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Special Feature Article

Background and Understanding of Developmental Trauma Disorder

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Abstract

A diagnostic concept of developmental trauma disorder was proposed by van der Kolk et al. to capture a comprehensive view of the psychological impact of adverse experiences (chronic repetitive traumatic experiences, which at their core are experiences of abuse) on children. The symptomatology encompasses, beyond trauma-related symptoms, a wide range of dysfunctions, including emotional/physical/cognitive dysregulation, attentional and behavioral dysregulation, and altered sense of self-attribution and expectations toward society. It is a co-occurrence of pathologies related to both attachment and trauma and can be understood as a childhood version of Complex Posttraumatic Stress Disorder.

Attachment is defined as "an individual's inclination to seek and maintain proximity to a specific object in a crisis situation or in preparation for a potential crisis", meaning that when stress increases in a crisis, proximity to an attachment object can soothe and restore disrupted emotions. In the event of a traumatic experience, the stable attachment style can assist in recovery from the trauma by acting as a regulating buffer, both physically and emotionally. Posttraumatic stress disorder with a lack of stable attachment style formation can be understood as Complex Posttraumatic Stress Disorder. With the recent rapid increase in the number of cases of child abuse, more and more children with

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clinical symptoms, as defined by developmental trauma disorder, are being referred to child psychiatric institutions. However, diagnostic criteria that consider the unique symptoms of such children do not yet exist; thus, the diagnoses are currently dispersed among various diagnostic categories. From this perspective, it would be meaningful to reexamine the clinical concept of developmental trauma disorder.

Keywords: developmental trauma disorder, posttraumatic stress disorder, attachment, adverse childhood experiences

Introduction

Developmental trauma disorder (DTD) is a clinical concept proposed by van der Kolk, B.A., et al.[30] Although a proposal[31] was submitted during the revision of the Diagnostic and Statistical Manual of Mental Disorders, 5th ed. (DSM-5),[5] it was ultimately not included and remains so to this day.

The basic concept posits that in children experiencing ongoing adversity, pathologies related to both attachment and trauma coexist and manifest. While sufficient clinical consensus has yet to be reached, with the increase in cases of child abuse, opportunities to encounter children whose clinical symptoms match this profile are becoming more frequent in child psychiatry practice. However, since DSM-5[5] contains no diagnostic categories related to attachment other than Reactive Attachment Disorder, children who exhibit specific symptoms due to attachment pathology who do not meet the criteria for Reactive Attachment Disorder are currently dispersed across various diagnostic categories. The author believes that it is meaningful to re-examine and reconsider the clinical concept of developmental trauma disorder. Furthermore, this concept exists within a broader trend of discussing post-traumatic stress disorder (PTSD) in adults as well, and it is important to understand it in the context of these developments.

In this paper, I intend to first touch upon attachment, then attempt to organize the concepts surrounding complex PTSD, and finally discuss developmental trauma disorder. Note that in this paper, "attachment" is generally translated as "*attachment*," but where it is translated as "*ai-chaku*" in established texts, I will use that term.

I. On Attachment

The theory of attachment was developed by J. Bowlby,[11] who

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empirically theorized the mother-infant relationship based on observational studies and further refined it by incorporating perspectives from evolutionary biology, animal behavior, and cognitive psychology. Attachment is defined as "an individual's tendency to seek and maintain proximity to a specific object in the face of a crisis or in preparation for a potential crisis,"[11)15)] and in a sense, it can be rephrased as a system for coping with stress (the attachment system). Thus, it demonstrates that we humans are innately equipped with a system that calms and restores our emotional balance by seeking proximity to an attachment figure (which is not necessarily a human) when stress levels rise during a crisis. The more stable this attachment system is, the more one can openly express signals when a crisis arises, making it easier to receive help from others.[23)] Even when experiencing trauma, the presence of a secure attachment figure (a person with a secure attachment style) acts as a regulatory buffer both physically and emotionally, thereby contributing to recovery from trauma.[17)]

The Strange Situation procedure,[2)] devised by Ainsworth, M.D. et al., targets infants aged 12 to 18 months and classifies attachment patterns (styles) based on their reactions to caregivers and unfamiliar adults (distress during separation and anger upon reunion).

Centered on the "Secure" type, the "Avoidant" type, which tends not to rely much on attachment as a stress-coping system, and the "Ambivalent-Resistant" type, which overactivates the attachment system, are positioned in opposition to one another. Later, the "Disorganized" type (Type D)[22)] was added to these three, and currently, four attachment patterns are defined. Regarding individual differences in attachment patterns, while innate factors such as temperament and heredity are not entirely ruled out, it is considered that subsequent environmental factors exert a stronger influence than genetic factors.[10)] Regarding Type D, it is considered that if a caregiver has an unresolved state of mind related to past loss or trauma, this manifests in their relationship with the child as "frightened" or "frightening" behavior. Consequently, the caregiver, who should be soothing and restore the child's emotional well-being, becomes a contradictory figure, thereby contributing to the child's Type D attachment pattern.[19)] Therefore, while child abuse, a prime example of a relationship that "frightens" the child, is not the sole cause of Type D attachment patterns, it is hypothesized that abused children may develop Type

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D attachment patterns or attachment patterns at a more pathological level.

Regarding the pathological levels of attachment, "secure" is considered the most adaptive pattern, while "avoidant," "ambivalent-resistant," and "Type D" are viewed as becoming increasingly maladaptive.[7] Furthermore, as a pathology of attachment patterns at a level even more maladaptive than Type D, Zeanah, C.H. Jr. et al. proposed the clinical concept of "attachment disorder (distortion of the secure base)."[34] This concept was derived from cases involving children who had experienced abuse or neglect and who, although they had tentatively selected a caregiver as an attachment figure, exhibited significantly distorted behaviors toward that caregiver. The characteristics of these children include: (i) self-endangering aggressive behavior, (ii) restricted exploration and excessive clinging, (iii) excessive wariness and anxious over-compliance toward a specific caregiver, and (iv) role-reversed caregiving. However, even with this concept, the pathology is at a more adaptive level than that defined as Reactive Attachment Disorder in DSM-5[5]; the condition medically classified as "Reactive Attachment Disorder" refers to an extremely rare, severe state in which the child lacks even a selective attachment figure. Conversely, this means that there are currently no child psychiatric diagnostic criteria centered on attachment that comprehensively address the various problems arising from the pathology at the level of "attachment disorder (distortion of the secure base)" proposed by Zeanah et al.

II. PTSD and Complex PTSD

Trauma consists of four elements: "intense fear," "a sense of isolation and helplessness," "loss of self-control," and "the threat of complete annihilation of the self." It refers to experiences that the traumatized individual perceives as "unbearable,"[6] and in practice, examples include disasters, crimes, physical/sexual violence, traffic accidents, and the loss of a loved one due to a sudden, unexpected death or an accidental death. PTSD is the most representative trauma-related disorder; however, for a medical diagnosis of PTSD, the presence of Criterion A (experiences involving a threat to life or incidents of sexual violence, etc.) as defined in DSM-5[5] is essential. The core symptoms of PTSD include intrusive thoughts and memories, avoidance of stimuli associated with the trauma, emotional numbing, and hyperarousal. In addition to these, DSM-5[5] added "negative changes in cognition and mood" as diagnostic criteria and began assessing whether dissociative symptoms are present. Although the pathogenesis of PTSD has not yet been

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conclusively established, it is common for individuals to exhibit symptoms consistent with the diagnostic criteria for PTSD as an immediate reaction to a traumatic experience. While many people gradually recover through internal and external resources, it is becoming increasingly recognized that in situations where such resources are lacking, recovery does not occur, and PTSD may become entrenched and chronic.[26)27)] From this perspective, as mentioned above, secure attachment can also be considered an important resource for recovery.

In DSM-5,[5)] criteria separate from the general PTSD diagnostic criteria are provided for children aged 6 or under (Table 1). Regarding Criterion A, "Exposure to the Traumatic Event," while the general criteria list various ways of experiencing trauma, the criteria for children aged 6 or under generally limit such experiences to those involving caregivers in cases other than the child's own direct experiences. Furthermore, regarding Criterion B, "Presence of Intrusive Symptoms," the criteria for children under 6 include several notes. Additionally, while the general criteria define triggers for intrusive symptoms as including symbolic or internal factors, the criteria for children under 6 define them simply as "things that remind the child of the event." Furthermore, while the general criteria divide Section C ("Persistent Avoidance") and Section D ("Negative Changes in Cognition and Mood"), the criteria for children under 6 combine them into a single Section C ("Avoidance or Negative Changes in Cognition and Mood"), and specify that either "persistent avoidance" or "negative change in cognition and mood" is sufficient. Finally, regarding Item E in the general criteria (Item D in the criteria for children aged 6 or under), "marked changes in arousal and reactivity," the general criteria list "irritability and anger manifested as aggression toward people or objects" and "reckless or self-destructive behavior," whereas the criteria for children aged 6 or under include "extreme tantrums" under "irritability and anger manifested as aggression toward people or objects," and the item regarding "reckless or self-destructive behavior" has been omitted.

Regarding complex PTSD, the concept originated with Herman, J.L., who conceptualized a cluster of trauma-related problems as "complex PTSD."[18)] Herman's definition of complex PTSD, triggered by long-term, repeated trauma such as hostage situations, concentration camp survival, physical and sexual abuse of children, and sexual exploitation, includes the following symptoms: (i) changes in emotional regulation (persistent irritability, self-

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harm, explosive anger, etc.), (ii) changes in consciousness (dissociative episodes, re-experiencing symptoms, etc.), (iii) changes in self-perception (feelings of isolation and helplessness, guilt, shame, and isolation), (iv) altered perceptions of the perpetrator (e.g., preoccupied by the relationship with the perpetrator), (v) altered relationships with others (e.g., social withdrawal, repeated seeking of rescuers, persistent distrust), and (vi) altered sense of meaning (e.g., loss of hope and feelings of despair).[18] Subsequently, van der Kolk et al. proposed to the DSM-IV[4] working group that the "somatization" symptom category be added to the six symptom categories of complex PTSD proposed by Herman, proposing the criteria for "disorders of extreme stress not otherwise specified: DESNOS."[29] However, a field trial[16] using the DESNOS criteria revealed that many individuals diagnosed with DESNOS also met the criteria for PTSD; consequently, DESNOS was not adopted as an independent official diagnosis in DSM-IV.[4,9]

Therefore, in the International Classification of Diseases and Related Health Problems, 11th Revision (ICD-11),[32] diagnostic criteria for complex PTSD were officially adopted. However, the diagnostic criteria differ from the complex PTSD proposed by Herman; specific event criteria could not be established for diagnosis, and the same criteria as for PTSD were adopted (although there is a proviso stating that "in many cases, the events are persistent and repetitive, and escape from them is difficult or impossible," this is not an event criterion).[20] The basis for distinguishing it from PTSD is symptom specificity; in addition to meeting the diagnostic criteria for PTSD, the presence of "affect dysregulation (AD)," "negative self-concept (NSC)," and "disturbances in relationships (DR)" is required.[8] These three factors, AD, NSC, and DR, are collectively referred to as "disturbances in self-organization (DSO)."[12]

While some individuals who have experienced chronic or repeated trauma exhibit only PTSD symptoms rather than complex PTSD, others exhibit symptoms of complex PTSD even after a single traumatic event. Although it has been suggested that individual vulnerability factors and environmental factors such as support systems influence DSO,[12] we cannot say that etiological verification has been sufficiently established. However, it has been suggested that the therapeutic approach for complex PTSD aims to reconstruct the internal working model through a secure attachment style.[13] Taking this into account, if we markedly simplify the condition, it can be understood as "complex PTSD = PTSD

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+ failure to form a secure attachment style."[8] Although further verification is expected to continue, the inclusion of Complex PTSD in ICD-11 has provided diagnostic criteria for conditions characterized by a wide range of mental health issues, beyond mere PTSD, resulting from chronic and repetitive interpersonal trauma or abuse.

III. Developmental Trauma Disorder

Developmental trauma disorder was a proposal submitted to DSM-5 by the National Child Traumatic Stress Network (NCTSN), led by van der Kolk and others, with the aim of comprehensively capturing the psychological impact on children resulting from adverse experiences (the core experience being abuse, which can also be described as chronic, repetitive trauma). The criteria are shown in Table 2. It is positioned as a co-occurrence of pathologies related to both attachment and trauma and can be understood as a childhood version of complex PTSD.

While PTSD-related symptoms are listed among the criteria, the condition does not require full fulfillment of the diagnostic criteria for PTSD; rather, it consists of a wide range of dysfunctions, including emotional, physical, and cognitive regulation disorders, as well as attention and behavioral regulation disorders, and changes in self-attribution and expectations toward society. Regarding this, it has long been suggested that PTSD is not the most common mental disorder among children with chronic trauma experiences. For example, in a study of 364 abused children, the most common disorders, listed in order of frequency, were separation anxiety disorder, oppositional defiant disorder, phobias, PTSD, and attention deficit hyperactivity disorder (ADHD). While PTSD is positioned as a representative disorder caused by trauma in adults, PTSD diagnosis does not take developmental stages into account and does not sufficiently or appropriately capture the wide-ranging impact that adverse experiences have on children still in the process of development. As mentioned earlier, while DSM-5 does provide diagnostic criteria for PTSD in children under 6 years, even these criteria fail to fully and accurately capture the condition of children who have experienced adversity. Consequently, various comorbid diagnoses independent of PTSD symptoms are often made. On this basis, van der Kolk et al. explain the significance of establishing criteria for developmental trauma disorder.

Furthermore, the most distinctive difference from adult Complex PTSD is inclusion of the category: "Attention and Behavioral Regulation Disorders."

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While ADHD is the most common disorder related to attention in child psychiatry, ADHD diagnostic criteria define symptoms based on "behavior" observed by others regarding hyperactivity, impulsivity, and inattention. In contrast, the "attention and behavioral regulation disorders" category in developmental trauma disorder requires a qualitative assessment, resulting in differences in detail. Specifically, when observing a child's "restlessness," it is not easy to distinguish, based solely on observing "behavior," whether it stems from ADHD's "hyperactivity and impulsivity symptoms" or PTSD's "hyperarousal symptoms"; it is clinically important to consider that the restlessness may be trauma-related. NCTSN's: "Is It ADHD or Child Traumatic Stress? A Guide for Clinicians," also discusses the relationship between trauma and ADHD, noting that symptoms related to childhood trauma may be mistaken for ADHD symptoms. However, it is also stated that ADHD and trauma may co-occur, in which case symptoms may become more complex.

Regarding the significance of introducing the diagnostic concept of developmental trauma disorder, Yamashita cites several points, including that: "the stigma associated with receiving multiple diagnoses can be avoided through a unified diagnosis," and "by clarifying that the condition stems from psychological trauma arising from relationships with attachment figures in early development, it becomes possible to formulate treatment focused on dyadic attachment." However, as Corrigan, F.M. et al. point out, because the reality of repeated stress exposure is difficult to grasp, complex PTSD is often excluded from randomized controlled trials and other studies, making it prone to falling outside the scope of standard treatment protocols. Therefore, while a perspective grounded in developmental trauma disorder may be significant, it is considered that further verification is needed regarding how to accurately assess this condition and accumulate knowledge on appropriate therapeutic interventions based on this diagnosis.

Conclusion

Amid recent concerns over rising rates of child abuse, it has become common for children who have experienced adversity to present to child psychiatric institutions for consultation regarding mental health issues. Comprehensively assessing the issues of such children is considered crucial for developing treatment plans. Although diagnostic criteria for complex PTSD were introduced in ICD-11, diagnostic criteria that fully account for symptoms specific to children do not yet

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exist; consequently, the current situation is one in which such cases are dispersed across various diagnostic categories. From this perspective, as van der Kolk et al. point out, the author believes that carefully re-examining the clinical concept of developmental trauma disorder is a highly meaningful endeavor, in that it promotes a perspective for "treatment formulation focused on dyadic attachment," as described by Yamashita.[33)]

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Conflicts of Interest

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表 1　PTSD 診断基準における一般と 6 歳以下との違い（DSM-5）

	一般の基準	6 歳以下の基準
A 項目（2）：トラウマの目撃	他人	他人，特に主な養育者
A 項目（3）：トラウマの伝聞	近親者または親しい友人	親または養育者
A 項目（4）：トラウマの繰り返しの曝露	仕事などでの曝露体験	
B 項目（1）～（3）：侵入症状		（6 歳以下の場合の注記）
B 項目（5）：侵入症状のきっかけ	内的または外的なきっかけ	出来事を想起させるもの
C 項目/D 項目：持続的回避/認知と気分の陰性変化	（別項目として区分け）	（併せて 1 つの項目化）
E 項目（6 歳以下 D 項目）：覚醒度と反応性の著しい変化	無謀または自己破壊的な行動	極端なかんしゃく

（文献 5 をもとに著者による要約作成）

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Table 1: Differences between general cases and children under 6 years of age in PTSD diagnostic criteria (DSM-5)

General criteria	Criteria for children under 6 years of age
Criterion A (2): Witnessing the trauma	
	Another person
	Another person, especially a primary caregiver
Criterion A (3): Hearing about the trauma	
	A close relative or close friend
	A parent or caregiver
Criterion A (4): Repeated exposure to the trauma	
	Exposure through work or other activities
Criterion B (1) – (3): Intrusive symptoms	
	(Note for children aged 6 or under)
Criterion B (5): Triggers of intrusive symptoms	
	Internal or external triggers
	Stimuli that remind the child of the event
Criterion C / Criterion D: Persistent avoidance / Negative changes in cognition and mood	
	(Classified as separate items)
	(Combined into a single item)
Criterion E (Criterion D for children aged 6 or under): Marked changes in arousal and reactivity	
Reckless or self-destructive behavior	
Extreme tantrums	

(Summary prepared by the author based on Reference 5)

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表 2　発達性トラウマ障害の診断基準

A．曝露：小児期および思春期の子どもが，継続的，あるいは反復的に有害な出来事を経験させられたり，目撃してきている．その経験は，小児期もしくは思春期早期に始まり，少なくとも 1 年間以上継続している．
　A1．人間関係における深刻で反復的な暴力のエピソードを直接経験する，もしくは目撃する．
　A2．主たる養育者の交代の繰り返しによって，保護的な養育に深刻な阻害が生じる．
B．感情調節および生理的調節の困難：興奮の調節に関する子どもの通常の発達的能力が阻害されており，以下の項目のうち少なくとも 2 つに該当する．
　B1．極端な感情状態（恐怖，怒り，恥辱など）を調整したり，堪えたりできない．あるいはそうした感情状態から回復できない．
　B2．身体的機能の調節の困難（睡眠，摂食，排泄に関する慢性的問題；身体接触や音に対する過剰反応性もしくは過少反応性；ルーティンとなっている行動の移行期における混乱など）
　B3．感覚，情緒，身体状態への意識の低下もしくは解離
　B4．情緒や身体状態を表現する能力の問題
C．注意および行動の調節障害：注意の持続，学習，ストレスへの対処に関する子どもの通常の発達的能力が阻害されており，以下の項目のうち少なくとも 3 つに該当する．
　C1．脅威に対して過剰にとらわれている，あるいは，脅威を認識する能力に問題がある．安全や危険を示すサインの誤認を含む．
　C2．自己防衛能力の低下．危険を顧みない（risk-taking）行動やスリルを求める（thrill-seeking）行動を含む．
　C3．自己の沈静化をはかるという意図で不適応的な行為がある（例えば，ロッキングなどの体のリズミカルな動きや強迫的なマスターベーションなど）．
　C4．習慣性（意図的もしくは自動的），あるいは反応性の自傷
　C5．目標に向かう行動を開始できない，もしくは持続できない．
D．自己および関係性の調節障害：個人的な自己感（sense of personal identity）と対人関係の領域における子どもの通常の発達的能力に問題がある．以下の項目のうち，少なくとも 3 つに該当すること．
　D1．養育者やその他の子どもの愛情の対象者の安全性について過剰なとらわれがある．あるいは，そうした対象者との分離後の再会に困難がある．
　D2．自責感，無力感，自己無価値感，無能感，「欠陥がある」という感覚など，否定的な自己感が継続してみられる．
　D3．大人や子どもとの親密な関係において，極端な不信感や反抗が継続してみられたり，相互関係が欠如している．
　D4．子ども，養育者，その他の大人に対し，何らかの刺激に反応して身体的暴力，あるいは言葉による暴力がみられる．
　D5．密接な関係（それに限定されるわけではないが，性的もしくは身体的親密さが中心となる）をもとうとする不適切な（過剰，もしくは年齢に不相応な）意図がある．または，安全や安心を他の子どもや大人に過剰に頼る傾向がある．
　D6．共感的興奮（empathic arousal）の調節能力の問題．他者の苦痛の表現に対する共感性が欠如していること，あるいは耐えられないこと，あるいは過剰な反応性を示すことで明らかとなる．
E．トラウマ後症状スペクトラム（posttraumatic spectrum symptoms）：子どもに，PTSD の 3 つの症状群（PTSD の診断基準の B～D）のうちで，2 つ以上の症状群について，各群に最低 1 項目に該当する．
F．障害の期間：上記の B～E の症状が 6 ヵ月以上継続している．
G．機能の問題：学習，家族関係，子ども同士の関係，法的領域，身体健康面，および職業面のうち，2 つ以上の領域で，症状のために問題が生じている．

（文献 25，31 より）

Table 2: Diagnostic criteria for developmental trauma disorder

A. Exposure: The child has been subjected to or witnessed harmful events on a continuous or repeated basis during childhood or adolescence. These experiences began during childhood or early adolescence and have persisted for at least one year.

A1. Directly experiencing or witnessing repeated episodes of severe violence in interpersonal relationships.

A2. Severe disruption of protective caregiving due to repeated changes in primary caregivers.

B. Difficulties with emotional and physiological regulation: The child's typical developmental capacity for regulating arousal is impaired, and at least two of the following criteria are met.

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B1. Inability to regulate or tolerate extreme emotional states (such as fear, anger, or shame), or inability to recover from such emotional states.

B2. Difficulties with the regulation of bodily functions (chronic problems with sleep, eating, or elimination; hyper- or hypo-reactivity to physical touch or sound; confusion during transitions between routine activities, etc.)

B3. Diminished awareness of or dissociation from sensory, emotional, or bodily states

B4. Problems with the ability to express emotional or physical states

C. Impairment in attention and behavioral regulation: The child's typical developmental abilities regarding sustained attention, learning, and coping with stress are impaired, and at least three of the following criteria are met:

C1. Excessive preoccupation with threats, or problems with the ability to recognize threats. This includes misinterpretation of signs indicating safety or danger.

C2. Impaired self-protection. This includes risk-taking and thrill-seeking behaviors.

C3. Maladaptive behaviors intended to self-soothe (e.g., rhythmic body movements such as rocking, or compulsive masturbation).

C4. Habitual (intentional or automatic) or reactive self-injury

C5. Inability to initiate or sustain goal-directed behavior.

D. Impairment in self-regulation and interpersonal regulation: Problems with the child's typical developmental capacities in the domains of personal identity and interpersonal relationships. Must meet at least 3 of the following criteria.

D1. Excessive preoccupation with the safety of caregivers or other significant others. Or, difficulty in reuniting with such individuals following separation.

D2. Persistent negative self-perception, such as feelings of guilt, helplessness, worthlessness, incompetence, or a sense of being "defective."

D3. Persistent extreme distrust or defiance in close relationships with adults or other children, or a lack of reciprocity.

D4. Physical or verbal aggression toward children, caregivers, or other adults in response to some provocation.

D5. Inappropriate (excessive or age-inappropriate) intentions to form close relationships (not limited to, but centered on, sexual or physical intimacy). Or, a tendency to rely excessively on other children or adults for safety and security.

D6. Problems with the ability to regulate empathic arousal. This is evident by a lack of empathy toward others' expressions of distress, an inability to tolerate

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such distress, or excessive reactivity.

E. Post-traumatic spectrum symptoms: The child meets criteria for at least two of the three symptom clusters of PTSD (criteria B through D of the PTSD diagnostic criteria), with at least one item in each cluster.

F. Duration of the disorder: Symptoms B through E above have persisted for at least 6 months.

G. Functional impairment: Symptoms have caused problems in at least two of the following areas: learning, family relationships, peer relationships, legal matters, physical health, and occupational functioning.

(Adapted from References 25 and 31)

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