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ASSESSING MENTAL HEALTH PROBLEMS IN CHILDREN EXPERIENCING ABUSE AND NEGLECT IN THE ABSENCE OF A COMPLEX TRAUMA DIAGNOSIS

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Cet essai est rédigé en anglais tel qu'il est permis dans les règlements des études de cycles supérieurs (136) de l'Université du Québec à Trois-Rivières. Dans ce cas, le règlement interne mentionne l'obligation de présenter un exposé substantiel rédigé en langue française dans lequel sont présentés les objectifs, la méthodologie et les résultats obtenus; une discussion sur l'ensemble des articles publiés ou rédigés pour publication et du travail réalisé.

Abstract

Child abuse and neglect are severe forms of *complex trauma,* impacting a youth's development due to its numerous consequences. This essay aimed at shedding the light on several issues. Specifically, we aspired to document the various and many mental health difficulties as perceived by the mothers of children who have experienced abuse and neglect. In highlighting the multiplicity of such difficulties for children, this accents the ensuing reality of increased risk for those children to eventually become over-diagnosed. Thus, for psychologists working with complexly traumatized youth, the assessment and elaboration of a treatment plan becomes all the more difficult namely due to the absence of a Developmental Trauma Disorder diagnosis in the current DSM. To illustrate the above mentioned goals, we considered data collected through questionnaires completed by the mothers of 17 maltreated children receiving services at a youth center with the objective of documenting, through their mothers' perceptions, a number of symptoms and difficulties of those children as possible indicators of eventual mental health disorders which they could develop in having faced long-term trauma. Findings suggest that fourteen out of the seventeen children in our sample display clinically significant difficulties in at least one domain and 14 display clinically significant difficulties in two domains or more, thus rendering it likely for them to receive one or more eventual diagnoses and complicating treatment modalities for the mental health professional.

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Résumé substantiel en français

La maltraitance est une forme particulière de trauma psychologique pouvant entrainer des difficultés développementales importantes. Les conséquences de la maltraitance dépassent largement celles associées au Trouble de stress posttraumatique (TSPT), le diagnostic usuel pour décrire les difficultés qui résultent d'un trauma psychologique. Le TSPT est une réaction à un stress extrême impliquant un évènement constituant une menace à l'intégrité physique, qui a causé ou failli causer la mort, un évènement dangereux, ou le fait d'apprendre la nouvelle d'une mort inattendue ou d'un évènement dangereux (APA, 2013). Les signes cliniques du TSPT chez les enfants ont des caractéristiques propres: les symptômes d'intrusion peuvent se manifester sous la forme d'activités ludiques répétitives (dessins, jeux) lors desquels ils remettent en scène le ou les évènements traumatiques. Le contenu des cauchemars peut être terrifiant sans reproduire littéralement le ou les évènements traumatiques. Les conduites d'évitement peuvent concerner tout ce qui peut rappeler ou symboliser l'évènement traumatique, en particulier les soins corporels ou les examens médicaux (APA, 2013). Contrairement au TSPT qui évoque un évènement ponctuel, la maltraitance peut être considérée comme un trauma complexe en raison de son caractère relationnel, prolongé et répété (Agaibi & Wilson, 2005; Alvord & Grados, 2005; Blaustein, Margaret, & Kinniburgh, 2010; Spinazzola et al., 2005). Les conséquences du trauma complexe se distinguent de ceux du TSPT d'au moins trois manières: les symptômes sont plus complexes, diffus et tenaces; des changements au niveau de la personnalité sont présents; il y a présence d'une vulnérabilité à répéter les blessures, par soi-même et par les autres (Herman,

1992). Le trauma complexe se caractérise aussi par sa tendance à survenir dans un moment clé du développement et à porter atteinte à l'intégrité du soi (Herman, 1992). Depuis plus de 20 ans, un groupe formé d'experts dans le domaine du trauma a travaillé à faire reconnaitre dans la nouvelle édition du DSM (le DSM-5, paru en mai 2013) un diagnostic qu'ils qualifient de plus approprié. Ce diagnostic, le *Developmental Trauma Disorder* (DTD), refléterait plus justement la symptomatologie du trauma complexe (van der Kolk et al., 2009). Cette proposition a cependant été rejetée. Malgré la non reconnaissance du DTD, certains chercheurs se sont penchés sur la question d'intervention pour soutenir les professionnels en santé mentale œuvrant auprès d'enfants victimes de maltraitance ou d'autres formes de traumas interpersonnels. Le *Trauma-Focused Cognitive Behavioral Therapy* (TF-CBT; Lawson & Quinn, 2013), le modèle Attachment, Regulation, and Competency (ARC; Blaustein et al., 2010), ainsi que le *Integrative Treatment of Complex Trauma* (ITCT; Briere, 2005) sont parmi les interventions prometteuses ayant fait l'objet d'études préliminaires mettant en évidence un potentiel pour son application auprès des enfants ayant vécus des traumas complexes (Lawson & Quinn, 2013).

Cet essai vise à documenter, du point de vu des mères, les difficultés de santé mentale potentielles d'enfants ayant vécu de la maltraitance. Ces difficultés sont des indicateurs d'éventuels troubles de santé mentale et mettent en évidence le danger pour cette clientèle à risque de devenir 'sur-diagnostiqués', c'est-à-dire de recevoir plus d'un diagnostic de trouble mental (Ford et al., 2013; Resick et al., 2012). Or, l'absence du *Developmental*

Trauma Disorder dans le DSM-5 risque de compliquer l'évaluation et la planification de l'intervention auprès de ces enfants (Schmid, Petermann, & Fegert, 2013; van der Kolk et al., 2009). Pour illustrer cette situation, nous avons examiné les données provenant de questionnaires pour 17 enfants (10 filles et 7 garçons avec un âge moyen de 94 mois) recevant des services en raison d'une situation de maltraitance. Ces questionnaires, complétés par la mère, permettent l'évaluation de diverses difficultés de santé mentale. Les données issues de ces questionnaires ont donc été utilisées comme des indicateurs de difficultés pouvant éventuellement se traduire par un ou plusieurs diagnostics éventuels de troubles mentaux. Ces questionnaires sont le *Trauma Symptoms Checklist for Young Children* (TSCYC; Briere et al., 2001), le *Child Dissociative Checklist* (CDC; Putnam, Helmers, & Trickett, 1993) et le *Child Behavior Checklist* (CBCL 6-18 ans; Achenbach & Rescorla, 2001). Le TSCYC permet d'évaluer les symptômes traumatiques chez l'enfant : intrusion, hypervigilance, évitement, peur, et dissociation. Le TSCYC possède des normes adaptées en fonction de l'âge et du sexe de l'enfant. Dans cet essai, nous avons utilisé l'échelle totale de symptômes traumatiques qui regroupent des symptômes d'intrusion, d'évitement et d'hypervigilance. Le CDC permet d'évaluer les symptômes dissociatifs chez l'enfant. Ce questionnaire permet d'identifier les enfants ayant reçu un diagnostic psychiatrique de trouble dissociatif. Dans cet essai, nous avons utilisé le score total de symptômes dissociatifs. Le CBCL permet d'évaluer les comportements problématiques de l'enfant tel le retrait, la réactivité émotionnelle, la dépression, le trouble de l'attention et l'agressivité. Il permet également de calculer six échelles pouvant éventuellement refléter la présence d'un trouble mental (troubles anxieux,

trouble déficitaire de l'attention avec ou sans hyperactivité, troubles affectifs, troubles d'opposition, ainsi que des plaintes somatiques. Ce sont ces six échelles que nous avons utilisées dans cet essai. Le CBCL possède des normes adaptées en fonction du sexe et de l'âge de l'enfant.

L'utilisation de ces trois questionnaires a donc permis de calculer, pour chaque enfant, un score aux des huit échelles décrites ici-haut. Il importe de noter que ces trois questionnaires ne permettent pas de confirmer la présence d'un diagnostic, mais qu'ils demeurent des indicateurs potentiels. Toutefois, ils possèdent tous des normes critériées permettant d'identifier les enfants dont les symptômes dans un domaine particulier sont suffisamment élevés (toujours selon la mère) pour nécessiter une intervention et, dans certains cas, une évaluation diagnostic plus approfondie. Considérant que ces enfants reçoivent des services pour mauvais traitements, il est fort probable qu'un certain nombre présenteront une ou plusieurs difficultés qui pourraient possiblement se traduire par le diagnostic éventuel de plusieurs troubles mentaux chez un même enfant.

Les résultats obtenus suggèrent que 14 enfants présentent un seuil cliniquement élevé pour au moins une échelle, et 11 pour au moins deux échelles. Cela pourrait éventuellement mener à un diagnostic éventuel d'un ou de plusieurs troubles mentaux chez un même enfant, compliquant ainsi la planification de l'intervention du professionnel aidant. De manière plus spécifique, six enfants ont obtenu un score cliniquement élevé sur l'échelle *état de stress post-traumatique total,* sept enfants sur l'échelle *troubles affectifs*, six enfants sur l'échelle *troubles anxieux*, deux enfants sur

l'échelle *plaintes somatiques*, six enfants sur l'échelle *trouble déficitaire de l'attention avec ou sans hyperactivité*, neuf enfants sur l'échelle *troubles d'opposition*, huit enfants sur l'échelle *trouble de la conduite*, et cinq enfants sur l'échelle de mesure *Child Dissociative Checklist*. L'échelle avec le score le plus élevé était *trouble d'opposition* avec un total de neuf enfants. Les résultats démontrent que 3 des 17 enfants de notre échantillon ne manifestaient pas de symptômes sur aucune des huit échelles; 3 des 17 enfants présentaient des symptômes sur une échelle; 2 des 17 enfants présentaient des symptômes sur deux échelles; 2 des 17 enfants présentaient des symptômes sur trois échelles; 3 des 17 enfants présentaient des symptômes sur quatre échelles; 2 des 17 enfants présentaient des symptômes sur cinq échelles; 1 des 17 enfants présentait des symptômes sur six échelles; aucun des 17 enfants ne manifestait des symptômes sur sept échelles; et enfin, 1 enfant sur 17 présentait des symptômes sur huit échelles.

Ces résultats mettent en évidence le risque pour les enfants à devenir 'sur-diagnostiqués', c'est-à-dire à recevoir plus d'un diagnostic psychiatrique simultanément, ce qui compliquerait l'évaluation et la planification de l'intervention des cliniciens et professionnels en santé mental auprès de cette clientèle à risque. En cohérence avec de nombreux autres auteurs et cliniciens, nous pensons que le DTD décrirait plus efficacement la large gamme de symptômes exprimés par les enfants ayant un traumatisme complexe (D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012). Afin de répondre à la gamme des besoins et des particularités de ces enfants il est souhaitable que des avenues d'intervention soient explorées et validées afin que se

bonifie le bassin préexistant de modèles de traitement jugées efficaces dans ce domaine. Toutefois, malgré le manque de reconnaissance officielle du trouble, le soutien pour l'établissement d'un diagnostic du DTD ne cesse de croitre de par sa capacité à englober plus adéquatement la réalité symptomatologique du trauma complexe non définit par le TSPT. Il permet aussi d'éviter de poser à un enfant une multitude de diagnostics (TSPT, trouble de personnalité limite, troubles dissociatifs, TDAH) et aussi d'offrir un traitement adapté qui tient compte de la complexité des symptômes contrairement à une somme d'interventions.

Introduction

In May of 2013, the DSM-5 was published, within which, many changes had been made, with some mental health diagnoses proposals being retained whereas others had not (American Psychiatric Association, 2013). In order to be included in this new edition, clinicians in the field of trauma suggested a diagnosis of Developmental Trauma Disorder (DTD), a term coined by van der Kolk to describe and capture the wide-range of impact that trauma and adverse life experiences in early childhood development may have in personality development, behavior, and affect (van der Kolk, 2003). In spite of the proposal for DTD to be included in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), it was not retained as a diagnosis. This essay explores the possible difficulties arising from an absence of a DTD diagnosis in the DSM on evaluation and treatment planning for clinicians and professionals working on therapeutic interventions with complexly traumatized children. Its specific angle aimed at documenting mental health difficulties as perceived by the mothers of children who have experienced abuse and neglect, knowing that they are at significantly more at risk of developing complex trauma (Dvir et al., 2014; Spinazzola et al., 2005; Cloitre et al., 2009). We intended to demonstrate that these children show multiple difficulties and while our chosen method does not allow verifying this, we suggest that that these various difficulties may eventually translate into a higher probability of over-diagnosis.

Context

The term 'complex trauma' is defined as experiences of an interpersonal nature occurring within the caregiving system and the social environment which is supposed to be the source of safety and stability in a child's life (Cloitre et al., 2012). Characteristically, complex trauma exposure denotes the simultaneous or sequential occurrences of child maltreatment such as emotional abuse and neglect, sexual abuse, physical abuse, as well as the witnessing of domestic violence which are chronic and usually begin in early childhood (Cloitre et al., 2012). In addition, those initial traumatic experiences (e.g., parental neglect, maltreatment and emotional abuse) and the resulting emotional dysregulation, loss of a safe base, loss of direction, and inability to detect or respond to danger cues, may often result in subsequent trauma exposure (e.g., physical and sexual abuse, or community violence) (Cloitre et al., 2012). Professionals involved in children or teenagers' life, such as psychologists, caregivers, teachers, pediatricians, and those in the juvenile justice system, can play an important role in helping them receive trauma-focused assessment or services (Blaustein et al., 2010). The following section introduces the concept of complex trauma by providing an in depth look into its impacts on traumatized children.

Complex Trauma

Child abuse and neglect are severe forms of *complex* or *relational trauma,* impacting a youth's development (Agaibi & Wilson, 2005; Alvord & Grados, 2005; Blaustein et al., 2010; Spinazzola et al., 2005). These severe and pervasive events can disrupt the very formation of the self and have been shown to increase children's

vulnerability to psychopathology (Agaibi & Wilson, 2005). Indeed, countless studies (e.g., Ethier, Lemelin, & Lacharité, 2004; Jaudes & Mackey-Bilaver, 2008) have shown that compared to non-maltreated children, children who had suffered chronic abuse presented with more behavioral and emotional problems such as a higher level of depression, aggression and delinquency. They also are more at risk of displaying social withdrawal problems, deficits in executive functions, difficulty regulating their emotions, and suffered from a lower self- esteem (Ethier et al., 2004; Jaudes & Mackey-Bilaver, 2008). Additionally, a meta-analytic study examining the differential impact of maltreatment on attachment security and disorganization shows the destructive impact of abuse in the acquisition of a secure attachment with a child's primary caregiver as well as disorganization (Cyr, Euser, Bakermans-Kranenburg, & van IJzendoorn, 2010), thus highlighting an important distinction from other types of traumas (i.e. natural or man-made disasters or experiencing a life-threatening medical procedure sometimes resulting in a *post-traumatic stress disorder*), and providing an explanation as to why children present with so many relational difficulties (Blaustein et al., 2010; Cloitre et al., 2011; Osofsky, 2004; van der Kolk, 2003). These negative traumatic experiences resulting from child maltreatment for example elicit 1) *intense affects* such as rage, betrayal, fear, resignation, defeat and shame, and 2) *efforts to ward off the recurrence* of those emotions, as well as the avoidance of experiences which trigger them or engaging in behaviors that convey a subjective sense of control in the face of potential threats (van der Kolk, 2003).

Another term to describe complex trauma, *Complex Post-Traumatic Stress Disorder* (CPTSD, 2016), was initially proposed by Judith Herman as a description for a syndrome observed in survivors of prolonged, repeated trauma (Herman, 1992). She wrote, "the diagnosis of post-traumatic stress disorder, as it is presently defined, does not fit accurately enough. The existing diagnostic criteria for this disorder are derived mainly from survivors of circumscribed traumatic events. They are based on the prototypes of combat, disaster, and rape" (Herman, 2012). Herman highlighted the conceptualizations of trauma in that era, specifically the PTSD diagnosis, and noted that they were too limited in scope, and focused on a single event or incident (Herman, 1992). She brought forth that while many people experience trauma due to a single incident (e.g., one car accident, one robbery, witness to a single act of violence or abuse), most stories of survivors are best described as series of multiple, layered experiences (Herman, 1992). Courtois and Ford have described complex PTSD as having some, or all of the following characteristics: repetitive or prolonged actions or inaction; involving direct harm and/or neglect or abandonment by caregivers or ostensibly responsible adults; that occur during developmentally vulnerable times in the victim's life, such as early childhood, and; Have great potential to severely compromise a child's development (Courtois, 2004; Ford et al., 2013). In other words, complexly traumatized children and teenagers often experience developmental delays across a broad spectrum (i.e., cognitive, language, motor, and socialization skills), whereas the PTSD diagnosis is not developmentally sensitive and does not adequately describe the impact of exposure to juvenile trauma on the developing child and teen (van der Kolk,

2003). Additionally, the loss of structure and safety in the formative years will lead the child to develop rigid control strategies to manage anxiety, among other maladaptive behaviours which may behaviorally appear as bossiness, lying, or manipulating (Blaustein et al., 2010).

Additionally, complex trauma encompasses conditions of prolonged trauma or trauma that occurs at vulnerable times during the development of an individual (Cloitre et al., 2009). For example, van der Kolk introduced the term *developmental trauma* to specifically describe the impact that trauma and adverse life experiences in early childhood development may have in personality development, behavior, and affect (van der Kolk, 2003). Moreover, the literature on developmental trauma disorder (DTD) as proposed by van der Kolk, has suggested seven primary domains of impairment observed in exposed youths: attachment (i.e. problems with boundaries and interpersonal difficulties), biology (i.e. sensorimotor developmental problems, somatization), affects regulation (i.e. difficulty with emotional self-regulation, labeling and expressing feelings), dissociation (i.e. alternations in states of mind, amnesia), behavioural regulation (i.e. poor modulation of impulsions, sleep disturbances, oppositional behaviour), cognition (i.e. difficulties in attention regulation and executive functioning, difficulty planning and anticipating) and self-concept (i.e. disturbances of body image, low self-esteem) (Spinazzola et al., 2005). In addition, those domains of impairment may manifest as flashbacks and nightmares of specific events, school problems, difficulties in attention regulation with orientation in time and space and as well as

sensorimotor developmental disorders are not uncommon symptoms of complexly traumatised youths (van der Kolk, 2003). Also, oftentimes youths impacted by complex trauma report being literally "out of touch" with their feelings, and often, in the case of young children, have no language to describe internal states (van der Kolk, 2003). They very seldom spontaneously share their fears and traumas, lacking insight into the relationship between what they do, what they feel and what has happened to them (Blaustein et al., 2010; Cloitre et al., 2011; van der Kolk, 2003). Moreover, those children and teenagers tend to repeat their traumatic past in the form of interpersonal enactments, in their play and/or in their fantasy lives, as opposed to communicating about it (Blaustein et al., 2010). As stated above, in terms of attachment, many maltreated children lack an organized attachment strategy and form instead a disorganized attachment to their caregiver (Courtois, 2004). For a child to realize that the powerful adult figure is dangerous and unavailable leads many of them to be in a frozen or hyperaroused state, preventing them to engage in social activities that might be able to soothe them (Williams, 2006). Thus, as a consequence of these profoundly disrupted relationships is the compromise of the child's development as well as changes in his or her neurobiology (Williams, 2006). The preceding examples highlight an important distinction between DTD from other types of traumas (i.e. natural or man-made disasters or experiencing a life-threatening medical procedure sometimes resulting in a post-traumatic stress disorder). Therefore, the findings in research have been supportive of the conception of developmental trauma as a separate diagnostic entity due to its wider range of trauma-related symptoms which must be specifically addressed to

render treatment with this specific population effective (Cloitre et al., 2011; Courtois, 2004; van der Kolk, 2003). It is crucial then that therapists consider the above mentioned factors when evaluating clients at risk for symptoms of complex trauma and when in the process of elaborating the most efficient intervention plan in the therapeutic process (Blaustein et al., 2010; Cook et al., 2005; Spinazzola et al., 2005).

Mental health diagnosis' importance in the elaboration of a treatment plan

Today, the use of diagnosis in the *Diagnosis and Statistical Manual of Mental Health Disorders* (DSM) permeates the mental health professions thus making it an important aspect of clinical assessment as it can provide the mental health professional a direction for their specifically chosen intervention (Seligman, 1999). In recognizing the use of diagnosis in the mental health professions, workshops to teach diagnosis and treatment planning are offered with one of the goals being to make clinicians more effective and more credible practitioners (Seligman, 1999). When 334 Certified Clinical Mental Health Counselors were surveyed on their use of the DSM in a study by Mead, Hohenshil, and Singh in 1997, 91% of those participants shared that the DSM is their most frequently used professional reference finding it especially useful for billing, case conceptualization, treatment planning, communication with other professionals, education, and meeting employers' requirements. In Québec also, the DSM is recognized as an important reference tool in the evaluation of various mental health conditions. For example, the Ordre des psychologues du Québec will issue a psychology permit to a member of that order only upon completion of several conditions, including that of

completing 180 hours on the classification of mental disorders, psychopathology and problems related to human development including understanding using various models of intervention, recognized classifications such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Order of Psychologists of Quebec, 2012). Therefore, an important aspect of clinical assessment and appraisal process in the mental health field is skillful diagnosis (Neukrug & Fawcett, 2010). Although there continues to be some question as to the helpfulness of a mental health diagnoses, it is clear that using them in treatment planning has become an integral part of what all mental health professionals do (Seligman, 1999).

As of yet in the DSM, there are no integrative psychiatric diagnoses to encompass the cluster of symptoms that research has repeatedly shown to occur in children exposed to interpersonal trauma and to guide assessment and treatment for children and youth (Blaustein et al., 2010; Cook et al., 2005; Spinazzola et al., 2005). The one diagnosis in the current DSM-5 to specifically identify trauma as an antecedent is post-traumatic stress disorder (PTSD; D'Andrea et al., 2012). With regards to PTSD, it was first introduced in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition, in 1980 to describe a collection of symptoms such as intrusive re-experiencing of traumatic memories, avoidance, emotional numbing, and hyper-arousal due to a traumatic event or a catastrophic stressor (American Psychiatric Association, 1980). In its latest revision, the DSM-5 (American Psychiatric Association, 2013), has made a number of significant evidence-based revisions to the PTSD diagnostic criteria: with PTSD

no longer being categorized as an Anxiety Disorder, it is now classified in a new category, Trauma- and Stressor-Related Disorders where the onset of every disorder is now preceded by exposure to a traumatic or otherwise adverse environmental event (American Psychiatric Association, 2013). Moreover, this new trauma category emphasizes the widespread impact that life events might have on an individual's emotional and physical well-being (American Psychiatric Association, 2013). The diagnoses included in this new category include: *reactive attachment disorder, disinhibited social engagement disorder, post-traumatic stress disorder, acute stress disorder, and adjustment disorders* (American Psychiatric Association, 2013).

In considering the criteria for a diagnosis of post-traumatic stress disorder, while it captures the fearfulness, worry and avoidance involved in DTD, it does not highlight the intensely changeable emotional states, negative self-beliefs and disorganized attachment feelings and behaviors that DTD does (Blaustein et al., 2010). Oftentimes, when a patient meets diagnostic criteria for PTSD, he or she is highly likely to also meet DSM-5 criteria for one or more additional diagnoses (Ford et al., 2013; van der Kolk et al., 2009). *Disruptive, Impulse-Control, and Conduct Disorders*, for example, is another category from which a comorbid diagnosis (oppositional defiant disorder, conduct disorder, intermittent explosive disorder, pyromania, and kleptomania) (American Psychiatric Association, 2013) might be given to children in addition to PTSD (usually oppositional defiant disorder, conduct disorder, intermittent explosive disorder) (Ford et al., 2013; van der Kolk et al., 2009). But while it takes into consideration the intense

anger, distrust and conflict in relationships, as well as distorted beliefs about people and the world, it does not include the guilt, shame, anxiety, dissociation and depressed mood seen in children with DTD (Blaustein et al., 2010). In addition, these comorbid diagnoses involve major affective disorders, dysthymia, alcohol or substance abuse disorders, anxiety disorders, or personality disorders (van der Kolk et al., 2009). It is therefore not surprising that due to the complex traumatic experiences, both past and present, and the ensuing array of traumatic stress symptoms in combination with other impairments, complex traumatic stress disorders tend to be difficult to diagnose accurately and treat effectively (Courtois, 2004; Ford et al., 2013). In fact, complexly traumatized children and adolescents are at risk of receiving numerous medical and psychiatric diagnoses which have often been found to be refractory to solidly grounded evidence-based mental health interventions and treatments (Ford et al., 2013; Resick et al., 2012). Those were but some of the many reasons why researchers have raised the legitimate question around the high rate of diagnostic comorbidity seen with PTSD as well as the clinical phenomenology of prolonged and repeated trauma, hence the proposal for an alternative, all-encompassing diagnostic formulation that of complex trauma or developmental trauma disorder (van der Kolk et al., 2009). Yet another reality with regards to intervention with traumatized patients is that high rates of comorbidity do indeed complicate treatment planning, partly due to the clinician having to decide whether to treat the comorbid disorders simultaneously or consecutively (Resick et al., 2012; Schmid, Petermann, & Fegert, 2013; van der Kolk et al., 2009).

Impacts and problems in the absence of a DTD diagnosis

In considering that childhood maltreatment or abuse is a major risk factor for mood, anxiety, substance abuse, psychotic, and personality disorders, it is no surprise that mental health studies have highlighted that children victims of abuse will receive more diagnoses in mental health disorders in comparison to other children (Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013; van der Kolk, 2003). As mentioned in the preceding section, there currently exists no integrative psychiatric diagnoses which encompass the constellation of symptoms experienced by children and youth exposed to complex trauma (Blaustein et al., 2010; Cook et al., 2005; Spinazzola et al., 2005), and in fact, it is common for maltreated children to get diagnosed with more than one disorder concurrently in the course of their lifetime (Ford et al., 2013; van der Kolk, 2003). Moreover, due to the body's considerable dysregulation (sensory and motor), affect (explosive/irritable or frozen/restricted), cognition (altered perceptions of beliefs, auditory and sensory-perceptual flashbacks and dissociation) and behaviour (multiple forms of regression), patients are at times misdiagnosed with bipolar, oppositional defiant disorder/conduct disorder, *Attention Deficit Hyperactivity Disorder* (ADHD) or other anxiety disorders (van der Kolk et al., 2009). These disorders are often co-morbid with developmental trauma disorder, and therefore it is of utmost importance for clinicians to recognize the eventual possible difficulties in assessing and treating their patient when they present with more than one diagnostic (D'Andrea et al., 2012). In addition, by limiting the number of given diagnoses, this allows for efficient treatment options thus making the route of intervention clearer for clinicians rather than the use of

a combination of lengthy and often disconnected intervention methods (D'Andrea et al., 2012; Ford et al., 2013). Thus, by having developmental trauma disorder as the primary diagnosis to guide the treatment plan, clinicians can then also consider the inclusion (or not) of other co-morbid disorders (van der Kolk et al., 2009).

In that sense, complexly traumatized youths have been shown to improve when provided with trauma-focused interventions which target the adverse consequences of maltreatment (Ford et al., 2013), thus highlighting the importance of efficient and appropriate diagnosis. In van der Kolk's proposal to the DSM-5 editors advocating that developmental trauma disorder be included was highlighted the major issue that in experiencing chronic trauma, current clinical practice often reveals *no diagnosis, inaccurate diagnosis or inadequate diagnosis* (van der Kolk et al., 2009). The absence of a trauma-related diagnosis may result in misguided, ineffective or total lack of treatment plans to those traumatized patients (van der Kolk et al., 2009). Verily, while for many complexly traumatized children who have received psychopharmacological treatment and seen an increase in symptoms when medicated, many have yet to receive psychotherapeutic intervention addressing their histories of trauma (Ford et al., 2013). Therefore, a DTD diagnosis in the DSM could have the potential of implementing trauma-informed care in mental health programs, thus resulting in the elimination or reduction of excessive over-diagnosing, under-diagnosing, misdiagnosing and not diagnosing seen in mainstream child psychiatric care (Courtois, 2008; van der Kolk, 2003). It also keeps at bay the risk of over-treating or under-treating a child, which may

lead to adverse reactions (Courtois, 2008). Consequently, with the disposal of a diagnosis for children that more than partly addresses the symptoms associated with impairments in self-regulation, emotional states, negative self-beliefs and disorganized attachment feelings and behaviors of DTD, a coherent and cohesive intervention model to treat and target all the spheres impacted by complex trauma rather than a blend of disjointed, lengthy interventions would become available (Ford et al., 2013).

Commonly used treatment options for complexly traumatized youths

The assessment of standard forms of PTSD through the use of instruments developed for DSM-IV criteria do not address the wide range of issues impacted by complex trauma, i.e. the developmental aspects of the trauma history, functional and self-regulatory impairment, personal resources and resilience, and patterns of revictimization (Courtois, 2004). Therefore, in recognizing the risk for complexly traumatized children and adolescents to receive numerous medical and psychiatric diagnoses which have often shown to be resistant to the usual evidence-based psychotherapeutic mental health treatment models (Ford et al., 2013; Resick et al., 2012), mental health researchers have been propelled to develop various approaches and treatments which can and have been used with complexly traumatized children, adolescents, and their families (Blaustein et al., 2010; Courtois, 2004, 2008). In a single intervention, those approaches target all of the spheres impacted by developmental trauma contrary to the current interventions to treat PTSD and other trauma-related symptoms, which aim at working through one disorder at a time (Blaustein et al., 2010;

Courtois, 2008). Three widely used intervention methods, The *Attachment, Self-Regulation, and Competency* (ARC) Framework , The *Integrative Treatment of Complex Trauma for Children* (ITCT-C), and the *Trauma-Focused Cognitive Behavioral Therapy* (TF-CBT), whose wide range of interventions draw from attachment theory, cognitive behavioral therapy, trauma theory, family and ecosystemic theory, and existential elements, target in their entirety the difficulties experienced by youths impacted by complex trauma, thus making the intervention conjoined and whole. In all of those three models, establishing and maintaining therapeutic relationship with both the child and their parent(s) is invaluable for the success of the clinical intervention (Lawson & Quinn, 2013). Also common to all three approaches is the invaluable importance of building affective self-regulation, anxiety tolerance skills, as well as cognitive coping by connecting thoughts, feelings, and behaviors related to the trauma, achieved either with the child or adolescent or through the caregiver (Lawson & Quinn, 2013). In sum, those interventions designed specifically to treat complex trauma symptoms are cohesive and un-scattered, connected rather than being disjointed, as they target all the difficulties resulted from prolonged trauma exposure.

Aim of the Essay

Presented in the context of this essay were the concepts of complex trauma and developmental trauma disorder, as well as the question of diagnosis in the mental health field and its importance in the assessment and elaboration of an adequate treatment plan when working with complexly traumatized youth. Therefore, given that the importance

of diagnosis in the mental health field has been established and that as of yet, there are no integrative psychiatric diagnoses to encompass the wide array of symptoms occurring in children exposed to interpersonal trauma, this essay explores possible complications in the absence of a DTD in the current DSM which may arise for psychologists during the assessment and elaboration of an intervention plan when working with complexly traumatized youth, especially children of youth centers. This essay's specific angle aspired to document mental health difficulties as perceived by the mothers of children who have experienced abuse and neglect, knowing that they are at significantly more at risk of developing complex trauma (Dvir et al., 2014; Spinazzola et al., 2005; Cloitre et al., 2009). We aimed to demonstrate that these children show a multiplicity of difficulties and while our chosen method does not allow verifying this, we suggest that that these numerous difficulties may eventually translate into a higher probability of over-diagnosis. For that, we will consider data collected through diverse questionnaires completed by the mothers of 17 maltreated children receiving services at a youth center. Those questionnaires allow us to document a number of symptoms and difficulties of those children as possible indicators of eventual mental health disorders resulting from having faced long-term trauma. The questionnaires completed by the mothers, namely the *Trauma Symptoms Checklist for Young children*, the *Child Behaviour Checklist* for ages 6-18, and the *Child Dissociative Checklist*, allowed us to document symptoms related to PTSD, dissociation, anxiety, ADHD, affective problems, oppositional defiance, conduct disorder and somatic complaints. Of importance is that those questionnaires were not conceived as a diagnostic tool, their content allows the

identification of children whose symptoms are markedly elevated on a scale to warrant considering a more in depth diagnostic assessment. Moreover, since all of those instruments report observers' ratings of the child by their mother, variations in the observers' interpretations of behavior as well as actual variations in the child's behavior can be a potential complication in any observer-based assessment due to the perceptions being clouded by the personal attachment to the child (Putnam, 1997) However, those questionnaires are considered to be very consistent with DSM-IV diagnostic categories (Achenbach & Rescorla, 2001; Briere et al., 2001). Also, all those tested norms allow for the identification of children whose difficulties in one or multiple domains reach a clinically significant threshold, thus making it worthwhile to investigate further in order to determine the possibility of an eventual mental health disorder. Given that the children in our study are currently accessing services for maltreatment, a number of them already do and will in the future present with one or more trauma-related symptoms. Should our obtained results reflect the preceding assumption, then those victimized children struggling with several difficulties might receive one or more eventual diagnoses. To reiterate, while our current method does not directly inform us of the difficulties encountered by psychologists when assessing and elaborating an intervention plan for complexly traumatized youth, our angle posits that the multiple difficulties experienced by children exposed to interpersonal traumas such as neglect and abuse can lead to eventual multiple diagnosis due to psychiatric comorbidities (Dvir et al., 2014), thus complicating the task of mental health workers in treatment planning.

Method

The following section focuses on providing to the reader a description of our participants, the procedure followed in undertaking this research, as well as measures used to assess for trauma-related symptoms with the aim of exploring the possible complications in the absence of a DTD in the current DSM which may arise for psychologists during the assessment and elaboration of an intervention plan when working with complexly traumatized youth.

Participants

Participants are 17 children aged 6 to 10 (10 girls and 7 boys) and their mothers who have been recruited through Child Protection Agencies. Those children were receiving services through those agencies mainly for neglect and psychological maltreatment. Few of them have also experienced physical or sexual abuse. Children were 6 years of age and older at the time of the recruitment, with a mean age of 94 months. They were all living with their biological mother on a full-time or part-time basis. Participants were part of a larger study, which received ethical approval, on family and child functioning including younger children (this involved 28 mother-child dyads where children were aged between the ages of 4 and 10 years old). However, because some measures are not the same for 4-5 years children and older, only those 6 years and older were included.

Procedure

Children and their mothers were met at their home. Mothers completed few questionnaires, including a sociodemographic questionnaire, the *Trauma Symptoms Checklist for Young Children* (TSCYC; Briere et al., 2001), the *Child Dissociative Checklist* (CDC; Putnam et al., 1993), and the *Child Behavior Checklist* (CBCL 6-18 ans; Achenbach & Rescorla, 2001). In addition, informed consent was obtained from mothers.

Measures

Trauma Symptom Checklist for Young Children (TSCYC)

The TSCYC, a 90-item caretaker-report instrument divided into 9 scales, was developed to assess trauma-related symptoms in children ages 3–12 (Briere, 2005). However, in this essay, only the 27 items assessing PTSD symptoms were considered. And while those items are usually divided into 3 distinct scales (intrusion, avoidance and hyperarousal), we used the PTSD total score scale which better reflects the presence of an ensuing disorder. Items are rated on a scale of 1 to 4, with 1 being "not at all and 4 being "very often" (Briere, 2005). The responses on each scale are summed to obtain the raw score which are then converted to their corresponding T scores determined by age group and gender. For all scores except the Post-traumatic Stress-Total score, T scores between 65 and 69 are interpreted as possibly problematic, and scores at 70 or above specify clinically significant distress (Briere, 2005). Post-traumatic Stress-Total T scores in the 65 to 69 range are indicators of mild to moderate post-traumatic stress, and scores

of 70 or above are indicators of relatively severe post-traumatic disturbance (Briere, 2005). The TSCYC is able to generate a possible diagnosis of PTSD, with acceptable sensitivity and specificity (Briere, 2005).

Child Behavior Checklist for Ages 6-18 (CBCL/6-18)

The CBCL/6-18 was designed to obtain caregivers' ratings of 120 problem items and it can be used for: Identifying behaviors/problems interfering with client's functioning, measuring initial behavior severity, tracking changes in emotional, acting out or behavior problems over the course of treatment, and treatment planning (Achenbach & Rescorla, 2001). Items of the instrument may be scored on *syndrome* scales (e.g.: emotionally reactive, anxious/depressed, somatic complaints. However, for the purpose of this essay, we used the following six *DSM-oriented scales:* affective problems, anxiety problems, pervasive developmental problems, attention deficit/hyperactivity problems, stress problems, autism spectrum problems, and oppositional defiant problems (Achenbach & Rescorla, 2001). The preceding items from the DSM-oriented scales have been rated by experienced psychiatrists and psychologists from many cultures as being very consistent with DSM diagnostic categories, namely depressive problems; anxiety problems; somatic problems; attention deficit/hyperactivity problems; oppositional defiant problems; conduct problems (Achenbach & Rescorla, 2001). The CBCL must be completed by the parent/caretaker who spends the majority of time with the child; and that person is asked to rate the child for how true each item is now or within the past 6 months using this scale: 0 = *not true* (as far as you know);

1 = *somewhat or sometimes true*; 2 = *very true or often true of the child* (based on the preceding two months) (Achenbach & Rescorla, 2001). The CBCL provides a total score indicative of clinical status as well as two broadband scores (externalizing, internalizing) and subscale scores. The cutting points for subclinical and clinical designation are based on t-scores formed on a clinical population (Achenbach & Rescorla, 2001) Validity and reliability are excellent, and extensive normative data are available for children ranging from 6 to 18 (Achenbach & Rescorla, 2001).

Child Dissociative Checklist (CDC)

The CDC, a screening measure developed by Putnam and colleagues, compiles observations by an adult observer regarding a child's behaviors on a 20 item list rated on a scale ranging from *not true* (0) to *very true* (2) (Putnam, 1997). The behaviors noted are those which occur in the present and have occurred in the last 12 months (Putnam, 1997). The CDC is able, among other things, to quantify dissociative behavior for dimensional approaches and can generate cutoff scores that categorize children into low and high dissociation groups (cutoff score equal to or greater than 12 is considered abnormal, particularly in older children) (Putnam, 1997). Research has shown that healthy, non-maltreated, normal children tend to usually score low on the CDC in comparison to maltreated children whose scores are higher than those with no trauma history (Putnam, 1997). As a clinical tool, the CDC has multiple uses, including that of being a routine screening instrument used in a clinic setting as a standalone tool or in addition to other reporting tools for parents (Putnam, 1997).

Results

The following section describes the results obtained for each participant in regards to perceived trauma-related symptoms by their mothers, thus highlighting the number of difficulties per scale for each child.

Analytic Strategy

For each of the 17 children, we initially calculated their continuous score on all eight scales considered. Those continuous scores were then transformed into categorical scores, depending on whether the symptom was levelled as normal, subclinical or clinical. Then, for each child, the number of scales for which they presented with symptoms at a subclinical and clinical level was added, for a combined total of those two levels. Thus, each child was rendered a score varying between 0 and 8, with a score of either 0 up to 8 indicating that all of the eight scales of that child were in the normal zone (therefore none of the scales were in the clinical or subclinical zone);

Table 1 provides the frequency of children presenting with subclinical, clinical and the combined total results on symptoms of all 8 scales of 1, 2, or all three assessment tools, namely the *Trauma Symptom Checklist for Young Children* (TSCYC), *Child Behavior Checklist for Ages 6-18* (CBCL/6-18), *and the Child Dissociative Checklist* (CDC). In sum, the following is the total number of children, per symptoms scale, who were perceived by their mothers as exhibiting symptoms: six children on the *TSCYC PTSD Total scale*, seven children on the *CBCL Affective Problems* scale, six children on the *CBCL Anxiety Problems* scale, two children on the *CBCL Somatic Complaints* scale,

six children on the *CBCL Attention Deficit/Hyperactivity Problems* scale, nine children on the *CBCL Oppositional Defiant Problems* scale, eight children on the *CBCL Conduct Disorder* scale, and five children on the *CDC Total Score* measure. The scale rendering the highest score was *CBCL Oppositional Defiant Problems* with a total of 9 children.

Table 1

Descriptive Information and Symptoms Scales

Symptoms scales	N subclinical	N clinical	N total
Trauma Symptom Checklist for Young Children (TSCYC)			
PTSD Total scale	3	3	6
Child Behavior Checklist for Ages 6-18 (CBCL/6-18)			
Affective Problems (AFF)	4	3	7
Anxiety Problems (ANX)	4	2	6
Somatic Complaints (SOM)	1	1	2
Attention Deficit/Hyperactivity Problems (ATT)	3	3	6
Oppositional Defiant Problems (OPP)	5	4	9
Conduct Disorder (CCD)	2	6	8
Child Dissociative Checklist (CDC)	n/a	5	5

Note. N total = subclinical and clinical results combined

Table 2 provides the breakdown in the frequency of children presenting with subclinical and clinical symptoms on the 8 scales. Results show 3 out of the 17 children in our sample were scored by their mothers as exhibiting no symptoms on any of the eight scales; 3 out of 17 children exhibited symptoms on one scale, 2 out of 17 children exhibited symptoms on two scales; 2 out of 17 children exhibited symptoms on three scales; 3 out of 17 children exhibited symptoms on four scales; 2 out of 17 children exhibited symptoms on five scales; 1 out of 17 children exhibited symptoms on six scales; none of the 17 children exhibited symptoms on seven scales; and lastly, 1 out of 17 children exhibited symptoms on eight scales.

Table 2

Number of Children with Difficulties on Combined Number of Scales

Number of scales in the subclinical/clinical range	Frequency of children (n = 17)
0	3
1	3
2	2
3	2
4	3
5	2
6	1
7	0
8	1

Discussion

This essay aimed at shedding the light on several issues. Specifically, we aspired to document the various and many mental health difficulties of children who have experienced abuse and neglect. In highlighting the multiplicity of such difficulties for children, this accents the ensuing reality of increased risk for those children to eventually become over-diagnosed. Thus, for psychologists working with complexly traumatized youth, the assessment and elaboration of a treatment plan becomes all the more difficult namely due to the absence of a *Developmental Trauma Disorder* diagnosis in the current DSM. To illustrate the above mentioned goals, we considered data collected through questionnaires completed by the mothers of 17 maltreated children receiving services at a youth center with the objective of documenting a number of symptoms and difficulties of those children as possible indicators of eventual mental health disorders which they could develop in having faced long-term trauma. The questionnaires completed by the mothers, namely the Trauma Symptoms Checklist for Young children, the Child Behaviour Checklist for ages 6-18, and the Child Dissociative Checklist, allowed us to document some symptoms and difficulties of those children. As for eventual mental health disorders which those children could develop when having faced long-term trauma, there is PTSD, dissociation, anxiety, ADHD, affective problems, oppositional defiance, conduct disorder and somatic complaints. Of note is that no threshold cut-off was established for the 8 symptoms scales used when identifying the children's difficulties. In terms of the participants themselves, we remind the reader that it is the mothers' perception of their child's symptoms and difficulties which was taken into consideration, as opposed to direct observation of the child by the clinician.

Our results revealed that, as noted by the mothers' perceptions, of the 17 children in our sample, 14 presented with difficulties on at least one symptom scale, and more than half of them (9 out of 17) show difficulties on three scales or more. These results are congruent with the substantial evidence connecting the experience of childhood exposure to interpersonal traumas such as neglect and abuse, with multiple mental health difficulties (Dvir et al., 2014; Spinazzola et al., 2005; Cloitre et al., 2009). Moreover, the findings that several children score at a clinical level for multiple difficulties raise the necessity to properly assess these children in order to verify whether they present with one of many specific mental disorders. According to these results, these children are at risk of receiving, for example, a diagnosis of *Bipolar Disorder/Pediatric Bipolar Disorder* (BD/PBD), often with comorbid *Attention Deficit Hyperactive Disorder* (ADHD), or *Severe Mood Dysregulation* (SMD; Levin, 2009). The presence of the many clinical difficulties might therefore render a proper assessment by the psychologist more complex. For example, when considering a decade of literature on PBD from a Research Update Review, the amount of diagnostic disagreement surrounding PBD is apparent, and the clinical presentation of PBD in pre-adolescence and early adolescence is seriously debated (Pavuluri, Birmaher, & Naylor, 2005). Due to the overlapping symptoms of BD and other psychiatric disorders, it is a challenge to differentiate BD from those other disorders (Pavuluri et al., 2005). Yet, the only alternatives Pavuluri et al. (2005) suggested were a differential diagnosis containing ADHD, schizophrenia, pervasive developmental disorder, and substance abuse. No mention of issues resulting

from trauma was made, thus increasing the risk of misdiagnosing children and providing them with inadequate treatment modalities.

Another probable diagnosis which could be attributed to those children is that of *Post-traumatic Stress Disorder* (PTSD), and while it helps conceptualize a focus on a history of trauma, it fails to recognize the complexity and the severity of the disruptions of functioning following early childhood developmental trauma, when it is overwhelming and sustained, and when it often involves caretakers who either inflict trauma or fail to shelter the child from trauma (van der Kolk, 2003). This stresses the critical importance of understanding the interrelatedness among various symptoms that are now captured by multiple, seemingly unrelated "comorbid" diagnoses which address affect dysregulation (e.g., bipolar illness), chronic distrust of authority (e.g., oppositional defiant disorder), inability to focus and concentrate (e.g., attention-deficit/hyperactivity disorder), and others, while not taking into consideration the trauma suffered by the children (Levin, 2009). Typically then, the children might receive diagnosis-specific treatments for the range of comorbid symptoms manifested, as opposed to trauma-focused interventions to target their trauma-related symptoms jointly.

It seems then that the more accurate diagnosis for many of those children, DTD, reconceptualises the treatment modality, thus leading to substantial clinical benefit. DTD more effectively describes the wide range of symptoms expressed by youth, namely difficulties that encompass rage reactions, problems with attachment and authority,

affect and impulse dysregulation, and impairment of cognition and attention (D'Andrea et al., 2012). For example, a child who acts out aggressively, while their behaviour can be explained partly biologically, it may more significantly reflect the patient's reaction to adverse and inhumane treatment. If so, it is safe to consider that children with histories of chronic and severe trauma could benefit more from efforts devoted to cope with their trauma rather than from non-trauma-focused approaches so often used which risk being ineffective. Therefore, by having the main focus on a biologic etiology, it is making it difficult to recognize that these severely symptomatic and complexly traumatized children need comprehensive treatment programs which makes use of psychodynamic play therapy, talk therapies, family interventions. That is, over-diagnosing and providing inadequate treatment plans may be counterproductive to the children.

To date, the body of literature documenting the effectiveness of complex trauma-focused interventions for a number of developmental trauma related difficulties in children and youth is promising (Blaustein et al., 2010; Courtois, 2004, 2008). The existing literature on treatment outcome lends preliminary, but consistent, additional credibility to both the specificity and utility of a complex trauma diagnosis (Blaustein et al., 2010; Courtois, 2008, van der Kolk et al., 2009). In fact, children victims of maltreatment who have received diagnoses such as conduct disorder, bipolar disorder, and ADHD do not respond as well to disorder-specific treatments as other children with the same diagnoses, and do respond to trauma-focused intervention modalities which

target the core instabilities of affect dysregulation, attention and consciousness, interpersonal skills, and attributions and schemas (D'Andrea et al., 2012). Thus, this adds to the argument that a new diagnosis of DTD could enhance treatment selection and outcomes for this difficult-to-treat cohort. It bears reminding that a developmental trauma diagnosis can aim at reducing the pathologizing of complex trauma survivors, who, by being labeled with a slew of diagnoses, are often excessively pathologized, and that can become a source of chronic stigma. The common continued practice of applying multiple distinct comorbid diagnoses to complexly traumatized children is putting in jeopardy etiological clarity, and there is a real risk of attributing trauma-informed treatment to only one disorder (PTSD) which characterizes only a small fraction of traumatized children who are in psychiatric treatment. On the other hand, a diagnosis which considers the interrelated difficulties resulting from childhood victimization could reduce diagnostic mistake and could promote a targeted treatment approach focused on post-traumatic bio-psychosocial dysregulation. Thus, the current essay lends further support for the use of interventions conceptualized through a trauma-lens vision as a means of providing the most accurate and effective treatment to complexly traumatized children. To better demonstrate the above mentioned information, the case of one child from our sample will be highlighted and discussed.

An Illustrative Case

Consider the case of this child from our sample. On all eight scales targeted for our study, this child displayed a number of difficulties (according to his mother). Namely,

on the *TSCYC PTSD Total scale*, the apparent symptom was in the clinical zone. As for the *Child Dissociative Checklist* scale, this child's symptoms scored at a subclinical level. Whereas the *CBCL-Affective Problems, CBCL-Somatic Complaints, CBCL-Attention Deficit/Hyperactivity Problems*, and *CBCL-Conduct Disorder* scales, the symptoms for this child presented at a clinical level, and on the *CBCL-Anxiety Problems* and *CBCL-Oppositional Defiant Problems* scales, at a subclinical level. When considering the diagnosis of PTSD, for example, one cannot disregard the fact that it is not developmentally sensitive and does not adequately describe the impact of exposure to childhood trauma on the developing child (Blaustein et al., 2010). Whereas although as of yet only a proposed diagnostic, it seems probable that applying the diagnosis of DTD would more accurately and effectively conceptualize the treatment plan for this child whereas receiving multiple comorbid diagnoses would lead to the use of various intervention methods by the mental health professional. As a possible result in the use of numerous interventions to treat the child, the discouragement of the patient, the parents and the treating personnel can surface, as well as poor adherence to the treatment plan. On the other hand, by conceptualizing a child with the singular diagnosis of DTD and by referring specifically to the child's life history, it will enable understanding, empathy, the need for safe and well-bounded attachments with others, and for dynamic psychotherapy in this child's environment (D'Andrea et al., 2012). Through a developmental trauma-focused intervention, mental health professionals work towards assisting the child to develop the capacity to cope with anxiety and to trust others, in

gaining a vocabulary and a tolerance for distressing affect, and in enhancing self-esteem (Courtois, 2008).

Limitations

Even though the literature and studies in support of DTD are persuasive, it remains that for the time being, this diagnostic is not reflected in the DSM. Therefore, the larger study from which the presented data are drawn were not formulated in the context of a specific existing diagnosis. A second limitation of this essay pertains to the small number of participants considered. Future research would benefit from the use of a larger sample of clinical participants. Next, with insufficient information to measure other aspects impacted by complex trauma such as attachment difficulties, language delays, and learning disabilities, we were unable to consider those in this study. However, they may very well be relevant to illustrate our reflection as they would most assuredly highlight the vast difficulties of children impacted by complex trauma. As for the questionnaires completed by the mothers, they are standardised and therefore it is not possible to explain any points in the questions that participants might misinterpret. This is another limitation of the present paper. In terms of the participants themselves, we recognize that it is the mothers' perception of their child's symptoms and difficulties which was taken into consideration, as opposed to direct observation of the child by the clinician. This raises the concern of the mothers' possible over-evaluation of their children's perceived difficulties when completing the questionnaires, thus possibly rendering different results than those obtained by trained clinicians who often use

various methods to collect and assess data when posing a diagnosis. Moreover, in comparison to mothers, mental health specialists' clinical understanding and views of children's behaviours might differ on certain spheres. As for the children's ages in this current study, those were specifically between the ages of 6 and 10 years of age as opposed to having a wider range of children's ages to work with. This inevitably highlights the question of whether the difficulties perceived by the mothers' of those children are specific to this age range only, and/or whether they are reflective of the difficulties of children who are younger or older in age. Lastly, when the larger study from which this essay drew its data from was conducted, the DSM-IV was in use at that time and therefore, only DSM-IV assessment instruments and questionnaires were available as opposed to using DSM-5 assessment tools.

Conclusion

In conclusion, the conception of DTD has been of utmost importance in the vast field of trauma. As presented in this essay, the specific manifesting symptoms and difficulties of the maltreated children are extremely important to acknowledge and categorize as it can direct research into treatment modalities for clinicians and professionals working with this vulnerable population. Moreover, the results of this study highlight the value of further research in the characterization and standardization of this proposed trauma-related disorder. The less mental health professionals are aware of the presenting symptoms and diagnosis of developmental trauma resulting in a lack of knowledge in available trauma-focused treatment options, the fewer the number of children accessing such therapeutic services, and the longer they remain untreated in their distressing symptoms. Moreover, the less knowledgeable mental health workers are about developmental trauma and readily available intervention plans, it seems that more harm is being done to the children by applying inappropriate and ineffective treatment, which are often lengthy and without a clear goal direction. Youth centers offering treatment programs can better serve children by increasing the competency and self-confidence of clinicians pertaining to developmental complex trauma, by carefully reconsidering the children's diagnoses and by re-evaluating intervention options.

Assuredly, there remains a need for much research to be undertaken on DTD to justify it as a psychiatric diagnosis. However, although complex trauma disorders are not diagnoses in the DSM-5, the *International Classification of Diseases-11* diagnostic manual (ICD-11) (a medical classification list by the World Health

Organization) due for release in 2017, plans to include Complex Post-traumatic Stress Disorder in its manual. Surely, this is a step in the right direction. It is our hope that the diagnosis of DTD will be included in the forthcoming DSM psychiatric manual, as it better reflects the symptomatic reality of childhood maltreatment, and that treatments with adequate empirical support will be modified or otherwise flexibly implemented in an attempt to accurately and effectively meet the needs of complexly traumatised children. While the impact of the current situation poses challenges to mental health worker, children and their caretakers, it also allows unique opportunities for further scientific investigations through the continued development of evidence-based interventions for complex trauma disorders.

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