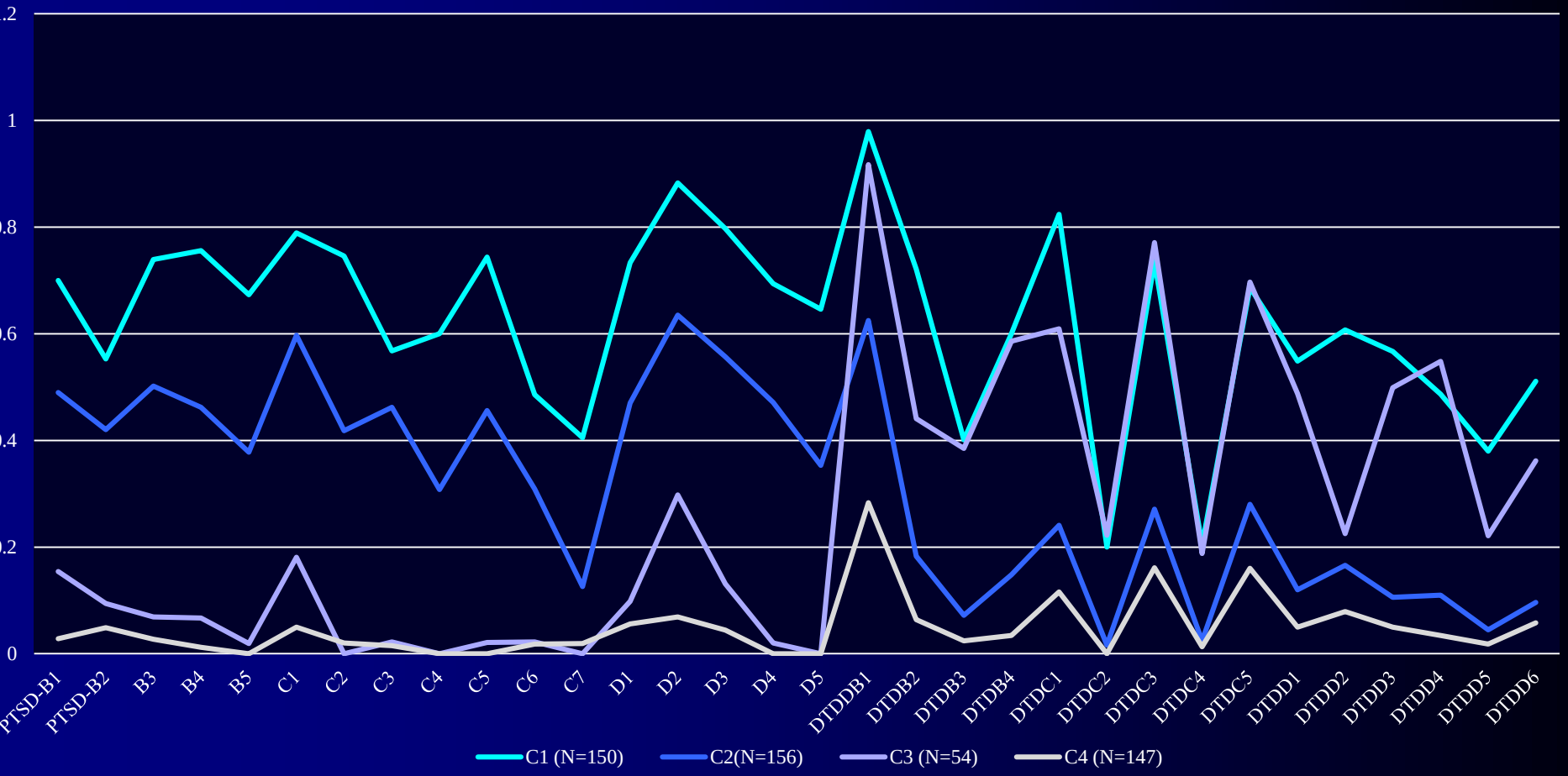
- ✓Symptoms (dysregulated affect, self, attachment)
- ✓Antecedents (emotional abuse, attachment loss)
- ✓Comorbidities (Depression, Disruptive Behavior)

Combined DTD+PTSD = SED/SMI?

- ✓ Bipolar, Psychosis, Panic, Conduct, ADHD, ODD

Future Directions

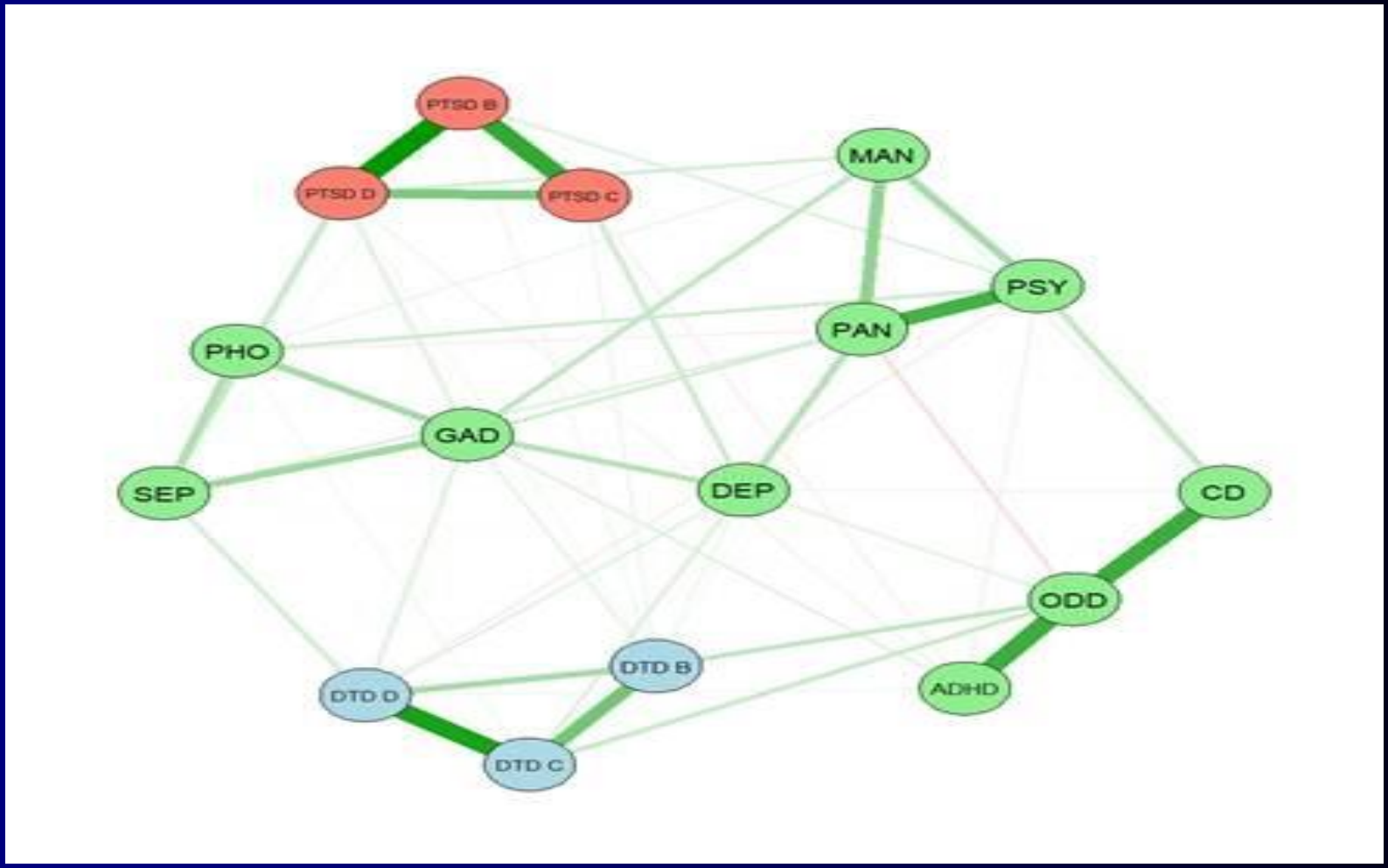
Empirical Profiles of DTD and PTSD by LCA



C1= PTSD+DTD
C2= Predominantly PTSD
C3= Predominantly DTD
C4= Minimal symptoms

Future Directions

Locating DTD and PTSD in the Network of Childhood Psychopathology



Future Directions

DTD=Precursor to Chronic Adult Psychiatric and Socio/legal Problems?

- ✓Dysphoric Disruptive Behavior
- ✓Dysregulation of Behavior, Motivation, Executive Functions, Relational Engagement

Or to cPTSD or Borderline PD?

- ✓Chronic Threat + Invalidation/Emotional Abuse
- ✓Multi-domain Dysregulation

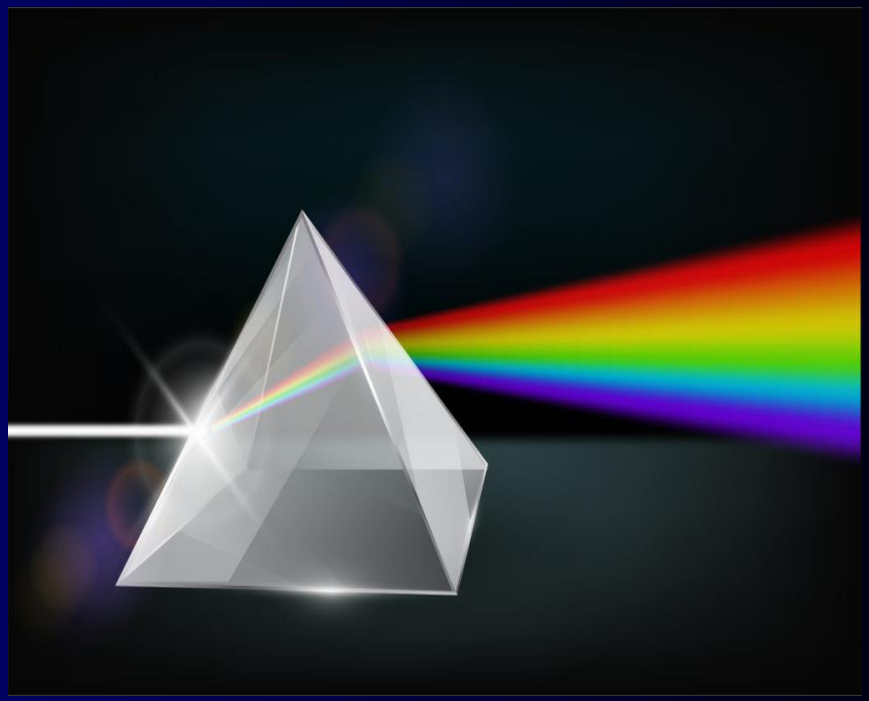
Therapeutic Foci for DTD

- ✓ Awareness and acceptance of affect/body/self states
- ✓ Differentiation of reactive vs. focused self-states
- ✓ Choosing and completing value-congruent goals
- ✓ Transforming defiance into value-based advocacy
- ✓ Reliability and continuity of primary relationships
- ✓ Developing adaptive boundaries and empathy
- ✓ Making meaning of memories of traumatic separation

PRISM (Courtois & Ford, 2023)

A trans-theoretical trans-diagnostic approach to therapeutic alliance, trauma memory processing, & crisis management after developmental trauma.

- Personalized
- Relational
- Integrative
- Sequenced
- Meaning Making



DTD Field Trial Phase I Publications

Ford, J. D., Spinazzola, J., van der Kolk, B., & Grasso, D. (2018). Toward an empirically-based Developmental Trauma Disorder diagnosis for children: Factor structure, item characteristics, reliability, and validity of the Developmental Trauma Disorder Semi-Structured Interview (DTD-SI). *Journal of Clinical Psychiatry, 79*(5), e1-e9. doi: doi.org/10.4088/JCP.17m11675

Spinazzola, J., van der Kolk, B., & Ford, J. D. (2018). When nowhere is safe: Trauma history antecedents of Posttraumatic Stress Disorder and Developmental Trauma Disorder in childhood *Journal of Traumatic Stress, 31*(5), 631-642. doi: 10.1002/jts.22320

van der Kolk, B., Ford, J. D., & Spinazzola, J. (2019). Comorbidity of developmental trauma disorder (DTD) and post-traumatic stress disorder: findings from the DTD field trial. *European Journal of Psychotraumatology*, *10*(1), 1562841. doi: 10.1080/20008198.2018.1562841

DTD Field Trial Phase 2 Publications

Ford, J. D., Spinazzola, J., van der Kolk, B., & Chan, G. (2022). Toward an Empirically-Based Developmental Trauma Disorder (DTD) Diagnosis and Semi-Structured Interview for Children: The DTD Field Trial Replication. *Acta Psychiatrica Scand*inavica https://doi.org/10.1111/acps.13424

Ford, J. D., Spinazzola, J., & van der Kolk, B. (2021). Psychiatric comorbidity of developmental trauma disorder and posttraumatic Stress disorder: findings from the DTD field trial replication (DTDFT-R). *European Journal of Psychotraumatology*, *12*(1), 1929028 https://doi.org/10.1080/20008198.2021.1929028

Spinazzola, J., van der Kolk, B., & Ford, J. D. (2021). Developmental Trauma Disorder: A Legacy of Attachment Trauma in Victimized Children. *Journal of Traumatic Stress*, *34*(4), 711-720. https://doi.org/10.1002/jts.22697

DTD Field Trial Combined Phase 1/2 Publications

Ford, J. D. (2021). Why We Need a Developmentally Appropriate Trauma Diagnosis for Children: a 10-Year Update on Developmental Trauma Disorder. *Journal of Child and Adolescent Trauma*. https://doi.org/10.1007/s40653-021-00415-4

Ford, J. D., Shevlin, M., Karatzias, T., Charak, R., & Spinazzola, J. (2022). Can Developmental Trauma Disorder be distinguished from posttraumatic stress Ddsorder? A confirmatory factor analytic test of four structural models. *Research in Child and Adolescent Psychopathology*. https://doi.org/doi.org/10.1007/s10802-022-00916-2

Hyland, P., Ford, J. D., Fox, R., Karatzias, T., & Spinazzola, J. (2022). The latent structure of child and adolescent psychopathology and their association with different forms of trauma and suicidality. *Research in Child and Adolescent Psychopathology*.