

Editorial Comments: Complex Developmental Trauma

The diagnosis of posttraumatic stress disorder (PTSD) was included in the *Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition (DSM-III;* American Psychiatric Association [APA], 1980) partially in response to a social demand to describe the pervasive psychological problems in many returning Vietnam veterans. The creation of a formal diagnosis offered legitimacy to the idea that traumatic experiences could result in serious psychological repercussions, and were not solely the result of intrapsychic processes. The creation of the PTSD diagnosis was a critical first step in naming the often overwhelming and disabling somatic and psychic symptoms that followed exposure to war and other traumatic events. Furthermore, it opened the possibility to systematically investigate how other types of traumatic events affect people, as well. At the time that the PTSD construct was being developed, a rather limited literature on “traumatic neuroses” was available to guide in its creation. Although descriptions of some other traumatized populations were available and other posttraumatic syndromes had been proposed that concentrated more on the effects of traumatic events on self-perception and on the negotiation of interpersonal relationships (e.g., “rape trauma syndrome,” “battered women’s syndrome”), the *DSM-III* diagnosis focused on three categories of symptoms: re-experiencing, numbing, and hyperarousal as the core criteria for making the diagnosis.

In retrospect, it is surprising that a construct built on such a limited empirical base proved to have as much validity as it did. Since 1980, a vast research literature has confirmed the relevance of PTSD for a large variety of traumatized populations beyond combat participants, such as rape victims, refugees, and victims of accidents, disasters, child abuse, and other forms of domestic violence. Results of these studies have contradicted many notions and popular prejudices about the effects of trau-

matic events and have led to the development of a new field of study, traumatic stress studies. Yet, from its inception, it has been clear that the diagnosis of PTSD captures only a limited aspect of posttraumatic psychopathology. A multitude of studies suggest that complex but consistent patterns of psychological disturbances occur in traumatized children as well as in adults who have been exposed to chronic or severe interpersonal trauma at any time in the lifespan. In particular, numerous studies have demonstrated the pervasive negative impact of chronic and cumulative childhood abuse and trauma on the developing child and later on the adult.

When the *DSM-IV* (APA, 1994) was under development, the American Psychiatric Association organized a field trial for PTSD to investigate the impact of several proposed changes in the PTSD diagnosis and, secondarily, to explore the psychopathology of chronic developmental trauma, labeled *disorders of extreme stress, not otherwise specified* (DESNOS). Criteria for this new proposed diagnosis were derived from the available aggregate literature on the long-term effects of childhood abuse and trauma. Seven categories of symptoms were included in the complex PTSD/DESNOS conceptualization: (a) alterations in ability to modulate emotions, (b) alterations of identity and sense of self, (c) alterations in ongoing consciousness and memory, (d) alterations in relations with the perpetrator, (e) alterations in relations with others, (f) alterations in physical and medical status, and (g) alterations in systems of meaning. The findings of the *DSM-IV* field trial supported the existence of a complex, but consistent, adaptation to chronic interpersonal violence, in both children and adults (Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005); however, DESNOS was listed in the *DSM-IV*, not as a freestanding diagnosis, but under “Associated and Descriptive Features” of PTSD (APA, 1994, p. 425). Since the complex PTSD/DESNOS diagnosis

was first conceptualized (Herman, 1992) and studied more than a decade ago, at least 30 research studies have provided some support for this construct. In addition, assessment instruments have been developed to evaluate the various dimensions of complex trauma and their relative degree of severity (described by Briere and Spinnazola, 2005).

In recent years, the validity of DESNOS has been buttressed by findings from two other fields of study: developmental psychopathology and neuroscience. In studies of abused versus normal children both scientific disciplines have identified significant developmental and neurobiological consequences of exposure to traumatic events. Attachment researchers, drawing from the work of John Bowlby (1988) and his followers, have highlighted the significance of nonresponsive or abusive caregivers and other disruptions in attachment within the family. Under most conditions when children are hurt or in danger, parents and other caregivers are able to help them restore a sense of safety and control. However, when caregivers are emotionally absent, inconsistent, demeaning, violent, intrusive, neglectful, or are themselves dealing with unresolved trauma and loss, they usually cannot serve as a source of security for their offspring. Under those conditions, children are liable to become intolerably distressed and to develop a sense that the environment is intrinsically unsafe. If children are exposed to unmanageable stress, and if caregivers are unable to help them modulate their arousal—the usual case when children are exposed to family violence—they are unable to organize themselves physiologically and fail to categorize experiences in a coherent fashion. This failure results in a breakdown in the capacity to process, integrate, and categorize what is happening: At the core of traumatic stress is a breakdown in the capacity to regulate internal states.

Studies from the neurosciences have reported findings consistent with those of attachment research. Children who have been subjected to ongoing abuse and neglect in the context of their primary relationships and whose family environments have lacked adequate support have been found to differ in their neurological and neurobiological development from children who have not been abused or neglected. Insecurely attached children have a variety of neurobiological abnormalities that affects their long-term psychological and physiological functioning (Van der Kolk, 2003). As a result, many traumatized children have problems regulating their emotions, knowing what they feel, verbalizing their experiences and feelings, and being comforted by an attachment figure.

The Need for an Expanded Diagnosis

The effects of the decision not to include DESNOS as a distinct diagnosis have been far-reaching. Subsequent treatment outcome research has focused almost exclusively on PTSD symptomatology as described in the *DSM-III* and *DSM-IV* (APA, 1980, 1994); posttraumatic problems not captured in the PTSD criteria, including affective, anxiety, dissociative and somatoform disorders, as well as substance abuse, have generally been referred to as “comorbid conditions,” issues secondary to the core posttraumatic psychopathology. For example, the Treatment Guidelines of the International Society for Traumatic Stress Studies (Foa, Freidman, & Keane, 2000), while recognizing that more than 80% of patients with PTSD suffer from “comorbid conditions,” refers readers to the “rich empirical literature of these comorbid conditions” (p. 375) for treatment guidance. Yet, no studies to date have demonstrated that treatment manuals for these other conditions are, in fact, useful in treating these comorbid conditions in patients with PTSD. On the contrary, research shows that bipolar, anxious, suicidal, substance abusing, dissociative, and depressed patients with childhood exposure to interpersonal violence often do not respond to conventional treatments for these conditions.

For a substantial proportion of traumatized patients, PTSD symptoms capture but a small part of their difficulties. A review of treatment outcome studies demonstrates that the typical subject who is screened out of PTSD studies due to their multiple comorbid conditions may well be the typical patient seen in mental health care settings (Spinazzola, Blaustein, & Van der Kolk, 2005). By diagnosing traumatized patients with complicated clinical presentations with a simple diagnosis of PTSD, clinicians run the grave risk of applying treatments that may not only be irrelevant to them, but may, in fact, be harmful (see article by Ford, Courtois, Van der Hart, Nijenhuis, & Steele, 2005). This special issue examines the likelihood that these other problems do not constitute comorbid diagnoses, but rather, are somatic, affective, behavioral, and characterological manifestations of chronic interpersonal trauma and thus are part of the primary disorder. We propose that a new diagnosis is necessary that provides a clear delineation of the enduring developmental effects of trauma, such as *Complex PTSD/DESNOS* or *Developmental Trauma Disorder* recently proposed by the National Child Traumatic Stress Network Workgroup on Diagnosis (Van der Kolk, 2005). Such an expanded diagnosis is helpful in conceptualizing the complex adaptations to trauma over the lifespan. Moreover, it

would stimulate the development of relevant and effective treatment approaches to clients with complex trauma over the course of development.

Treatment Outcome

Chambless and Hollon (1998) have appealed to researchers to strive to establish not only the *efficacy*, but also the *effectiveness* of interventions, and to address both the statistical and clinical significance of interventions. In PTSD research, most treatment outcome studies have primarily utilized samples of adults after motor vehicle accidents, rapes, and combat. Because most treatment outcome studies involving veterans have been disappointing, conclusions about PTSD treatment efficacy largely rely on studies of adult motor vehicle accident victims and survivors of stranger rape. There are serious questions whether the existing empirically validated PTSD treatments do constitute effective treatment for patients with histories of complex interpersonal trauma. Only recently have research studies started to investigate this very issue (see Ford et al., 2005).

Many clinicians do not find the existing PTSD research literature or treatment guidelines helpful in their day-to-day treatment of traumatized individuals. The disparity between existing treatment research samples and actual clinical populations may account for the fact that many clinicians treating patients with complex presentations continue to adhere to treatment models that are not supported by empirical research, but rather, are based on accumulated clinical experience (see Ford et al., 2005). Of necessity, clinicians have learned to focus more on issues of patient safety, affect regulation, coping and self-management skills, as well as on the therapeutic relationship itself, rather than on the processing of traumatic memories, the focus of most empirical research with PTSD patients. At present, the clinical consensus model for the treatment of patients with complex trauma histories is sequenced and progressive. It involves three primary phases, each with a variety of healing tasks: (a) symptom reduction and stabilization, (b) processing of traumatic memories and emotions, and (c) life integration and rehabilitation after trauma processing (see Ford et al., 2005).

This Special Issue

Dr. Bonnie Green, during her year as President of the International Society for Traumatic Stress Studies

(ISTSS), appointed a Complex Trauma Task Force¹ giving it the mandate to review the literature on the developmental impact of exposure to chronic interpersonal–familial traumatic events in early life, the complexity of adaptation to such trauma through the life cycle, and issues related to assessment and treatment. This special section of the *Journal of Traumatic Stress* is a direct result of that mandate. As editors and authors of this special section, it is our shared hope that the material presented here stimulates discussion and research efforts concerning differing adaptations to traumatic events above and beyond what is now included in the criteria for the diagnosis of PTSD. It is also our collective hope that these articles will serve as a stimulus for additional research on complex trauma and on the development of innovative clinical strategies organized around hypotheses that are subject to empirical investigation. In particular, future research efforts must address the many patients who are currently excluded from research studies because of the complex posttraumatic adaptations associated with their PTSD. Future treatment outcome studies should maintain precise records of participant exclusion and attrition at all phases—from initial screening and intake through treatment sessions and all follow-up assessments—to yield greater understanding of exactly what symptoms are and are not addressed by these studies.

Additional research needs to identify the effect of specific developmental, contextual, and genetic factors on the eventual phenomenology of the posttraumatic adaptation. Continued evolution of the concepts of DESNOS, complex PTSD, or developmental trauma disorder will require continued support from granting agencies, and will require the incorporation of contributions from the fields of developmental psychopathology and the neurosciences. In addition, there is an urgent need for more research to identify the efficacy of self-regulatory techniques besides those involving the use of pharmacological agents. Finally, the necessary components of the therapeutic relationship in the recovery of interpersonally traumatized individuals, as well as the training necessary for therapists treating this population also require ongoing articulation and research substantiation.

Bessel A. van der Kolk and Christine A. Courtois
Guest Editors

¹Members appointed to the Complex Trauma Task Force: Laurie Pearlman and Onno van der Hart, co-chairs; John Briere, Christine Courtois, Julian Ford, and Bessel van der Kolk. Current co-chairs are Christine Courtois and Laurie Pearlman; Pamela Alexander and Marylene Cloitre have been appointed to the Task Force. Bonnie Green has been an active participant in Task Force discussions.

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