APPENDIX: CONSENSUS PROPOSED CRITERIA FOR DEVELOPMENTAL TRAUMA DISORDER

You are being provided with a book chapter by chapter. I will request you to read the book for me after each chapter. After reading the chapter, 1. shorten the chapter to no less than 300 words and no more than 400 words. 2. Do not change the name, address, or any important nouns in the chapter. 3. Do not translate the original language. 4. Keep the same style as the original chapter, keep it consistent throughout the chapter. Your reply must comply with all four requirements, or it's invalid.
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The goal of introducing the diagnosis of Developmental Trauma Disorder is to capture the reality of the clinical presentations of children and adolescents exposed to chronic interpersonal trauma and thereby guide clinicians to develop and utilize effective interventions and for researchers to study the neurobiology and transmission of chronic interpersonal violence. Whether or not they exhibit symptoms of PTSD, children who have developed in the context of ongoing danger, maltreatment, and inadequate caregiving systems are ill-served by the current diagnostic system, as it frequently leads to no diagnosis, multiple unrelated diagnoses, an emphasis on behavioral control without recognition of interpersonal trauma and lack of safety in the etiology of symptoms, and a lack of attention to ameliorating the developmental disruptions that underlie the symptoms.

The Consensus Proposed Criteria for Developmental Trauma Disorder were devised and put forward in February 2009 by a National Child Traumatic Stress Network (NCTSN)-affiliated Task Force led by Bessel A. van der Kolk, MD and Robert S. Pynoos, MD, with the participation of Dante Cicchetti, PhD, Marylene Cloitre, PhD, Wendy D'Andrea, PhD, Julian D. Ford, PhD, Alicia F. Lieberman, PhD, Frank W. Putnam, MD, Glenn Saxe, MD, Joseph Spinazzola, PhD, Bradley C. Stolbach, PhD, and Martin Teicher, MD, PhD. The consensus proposed criteria are based on extensive review of empirical literature, expert clinical wisdom, surveys of NCTSN clinicians, and preliminary analysis of data from thousands of children in numerous clinical and child service system settings, including NCTSN treatment centers, state child welfare systems, inpatient psychiatric settings, and juvenile detention centers. Because their validity, prevalence, symptom thresholds, or clinical utility have yet to be examined through prospective data collection or analysis, these proposed criteria should not be viewed as a formal diagnostic category to be incorporated into the DSM as written here. Rather, they are intended to describe the most clinically significant symptoms exhibited by many children and adolescents following complex trauma. These proposed criteria have guided the Developmental Trauma Disorder field trials that began in 2009 and continue to this day.

CONSENSUS PROPOSED CRITERIA FOR DEVELOPMENTAL TRAUMA DISORDER

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, including:

A. 1. Direct experience or witnessing of repeated and severe episodes of interpersonal violence; and

A. 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

B. Affective and Physiological Dysregulation. The child exhibits impaired normative developmental competencies related to arousal regulation, including at least two of the following:

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

B. 2. 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)

B. 3. Diminished awareness/dissociation of sensations, emotions and bodily states

B. 4. Impaired capacity to describe emotions or bodily states

C. Attentional and Behavioral Dysregulation: The child exhibits impaired normative developmental competencies related to sustained attention, learning, or coping with stress, including at least three of the following:

C. 1. Preoccupation with threat, or impaired capacity to perceive threat, including misreading of safety and danger cues

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

C. 3. Maladaptive attempts at self-soothing (e.g., rocking and other rhythmical movements, compulsive masturbation)

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

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

D. Self and Relational Dysregulation. The child exhibits impaired normative developmental competencies in their sense of personal identity and involvement in relationships, including at least three of the following:

D. 1. Intense preoccupation with safety of the caregiver or other loved ones (including precocious caregiving) or difficulty tolerating reunion with them after separation

D. 2. Persistent negative sense of self, including self-loathing, helplessness, worthlessness, ineffectiveness, or defectiveness

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

D. 4. Reactive physical or verbal aggression toward peers, caregivers, or other adults

D. 5. 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