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**Special Feature Article**

# "Developmental Trauma Disorder (DTD)" in a Psychological Treatment Facility for Children: A New Evaluation of Children's Behaviors

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## Abstract

In psychological treatment facility for children, which are established to support children with emotional problems that interfere with their daily lives, most of the children have a history of adverse childhood experiences (ACE). The impact of ACE ranges widely from psychological to behavioral aspects, and lasts into adulthood. The behaviors of children with a history of ACE are diverse, and the staff at such facilities pay attention to different aspects of those. Consequently, there is inadequacy in consensus over the therapeutic goals for the sheltered children and over the criteria for the therapeutic efficacy at psychological treatment facilities for children. Van der Kolk made a critique that the current diagnostic system fails to conceptualize their difficulties properly, and proposed a new diagnostic concept of developmental trauma disorder (DTD). Although this was not adapted in the DSM-5, it has enabled us to conceptualize symptoms that had been captured separately in the conventional diagnostic system as a single entity rather than as multiple comorbid diagnoses, and to further evaluate symptoms that had been previously overlooked under the current

diagnostic system. After evaluating children at the facility from the perspective of DTD, we found that, with exceptions of a few items, over 60% of the children demonstrated behaviors characteristic of DTD. DTD can provide clinically useful assessment criteria when we discuss treatment goals and evaluate treatment efficacy. Henceforth, we aim to accumulate data and examine the efficacy of DTD while exploring optimal treatment options for children with a history of ACE.

**Keywords**: developmental trauma disorder, psychological treatment facility for children (short-term therapeutic facility for emotionally disturbed children), adverse childhood experiences, childhood abuse

## Introduction.

Psychological treatment facilities for children (formerly known as short-term treatment facilities for emotionally disturbed children) are stipulated in the Child Welfare Law, and are child welfare facilities that provide support for children who have emotional problems that interfere with their daily lives. At these facilities, psychological treatment based on life support is provided, and comprehensive support is provided in cooperation with school education. Admission is decided by the Child Guidance Center, a specialized organization for child welfare. Some children are admitted with the consent of their parents, while others are admitted without parental consent after a judicial decision that institutionalization is appropriate for protecting children from childhood abuse. Most of these children have had adverse childhood experiences (ACE), such as childhood abuse. The Ministry of Health, Labor and Welfare (MHLW) reported that childhood abuse cases at child guidance centers were 122,575 in fiscal year 2016, and the number is increasing year by year (6). The effects of ACEs are long-lasting into adulthood, and have a negative impact on future mental and physical health (2)(3).

However, as pointed out by Takagishi et al (7), there has been no consensus to date on the criteria for judging what behaviors of children admitted to psychological treatment facilities should be considered as treatment goals. One of the reasons for this is the wide variety of behaviors exhibited by children with ACEs. They may have a variety of diagnoses depending on the symptoms that appear on the surface,

such as separation anxiety disorder, oppositional defiant disorder, posttraumatic stress disorder (PTSD), attention- deficit/hyperactivity disorder (ADHD), etc (1). At our facility, in addition to the symptoms that can be explained by existing diagnoses, the following symptoms were also observed: holding the bidet against his buttocks in the bathroom more than 30 minutes, complaining that "I don't want you to spend money on me" when he was injured and the staff tried to take him to the hospital, hugging the staff all the time even during the hot summer season, adding a lot of chili peppers and other spices to the ramen until it turns bright red, wearing short sleeves and short pants and using fans or air conditioners to lower the room temperature even in winter, going out at night with strangers of the opposite sex, and do not understand the danger even when we tell them about it. Many children are truant from school (our facility does not have a specialized classroom for our children, and they must attend the local school with local children).

In such situations, even if we evaluate children's behaviors as existing symptoms, many of them may be omitted from the list of standard diagnosis system. And different staff members involved in supporting the child may pay attention to different behaviors , which may lead to inconsistency in setting treatment goals. In addition, externalizing behaviors such as hyperactivity, impulsivity, and defiance toward adults are easily noticed, while children who are quiet and rarely interact with others or who tend to be over-adjusted often go unnoticed, even if they have many internal problems. Considering the background of the children, a diagnosis based only on surface behaviors will not lead to an appropriate assessment of the children's condition or treatment methods for them (11).

Van der Kolk, B. A. proposed developmental trauma disorder (DTD) as a concept that can explain the behaviors of children with ACE in a unified manner, saying that the current diagnostic system does not capture the behaviors of children with ACE and does not adequately grasp the difficulties they face (10). Although developmental trauma disorder (DTD) was not included in the DSM-5, it is useful in that it allows us to view children's behaviors as a unified concept rather than as a combination of multiple diagnoses, and to evaluate those that cannot be captured by existing diagnoses. Although there have been several references to DTD in the literature (9)(13), there have been no reports in Japan that have actually evaluated a group of children based on

the concept of DTD. In the present study, we conducted a survey to assess whether the children admitted to our facility met the items of the DTD, and report the results.

## I. Survey Methodology

### 1. Subjects

The subjects consisted of 28 children in our facility as of December 31, 2017, 20 of whom had consent from the children themselves and their custodial parents or guardians, if any, and for whom the following data were available.

### 2. Acquired data

From Child Guidance Center records and institutional records, medications, intelligence quotient (IQ) assessed by the Wechsler Intelligence Scale for Children III or IV, whether the child had ever been diagnosed with Autism Spectrum Disorder (ASD) or ADHD prior to admission, information on childhood ACEs such as abuse or neglect information , and whether or not they were taking antipsychotic and ADHD medications were investigated. It is said that the number of ACEs correlates with psychiatric disorders (depression, alcohol and other substance abuse, etc) and various physical diseases (e.g. ischemic heart disease, cancer, chronic respiratory disease, liver disease, etc) (3)(4). Different studies use different methods to calculate ACEs, but in this study, we set 10 items based on other study (8) and counted the number of items that were judged to be definitely applicable (Table 1). For DTD, we conducted an evaluation by psychiatrists and clinical psychologists who observed the child from September 1 to December 31, 2017. Data on school attendance between January and March 2018 were obtained from school report cards. In addition, the Attention-Deficit Hyperactivity Disorder Rating Scale-IV (ADHD-RS-IV), and Pervasive Developmental Disorders Autism Society Japan Rating Scale (PARS) were used. In the end, statistical analysis was conducted using the attendance rate for estimating an outcome, and the results of this analysis will be reported in a separate paper. R-3.5.1 was used as the analysis software.

### 3. Ethical considerations

Consent was obtained not only from the children, but also from their parents or guardians if they had parental authority or guardians. Documents describing the purpose of the survey, protection of personal information, and other information related to the survey were prepared for both adults and children. The documents were mailed to adults and posted in the facility for children, respectively, to inform them that they could refuse the use of their data, and we confirmed that there were no refusals. The study was approved by

the Ethics Review Committee of the Kyoto Katsura Hospital, which is affiliated with the institution, in accordance with the Declaration of Helsinki.

## II. Results

Table 2 shows the background of the 20 subjects. The ages of the subjects ranged from 10 to 17 years (median 13 years), and the sexes were 9 males and 11 females. Five were taking antipsychotic medications and four were taking ADHD medication. In terms of childhood abuse, 18 had experienced psychological abuse, 18 had experienced physical abuse, and 2 had experienced sexual abuse (excluding 3 who were not sure of the facts regarding sexual abuse). The number of children who had experienced sexual exposure, such as being shown sexual videos or witnessing adults having sexual intercourse, even if they had not been directly sexually abused, was 7 (excluding 2 children for whom the facts were not clear).

The median values for each were 87 for total IQ, 16 months for institutionalization, 5 for ACE, and 67.1% for attendance, with 8 children attending more than 80% of the time.

In van der Kolk's paper (11) , DTD is divided into items A to G. Item A is ACE, item B is emotional and physiological dysregulation, item C is attention and behavioral dysregulation, item D is self dysregulation and interpersonal dysregulation, item E is assessment of PTSD symptoms, item F is persistence of symptoms evaluated in DTD, and item G is an assessment of functional impairment in life. In this article, we report on items A through D, which relate to ACE and the child's specific behaviors. Table 3 shows the number of children who were judged to fall into each category.

The results of the survey showed that all of the 20 children fell into item A. The percentage of children who fell into item B exceeded 60% for all items from B1 to B4, especially 80% for B1 and 90% for B4. For item C, the percentages were low: 15% for C2, 35% for C3, and 15% for C4, but 65% and 75% for C1 and C5, respectively. In item D, the percentages of children in items D2 through D6, except for D1, exceeded 60%.

## III. Discussion

The results of this study showed that the percentage of children who were judged to fall into each category of DTD exceeded 60%, excluding some items. It was found that children's behaviors that could not be grasped as symptoms by existing diagnoses, such as those listed in the introduction, could be evaluated based on the concept of DTD. For example, item C3 included using the bidet on the buttocks for a long time, D2

did saying "I don't need to spend money on myself," D5 did wanting to hug the staff, B2 and B3 did being fine with eating unusually spicy food and wearing light clothes even when it was cold, in D3 to D6 did not going to school (One child who does not go to school once said, "Why should I go to school and spend time with children who live happily with their mothers even though I am in an institution? I hate just looking at those kids). It is considered C1, C2, and D5 to go out with unknown members of the opposite sex at night, and C1 to be unable to predict danger.

Item B can be used to evaluate children's verbal expressions and behaviors that seem emotionally unstable because children are not aware of their own emotions and are therefore unable to express them to the outside world, making it difficult for others to know what they are thinking. Item C can be used to evaluate children's verbal expressions and behaviors that show lack of ability to properly recognize external dangers and to get a long-term perspective, and tendency to seek out dangers on their own. In item D, we can evaluate low self-esteem, deep-seated distrust of society and others, and difficulty in building interpersonal relationships based on trust.

Through this survey, staff members said that they could understand for the first time the influence of ACE on children's behavior, which had been considered empirically acceptable, and that some behaviors were newly noticed. In addition, the staff members shared their perceptions more deeply. The evaluation based on the concept of DTD will be clinically useful to improve the current situation where there is not enough consensus on how to set treatment goals for children and how to judge the effectiveness of treatment. For example, the fact that a child can eat unusually spicy food and wear light clothes even when it is cold, which were considered to be B2 and B3, will be recognized as ACE effects by the staff who had not paid special attention to them before. If items that correspond to B2 and B3 are evaluated as decrease by successive evaluation, it is possible to evaluate that the treatment progresses for those items. In this study, the sample size was small, and it is necessary in our facility to accumulate more data to verify the clinical usefulness of DTD. We plan to conduct assessments based on the concept of DTD in succession and observe the changes. If the DTD can be assessed in a multi-center study, it will be possible to examine the differences in the appearance of behaviors of children among those facilities.

In terms of treatment, van der Kolk et al. stated that trauma-focused treatment is warranted for children who

do not meet all the diagnostic criteria for DTD, but still have behaviors that fall into the categories (12). At our facility, we have begun to provide such treatment in addition to conventional support for children. Eventually, we would like to accumulate therapeutic experience based on DTD and explore the optimal treatment for children with ACE.

By the way, ICD-11 is scheduled to adopt a diagnosis of complex PTSD for adults. It is characterized by three symptoms called disturbance in self-organization (DSO) symptoms: difficulties in controlling emotions, negative self-concept, and difficulties in interpersonal relationships (5) . This constitution of symptoms is similar in content to DTD. In this way, the concept of unifying the various symptoms caused by trauma, which cannot be captured by PTSD alone, is expected to expand in the future.

In addition, reactive attachment disorder (RAD) is known as a mental disorder resulting from an inappropriate nurturing environment, and the difference between RAD and DTD may be problematic. In this regard, van der Kolk et al. state, "Both DTD and RAD result from significant disturbances in protective parenting, but RAD does not address (a) the effects of interpersonal violence, (b) difficulties with emotion regulation, (c) aggressive or risky behaviors, (d) self-injury or self-consolation, or (e) a persistent negative sense of self (11). Therefore, it should be treated as a different condition at this time.

## Conclusion.

Children with ACEs, such as those who have been abused in childhood, exhibit a wide variety of behaviors. In child psychological treatment facilities, each facility implements the treatment it deems best, but at present, there is no consensus on treatment goals or criteria for judging the effectiveness of treatment. Although DTD has not been adopted as an official diagnosis, it may be useful in improving the current situation. We will continue to investigate the clinical usefulness of DTD and seek the optimal treatment for children with ACE.

There are no conflicts of interest to be disclosed in relation to this paper.

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| | |
|---|---|
| 1 | あなたの父，母，あるいは同居する大人（両親以外）は，よく，またはとてもよく…<br>あなたを罵る，侮辱する，けなす，またはあなたに恥をかかせるようなことをしていましたか？<br>もしくは，あなたの身体が傷つけられるかもしれないと怖くなるような振る舞いをしていましたか？ |
| 2 | あなたの父，母，あるいは同居する大人（両親以外）は，よく，またはとてもよく…<br>あなたを押す，つかむ，あなたに平手打ちをする，または物を投げつけるようなことをしていましたか？<br>もしくは，あなたに傷跡が残ったりあなたが怪我をしたりするほど強く，あなたのことを殴ったことが一度でもありましたか？ |
| 3 | 大人，またはあなたよりも５歳以上年上の他人が…<br>あなたを触る，なでまわす，またはあなたにその人の身体を性的に触らせるといったようなことが一度でもありましたか？<br>もしくは，その人が，口，肛門，または膣を介した性交を行おうとする，または実際に行うといったようなことが一度でもありましたか？ |
| 4 | あなたはよく，またはとてもよく…<br>家族の誰一人としてあなたのことを愛していない，またはあなたのことを大切だ，特別だと思っていないと感じていましたか？<br>もしくは，あなたの家族は，お互いを気にかけたり，お互いに親しみを感じたり，お互いを支え合ったりしていないと感じていましたか？ |
| 5 | あなたはよく，またはとてもよく…<br>食事を十分に与えられていない，汚れた服を着なければならない，または自分を守ってくれる人は誰もいないと感じていましたか？<br>もしくは，両親がお酒や麻薬の影響であなたの世話をしてくれない，または必要なときにあなたを医師のもとへ連れて行ってくれないと感じていましたか？ |
| 6 | あなたの両親は，別居，または離婚をしたことが一度でもありましたか？ |
| 7 | あなたの母親，または義理の母親は，<br>よく，またはとてもよく，押される，つかまれる，平手打ちされる，または物を投げつけられるといったようなことをされていましたか？<br>もしくは，たまに，よく，またはとてもよく，蹴られる，かまれる，またはこぶしや他の何か硬い物で殴られるといったようなことをされていましたか？<br>もしくは，少なくとも数分の間くり返し殴られる，または銃や刃物でおどされるといったようなことが一度でもありましたか？ |
| 8 | あなたは，酒に酔うと自身の生活や人間関係を損なうような振る舞いをする人，アルコール中毒の人，または薬物乱用者と一緒に住んでいましたか？ |
| 9 | 当時，あなたが同居していた人のなかに，うつ病やその他の精神疾患を患っている人，または自殺（未遂を含む）をした人はいましたか？ |
| 10 | 当時，あなたが同居していた人のなかに，刑務所に服役した人はいましたか？ |

Table 1 ACE 10 items

1 Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?

2 Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?

3 Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?

4 Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?

5 Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

6 Were your parents ever separated or divorced?

7 Was your mother or stepmother:
Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

8 Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

9 Was a household member depressed or mentally ill, or did a household member attempt suicide?

10 Did a household member go to prison?

| | |
|---|---|
| 年齢 | 中央値 13（最小値 10～最大値 17） |
| 男/女 | 9/11 |
| 入所期間（月） | 中央値 16（最小値 2～最大値 84） |
| 全検査 IQ | 中央値 87（最小値 72～最大値 120） |
| 入所までに ASD と診断された | 3（15.0%） |
| 入所までに ADHD と診断された | 8（40.0%） |
| 抗精神病薬の内服 | 5（25.0%） |
| ADHD 治療薬の内服 | 4（20.0%） |
| 心理的虐待 | 18（90.0%） |
| 身体的虐待 | 18（90.0%） |
| 性的虐待（17 名） | 2（11.8%） |
| 性的虐待＋性的曝露（18 名） | 7（38.9%） |
| 地元学校への出席率 | 中央値 67.1%（最小値 0.0～最大値 100.0） |
| 出席率が 80%以上 | 8（40.0%） |
| ACE の数（0～10） | 中央値 5（最小値 2～最大値 7） |

Table 2 Background of the 20 subjects

Age Median 13 (minimum 10 to maximum 17)

Male / Female 9 / 11

Length of stay (months) Median 16 (min. 2 to max. 84)

Total total IQ Median 87 (min 72 to max 120)

Diagnosed with ASD by the time of admission 3 (15.0%)

Diagnosed with ADHD by the time of admission 8 (40.0%)

Taking antipsychotic medication 5（25.0%）

Medication for ADHD 4（20.0%）

Psychological abuse 18（90.0%）

Physical abuse 18（90.0%）

Sexual abuse (17 respondents) 2 (11.8%)

Sexual abuse + sexual exposure (18 respondents) 7 (38.9%)

Attendance at local school Median 67.1% (minimum 0.0 to maximum 100.0)

Attendance more than 80% 8 (40.0%)

Number of ACEs (0-10) Median 5 (min. 2 to max. 7)

| 項目 | 内容 | 数と割合 |
|---|---|---|
| A | 曝露，児童または青年が児童期または初期青年期にはじまる，少なくとも1年以上に続く，以下のような苛酷な出来事を，複数または長期間，経験または目撃すること（1，2どちらか1つ）<br>1：反復的で重篤な対人暴力の，直接の体験または目撃<br>2：主要な養育者の再三の変更，主要な養育者からの再三の分離，あるいは，過酷で執拗な情緒的虐待への曝露の結果としての，保護的養育の重大な妨害 | 20（100.0%） |
| B1 | 極端な感情状態（例えば恐れ，怒り，恥）を調節したり，それに耐えたり，それから立ち直ったりする能力の欠如，持続的で極端な癇癪，または動けなくなる状態を含む | 16（80.0%） |
| B2 | 身体的機能の調節の障害（睡眠，摂食，排泄における持続的障害，接触や音に対する過大または過少な反応，日常生活で1つの活動から別の活動に移るときの統制の混乱など） | 14（70.0%） |
| B3 | 感覚，情動および身体的状態の気づきの減少/解離 | 12（60.0%） |
| B4 | 情動または身体的状態を説明する能力の障害 | 18（90.0%） |
| C1 | 脅威にとらわれること，または安全の手がかりや危険の手がかりの誤認を含む，脅威を認知する能力の障害 | 13（65.0%） |
| C2 | 極端に危険な行為またはスリル追求を含む，自己防衛の能力の障害 | 3（15.0%） |
| C3 | 自己慰撫のための不適切な試み（体を揺り動かすことなどのリズミカルな動き，強迫的自慰など） | 7（35.0%） |
| C4 | （意図的または無意識的で）常習的，または反応性の自傷行為 | 3（15.0%） |
| C5 | 目的志向的行動を開始したり継続したりできないこと | 15（75.0%） |
| D1 | 養育者またはその他の親密な人の安全に極度にとらわれること（大人びた奉仕を含む），あるいは，それらの人物と分離した後，再会が我慢できないこと | 4（20.0%） |
| D2 | 自己嫌悪，無力感，無価値感，無能感，不完全感を含む，継続的な否定的自己感覚 | 16（80.0%） |
| D3 | 大人や仲間との親密な人間関係における，極端で継続的な不信，反抗的態度，互恵的行動の欠如 | 13（65.0%） |
| D4 | 仲間または養育者またはその他の大人に対する，反応性の身体的または言語的攻撃 | 13（65.0%） |
| D5 | 親密な接触（性的または身体的親密さを含むがそれに限らない）を得るための不適切な（過剰またはみさかいのない）試み，あるいは安全と安心確保のための仲間または大人への過度な依存 | 12（60.0%） |
| D6 | 他者による苦悩の表出への共感または寛容性の欠如，あるいは他者の苦悩に対する過度な反応性によって裏づけられる共感的覚醒を調節する能力の障害 | 12（60.0%） |

Table 3 DTD contents (items A, B, C, and D) and the number and percentage of children who responded

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 (1 or 2)　20 (100%)

1: Direct experience or witnessing of repeated and severe episodes of interpersonal violence

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

B1 Inability to modulate, tolerate, or recover from extreme affect states (e.g., fear,

anger, shame), including prolonged and extreme tantrums, or immobilization 16 (80.0%)
B2 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) 14 (70.0%)
B3 Diminished awareness/dissociation of sensations, emotions and bodily states 12 (60.0%)
B4 Impaired capacity to describe emotions or bodily states 18 (90.0%)
C1 Preoccupation with threat, or impaired capacity to perceive threat, including misreading of safety and danger cues 13 (65.0%)
C2 Impaired capacity for self-protection, including extreme risk-taking or thrill-seeking 3 (15.0%)
C3 Maladaptive attempts at self-soothing (e.g., rocking and other rhythmical movements, compulsive masturbation) 7 (35.0%)
C4 Habitual (intentional or automatic) or reactive self-harm 3 (15.0%)
C5 Inability to initiate or sustain goal-directed behavior 15 (75.0%)
D1 Intense preoccupation with safety of the caregiver or other loved ones (including precocious caregiving) or difficulty tolerating reunion with them after separation 4 (20.0%)
D2 Persistent negative sense of self, including self-loathing, helplessness, worthlessness, ineffectiveness, or defectiveness 16 (80.0%)
D3 Extreme and persistent distrust, defiance or lack of reciprocal behavior in close relationships with adults or peers 13 (65.0%)
D4 Reactive physical or verbal aggression toward peers, caregivers, or other adults 13 (65.0%)
D5 Inappropriate (excessive or promiscuous) attempts to get intimate contact (including but not limited to sexual or physical intimacy) or excessive reliance on peers or adults for safety and reassurance 12 (60.0%)
D6 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 12 (60.0%)