Addressing Developmental & Early Attachment Trauma

in Childhood

An Evidence-Based Clinical Workshop for Registered Psychologists and Allied Health Professionals

Presented by: Dr. Carissa Muth Date: May 14, 2026

Sunshine Coast Health Centre • Georgia Strait Women's Centre • 3 CEU Hours

FOUNDATIONS

What Is Attachment?

Bowlby, Ainsworth & the Science of Early Bonds

Bowlby's Definition

An innate biological system that keeps infants close to caregivers for survival. Attachment is not dependency — it is the secure base from which exploration is possible.

Internal Working Models

Repeated attachment experiences form 'templates' — unconscious representations of self and other that guide all future relationships. These are literally encoded in neural circuitry.

Ainsworth's Strange Situation

Identified 3 primary patterns via systematic observation: Secure (B), Insecure-Avoidant (A), and Insecure-Ambivalent/Resistant (C). Later, Main & Solomon added Disorganized (D).

The Secure Base

The caregiver provides a safe haven (return to when distressed) and a secure base (launch from for exploration). Both are neurobiologically necessary for healthy development.

Bowlby 1969 • Ainsworth 1978 • Main & Hesse 1990 • Mikulincer & Shaver 2016

The Four Attachment Patterns

Ainsworth, Main & Solomon — Clinical Implications

B Secure

Caregiver: Consistently responsive, attuned, available

Child: Uses caregiver as safe base; distressed by separation, reassured by return; explores freely

→ ***Best predictor of social competence, emotional regulation, and resilience***

C Ambivalent/Resistant

Caregiver: Inconsistently responsive; sometimes available, sometimes not

Child: Preoccupied with caregiver; hyper-activates attachment; difficulty exploring

→ ***Under-regulation; chronic anxiety; preoccupied adult attachment style***

A Avoidant

Caregiver: Consistently rejecting of emotional needs; values self-sufficiency

Child: Appears independent; suppresses attachment bids; low visible distress on separation

→ ***Over-regulation; somatization; intimacy difficulties; dismissing adult attachment style***

D Disorganized

Caregiver: Frightening or frightened; source of both threat and comfort

Child: No coherent strategy; contradictory behaviors; freeze, collapse, disorientation

→ ***Highest risk for trauma sequelae, dissociation, psychiatric disorders, and perpetuating abuse***

Defining Developmental Trauma

When the Caregiving System Becomes the Source of Threat

> *"Developmental trauma refers to repeated, chronic, interpersonal adversity occurring within the caregiving system during sensitive periods of development — fundamentally disrupting the child's capacity to regulate affect, form relationships, and construct a coherent sense of self."*

— van der Kolk, 2005; Herman, 1992; Cook et al., 2005

Not Just Single-Incident PTSD

Developmental trauma is distinct from single-incident PTSD. It is cumulative, relational, and occurs during critical windows — reshaping the architecture of development itself.

Why Timing Matters

Trauma during the first 3 years has disproportionate impact: the brain is at peak plasticity, attachment systems are being wired, and the child has no narrative or language to process experience.

The 7-Domain Impact

Cook et al. (2005) identified 7 domains: attachment, biology, affect regulation, dissociation, behavioral control, cognition, and self-concept — each requiring targeted assessment.

CDC-Kaiser ACE Study

- Conducted at Kaiser Permanente from 1995 to 1997
- Sample- 17,000 Health Maintenance Organization members completed confidential surveys regarding their childhood experiences and current health status and behaviors
- One of the first studies considering correlation between “adult health risk behaviours, health status, and disease states to childhood abuse and household dysfunction” p. 246)

Source: Centers for Disease Control and Prevention, Kaiser Permanente. The ACE Study Survey Data [Unpublished Data]. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2016.

EPIDEMIOLOGY

The ACE Study: Population-Level Impact

Felitti et al. 1998 — 17,000+ Participants

64%
of adults report ≥1 ACE
Felitti et al. 1998

12.5%
report ≥4 ACEs
Dose-response risk

4–12×
increased risk of substance dependence with 4+ ACEs
Felitti et al. 1998

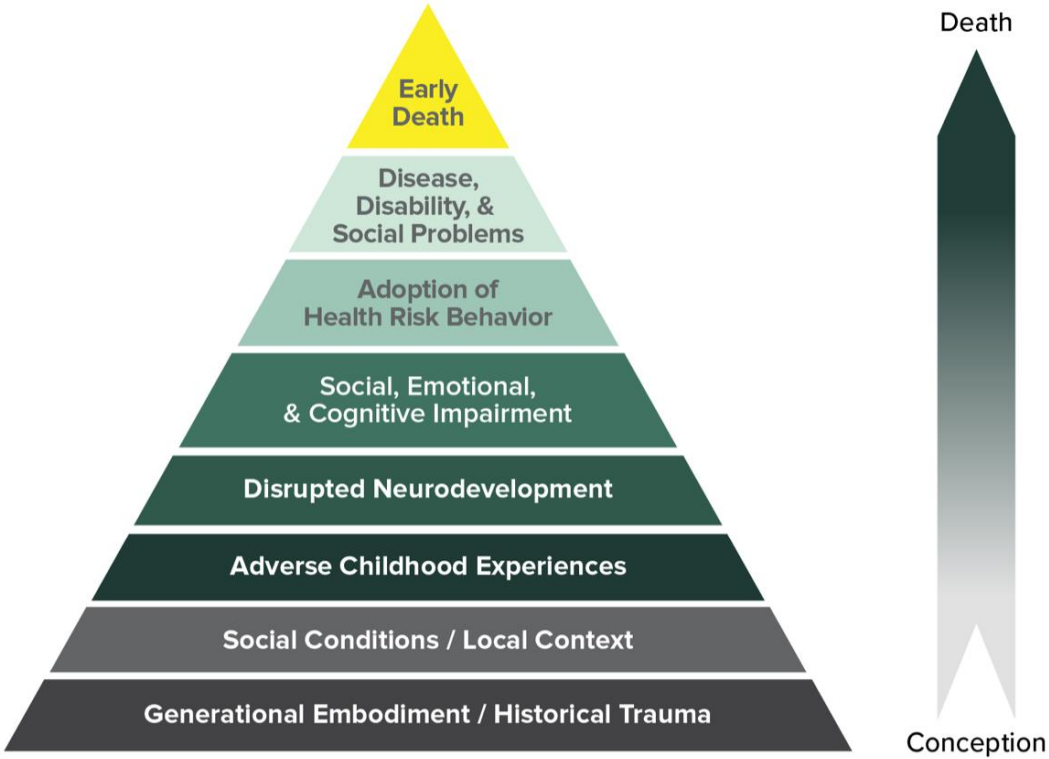
20yr
shorter life expectancy with 6+ ACEs
Brown et al. 2009

ACE Categories Include:

- Abuse: Physical, Emotional, Sexual
- Neglect: Physical, Emotional
- Household dysfunction: Domestic violence, substance abuse, mental illness, incarceration, divorce

Dose-Response Relationship:

- More ACEs = exponentially worse health outcomes
- ACEs are highly interrelated — rarely occur in isolation
- Effects are cumulative and biologically embedded
- Childhood is the critical window for ACE prevention and mitigation



Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Source: Centers for Disease Control and Prevention, Kaiser Permanente. The ACE Study Survey Data [Unpublished Data]. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2016.

Risk of Psychopathology

- It was found that exposure to 2–3 ACEs and exposure to 4–5 ACEs were significantly associated with PTSD diagnosis, while exposure to sexual abuse, bullying, threats of violence, and near-drowning were significantly related to CPTSD diagnosis.
- Fearful attachment style was significantly associated with PTSD diagnosis (not CPTSD)
- Individuals with higher exposure to ACEs had higher PTSD symptom levels compared to individuals with lower levels of exposure or exposure to a single ACE

Ferrajão, P., Frias, F., & Elklit, A. (2024). Exploring Independent and Cumulative Effects of Adverse Childhood Experiences on PTSD and CPTSD a Study in Ugandan Adolescents. *Children (Basel, Switzerland)*, *11*(5), 517. https://doi.org/10.3390/children11050517

Complex Trauma & C-PTSD

Herman 1992 / ICD-11 — Beyond the Single-Incident Model

PTSD (DSM-5 / ICD-11)

- Single or limited incidents
- Intrusion, avoidance, hyperarousal, negative cognitions
- Trauma memory intact but unwanted
- Core self relatively preserved
- More amenable to short-term trauma processing

Complex PTSD (ICD-11)

- Repeated, prolonged, interpersonal, often childhood
- PTSD symptoms PLUS: affect dysregulation, negative self-concept, relational disturbances
- Fragmented / incoherent trauma narrative
- Core sense of self disrupted
- Requires phase-based, relationship-grounded treatment
- The evidence suggests that while PTSD can arise at any point in life, CPTSD is overwhelmingly the result of childhood trauma due to emotional neglect, bullying, humiliation, and disrupted attachment.

Herman (1992) first described Complex Trauma Syndrome. ICD-11 (2018) formally recognized Complex PTSD as a distinct diagnosis — a landmark for clinical practice. DSM-5 does not yet include it; practitioners may use PTSD with specifier or DTD framework.

- Exposure to trauma during childhood has long been recognized as a significant predictor of PTSD in adulthood in addition to other disorders such as depression
- Age 10 as period when trauma severity recall was the greatest. Also period of strengthening safety cues and threat differentiation
- Cumulative stressors prior to age 13 significantly increase the odds of psychological distress in adulthood
- Development of fear circuitry may contribute to risk for later PTSD and other trauma- related pathology

Stevens et al., 2018

- Middle childhood is a sensitive period in which adverse experiences have long-lasting neurobiological impacts (around age 10)
- Timing of trauma exposure during development as significant consequences on PTSD symptoms as well as neural underpinnings
- A supportive and enriching environment in childhood cannot completely counteract the negative effects of the early environment
- Cortisol response to a social stressor in children, but not adolescents (above 10 yrs), is reduced by the presence of their mother

Stevens et al., 2018

ICD-11: Rationale for Separating Complex PTSD (CPTSD) from PTSD - Prioritizing Clinical Utility

WHO GUIDING PRINCIPLE: PRIORITIZING CLINICAL UTILITY
(Diagnosis must lead to better treatment outcomes)

EVIDENCE COLLECTED TO JUSTIFY THE SPLIT

DISTINCT SYNDROME EVIDENT:
Chronic, repetitive trauma creates a symptom profile beyond fear-based PTSD.

SYMPTOM CLUSTER DIFFERENCES:
Statistical analysis confirmed two distinct patient groups based on symptom patterns.

TREATMENT NEEDS DIFFER:
Evidence showed PTSD protocols often fail for CPTSD patients without prior stabilization.

TRADITIONAL PTSD
(The 'Fear' Response)

1. **Re-experiencing** (Flashbacks)
2. **Avoidance** (Triggers)
3. **Sense of Threat** (Hypervigilance)

CLINICAL FOCUS & PATHWAY: Conditioning to specific threat.
→ **Trauma-Focused Therapy** (e.g., Exposure) to process memory.

THE "SIBILING" MODEL
(Mutually Exclusive Diagnoses)

COMPLEX PTSD (CPTSD)
(The 'Self' Disturbance)

1. PTSD clusters
Avoidance (Triggers)
PLUS
4. **Affect Dysregulation** (Emotional storms/ numbing)
5. **Negative Self-Concept** (Shame, worthlessness)
6. **Relational Disturbances** (Distrust, isolation)

CLINICAL FOCUS & PATHWAY: Alteration of personality & self-organization.
→ **Phase-Based Therapy** (Stabilization & skill-building FIRST, then trauma processing).

WHY THE SPLIT MATTERS FOR CLINICAL UTILITY

More precise treatment for event-based fear. ← **PTSD DIAGNOSIS** — **CPTSD DIAGNOSIS** → Ensures appropriate phase-based care & reduces BPD misdiagnosis.

The split ensures patients receive the most effective, targeted treatment for their specific trauma profile.

Disorganized Attachment

Main & Hesse 1990 — The Highest-Risk Pattern

The Impossible Bind

The caregiver is simultaneously the source of threat AND the only available source of comfort. The child's attachment system activates AND inhibits simultaneously — producing behavioral collapse.

Observable Behaviors

Freezing/stilling, contradictory approach-avoidance sequences, disorientation, stereotyped movements, apprehension near caregiver. These are not willful behaviors — they are neurobiological collapse.

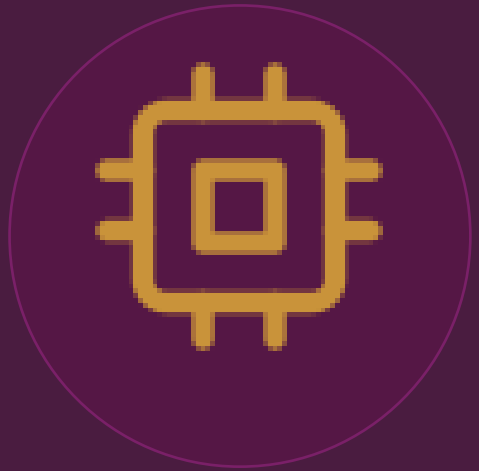
Long-Term Risk

Disorganized attachment in infancy predicts: dissociation (Liotti, 2004), externalizing/internalizing problems, C-PTSD, BPD features, and perpetuating the attachment cycle across generations.

Neural Substrate

Schore (2003): disorganized attachment disrupts right-hemisphere limbic development — the neural substrate for implicit relational knowing, affect regulation, and somatic self-awareness.

Prevalence: ~15% in low-risk community samples; 80%+ in maltreated populations (van IJzendoorn et al., 1999).
Primary clinical target: Build the child's regulatory capacity via a consistent, safe therapeutic relationship BEFORE attempting trauma processing.



BLOCK 2 • SLIDES 9–15

Neurobiology of Trauma

How Adversity Rewires the Developing Brain

NEUROBIOLOGY

The Stress Response System

HPA Axis, Amygdala, PFC & the Threat-Detection Network

Threat Perceived

Sensory cortex / thalamus

Amygdala Activates

Fear memory, alarm signal

HPA Axis Activates

CRH→ACTH→Cortisol

PFC Inhibited

Reflection reduced

Survival Response

Maladaptive cognitions

Key Clinical Insights:

- Chronic stress keeps the amygdala hyperactivated — the threat-detection system is chronically 'on' (the relationship between chronic stress and cortisol follows a "U-shaped" curve or a two-phase process)
- Elevated cortisol over time is neurotoxic to the hippocampus (memory, context) and PFC (regulation, planning)
- Traumatized children are not overreacting — they are accurately detecting threat based on their prior experience

BRAIN DEVELOPMENT

How Trauma Reshapes the Developing Brain

De Bellis, Teicher, Perry — Structural & Functional Changes

Reduced Brain Volume

De Bellis et al. (2002): maltreated children show significantly smaller total brain volume, corpus callosum, and prefrontal cortex. Structural impact is greatest in early childhood.

Hippocampal Damage

Teicher et al. (2016): childhood trauma associated with reduced hippocampal volume — impairing contextual memory, fear extinction, and the ability to distinguish past threat from present safety.

Sensitized Amygdala

Perry (2006): use-dependent sensitization of the amygdala means that repeated threat exposure produces an increasingly reactive alarm system — misreading neutral cues as dangerous.

Corpus Callosum

Teicher (2000): reduced corpus callosum in traumatized children impairs left-right hemispheric integration — the neurobiological basis of the fragmented trauma narrative.

Perry's Neurosequential Model: brain development proceeds bottom-up. Chronic dysregulation keeps the child 'stuck' in lower brain functioning. Effective treatment must also proceed bottom-up — regulation first, relationship second, cognition third.

EPIGENETICS

Epigenetics & Intergenerational Transmission

How Trauma Gets Under the Skin — and Across Generations

3×

increased methylation of NR3C1 (glucocorticoid receptor gene) in maltreated children vs. controls

McGowan et al. 2009

Key Epigenetic Mechanisms:

- **DNA Methylation:** Early adversity methylates stress response genes, altering HPA axis set-points for life
- **Glucocorticoid receptor downregulation:** Reduces cortisol sensitivity — the system stops responding normally to stress
- **Transmission:** Yehuda et al. (2016) demonstrated Holocaust survivor offspring show PTSD-related epigenetic changes — trauma biology can be inherited
- **Meaney (2001):** Maternal licking/grooming in rats directly reverses adverse methylation patterns — caregiving has biological consequences at the genomic level

Clinical Implications: Intergenerational trauma transmission is real and biological — not just behavioral modeling. Family treatment, parent coaching, and attention to the parent's own trauma history are not optional adjuncts. They are core components of intervention for childhood trauma.

Dissociation in Children

Liotti's Theory, Presentation, and Clinical Recognition

What Is Dissociation?

A disruption in the normally integrated functions of consciousness, memory, identity, emotion, perception, behavior, and sense of self. In children it ranges from mild detachment to complex identity disruption.

Liotti's Structural Dissociation

Disorganized attachment is the primary developmental precursor. When the caregiver is both threat and haven, the child dissociates between an 'apparently normal' self and an 'emotional' self that holds the terror.

How Dissociation Presents in Children

Trance-like staring, 'checked out' episodes, amnesia for recent events, confusion about time, identity, age regression, somatic complaints without medical explanation, sudden mood shifts without apparent trigger.

Misdiagnosis Risk

Dissociation is frequently misdiagnosed as: ADHD (inattention), absence seizures, psychosis, or willful non-compliance. A trauma-informed lens is essential for accurate recognition.

Assessment: Child Dissociative Checklist (CDC); MID Adolescent version; dissociation items embedded in TSCC (ages 8+). Rule out neurological causes. Establish safety before any direct trauma processing.

Toxic Shame & Disrupted Identity

The Core Wound of Developmental Trauma

"Trauma-based shame is not guilt about a behaviour — it is a belief about the self: 'I am bad, broken, unworthy, unlovable.' This distinction determines treatment approach."

Neurobiological Roots

Schore (2003): excessive shame dysregulation in infancy — caregiver contempt, withdrawal, or humiliation — directly disrupts right orbitofrontal development, the neural substrate of self-regulation and identity.

Clinical Presentations

Aggression and rage as shame defenses; self-harm as self-punishment; grandiosity; hypervigilance to social rejection; perfectionism; chronic emptiness. All may be shame-driven.

Treatment Implications

Deane & Kezelman (2022): shame is the primary barrier to therapeutic engagement. The therapeutic relationship itself is the primary antidote — consistent positive regard, rupture repair, and non-shaming responses.

Self-Concept Reconstruction

Trauma-focused treatment must explicitly target negative self-schema. TF-CBT includes a trauma narrative specifically to reframe 'I caused this' → 'This happened to me and it was not my fault.'

Stress, Trauma & PFC–Subcortical Dysregulation

Why a child cannot 'just calm down' — and what the brain science tells us to do instead

Prefrontal Cortex — the 'Thinking Brain'

Appraise • Reflect • Plan • Regulate emotions • Learn from context

top-down inhibition

Limbic System — the 'Alarm Brain'

Detects threat • Stores fear memories • Triggers stress hormones • Acts fast

drives arousal

Brainstem / Body — the 'Survival Brain'

Fight • Flight • Freeze • Releases cortisol & adrenaline • Drives the body

UNDER STRESS & TRAUMA — what changes:

① High stress chemically shuts down the thinking brain (Arnsten, 1998, 2015)

Stress floods the brain with norepinephrine and dopamine. At high levels these chemicals paradoxically switch OFF the prefrontal cortex — the very part needed to stay calm, think clearly, and make choices. This is why a highly activated child cannot reason, comply, or self-regulate on demand: their thinking brain is temporarily offline.

② The alarm fires before the thinking brain even knows there's a threat (LeDoux, 1996)

The amygdala receives danger signals ~12 milliseconds before the cortex does — the body is already in threat-response before any conscious thought occurs. In traumatised children, repeated threat lowers this trigger threshold further, so the alarm fires to smaller and smaller cues. They react before they think — because that is the neurological sequence.

③ Chronic stress physically shrinks the thinking brain (Radley et al., 2004)

Sustained stress hormones (cortisol) cause the prefrontal cortex to literally lose neural connections — while simultaneously strengthening the alarm centre (amygdala). Over time, a traumatised child develops a structurally weakened regulator and a structurally overdeveloped threat detector. This is not a behaviour problem. It is a brain shaped by its history.

④ The brain loses its ability to learn 'it's safe now' (McEwen, 2007)

The hippocampus tells the amygdala when a past danger is no longer present — it is the brain's 'context' system. Chronic stress damages the hippocampus, so the alarm keeps firing to old cues even in genuinely safe environments. This explains why reassurance alone doesn't work, and why the therapeutic relationship must build new safety experiences slowly and repeatedly.

Arnsten (1998, 2015) Nat Rev Neurosci • LeDoux (1996) Emotional Brain • Radley et al. (2004) J Neurosci • McEwen (2007) Physiol Rev • Lupien et al. (2009) Nat Rev Neurosci

Polyvagal Theory: The Framework

Porges (1994, 2011) — Three Neural Circuits

1

Ventral Vagal Complex (VVC)

Myelinated vagus nerve (C-fibers)

Social Engagement

Safe, connected, regulated. Enables facial expression, prosody, listening. The biological substrate of felt safety. Predominant when in safe relationships.

2

Sympathetic Nervous System

Spinal sympathetic chain

Fight / Flight

Mobilization response. Activated by perceived threat. Prepares the body for action. Functional and adaptive in genuine danger — pathological when chronically activated.

3

Dorsal Vagal Complex (DVC)

Unmyelinated vagus nerve

Freeze / Collapse / Shutdown

Immobilization response. Proposed to be an ancient, last-resort survival response. Associated with dissociation, emotional numbing, collapse. Most contested aspect of PVT.

Porges, S.W. (2011). The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, and Self-Regulation. Norton.

Polyvagal Theory: Clinical Applications

Body-Based, Relational, and Regulatory Interventions

Therapeutic Voice & Prosody

Slow, warm, melodic speech activates the VVC through prosodic cues. Clinicians can use voice pitch variation consciously as a co-regulation tool. Monotone or harsh voices trigger sympathetic activation.

Safe Touch & Proximity

For children who have been touch-traumatized, proximity choices should follow the child's lead. Safety in the body is prerequisite to safety in the mind. OT sensory integration work can precede talk therapy.

Breath & Vagal Tone

Extended exhale (longer out than in) activates parasympathetic tone via the vagus nerve. Box breathing, 4-7-8 breathing, and humming all increase HRV. These are biologically grounded, not just relaxation techniques.

Co-Regulation First

Children cannot self-regulate before they have experienced consistent co-regulation. The therapist's regulated nervous system is the intervention. This is why personal therapy and supervision are professional obligations.

Somatic Awareness

Tracking body sensations in session (Somatic Experiencing approach): noticing where threat is felt in the body, titrating exposure, completing incomplete survival responses, building interoceptive awareness.

Play as Regulation

Active play mobilizes sympathetic energy within a safe relational context — practicing the move between activation and settling. The therapist as playmate is a VVC-activating experience.

Scientific Critiques of Polyvagal Theory

What the Peer-Reviewed Literature Questions — and Why It Matters

Grossman (2022): Neuroanatomical Inaccuracy

The phylogenetic claim — that myelinated ventral vagal fibers are uniquely mammalian — is empirically incorrect. Non-mammalian vertebrates also possess myelinated cardiac vagal neurons. The evolutionary hierarchy proposed by Porges does not accurately reflect comparative neuroscience.

Mobbs & Trimmer (2022): DVC Collapse Mechanism Unproven

The dorsal vagal 'death feint' / shutdown hypothesis as applied to human trauma dissociation lacks direct empirical support in humans. Animal studies used for this claim involve different neural circuits than those operative in human freeze responses.

Beauchaine & Thayer (2015): HRV Overstated

Heart rate variability (HRV) is presented in PVT as the primary measure of vagal tone and emotional regulation. The empirical relationship is more complex — HRV is not specific to the ventral vagal circuit, and its associations with psychiatric outcomes involve multiple systems.

Unfalsifiability Concerns

Critics (Grossman; Dana & others) note that PVT can explain almost any behavioral outcome post-hoc, making it difficult to falsify. A theory that can explain everything explains nothing. Clinicians should hold PVT as a useful metaphor, not established neurophysiology.

Assessment & Diagnosis

Mapping the Full Complexity of Developmental Trauma

7-DOMAIN MODEL

The 7 Domains of Developmental Trauma

Cook et al. 2005 — Beyond PTSD Symptom Checklists

01

Attachment

Boundary problems, trust impairment, social difficulties, re-enactment of relational trauma

02

Biology

Sensory processing, somatic complaints, somatization, altered pain thresholds, sleep dysregulation

03

Affect Regulation

Limited emotional language, dysregulated arousal, difficulty identifying feelings, impulsive emotion expression

04

Dissociation

Memory gaps, depersonalization, de trance-like states

05

Behavioural Control

Impulsivity, aggression, self-harm, risk-taking, difficulties with rules and authority

06

Cognition

Attention, learning, language processing, executive function impairment; school as a triggering environment

07

Self-Concept

Shame, guilt, damaged sense of self, poor body image, low self-efficacy, chronic hopelessness

ASSESSMENT TOOLS

Assessment Instruments

Multi-Method, Multi-Informant Protocol for Developmental Trauma

TSCYC	**Trauma Symptom Checklist for Young Children** Ages 3–12 • Parent-report	Anxiety, Depression, Anger, PTSD, Dissociation, Sexual Concerns	**Gold standard for 3–12 yr**
TSCC	**Trauma Symptom Checklist for Children** Ages 8–16 • Self-report	Anxiety, Depression, Anger, PTSD, Dissociation, Sexual Concerns	**Self-report 8–16 yr**
CDC	**Child Dissociative Checklist** Ages 5–12 • Parent-report	Dissociative behaviors, amnesia, identity alteration	**Dissociation screen**
BRIEF-P/2	**Behavior Rating Inventory of Executive Function** Ages 2–18 • Parent & Teacher	Inhibit, Shift, Emotional Control, Working Memory, Plan/Organize	**EF in real-world context**
DCCS	**Dimensional Change Card Sort** Ages 3–7 • Performance	Cognitive flexibility, rule-switching	**Preschool flexibility screen**

Also consider: AAI / Adult Attachment Interview (parents); CAI (Child Attachment Interview); Trauma History Screen; functional observation; school report; multi-informant clinical interview.

DIFFERENTIAL DIAGNOSIS

The Diagnostic Landscape

PTSD, C-PTSD, RAD, DSED, ADHD, DTD — Distinguishing Features

PTSD (DSM-5)	Trauma exposure + intrusion + avoidance + arousal + negative cognition	*Single/limited incidents; core self intact; PTSD symptoms primary*
Complex PTSD (ICD-11)	PTSD criteria + affect dysregulation + negative self-concept + relational disturbance	*Chronic interpersonal trauma; often childhood onset; self/relational disruption prominent*
RAD (Reactive Attachment)	Inhibited social engagement; emotional withdrawal from caregivers	*Requires grossly pathological care; inhibited type; minimal emotional responsiveness*
DSED (Disinhibited Social Engagement)	Disinhibited, culturally inappropriate approach to unfamiliar adults	*Distinguishable from RAD; can co-occur with secure attachment; requires intervention*
ADHD	Inattention, hyperactivity, impulsivity; multiple settings	*Can be trauma-mimicry or comorbid; BRIEF-2 and trauma history essential for differential*

FORMULATION

Trauma-Informed Formulation Framework

Moving Beyond Diagnosis to Understanding

1. Trauma History

- Types, timing, duration, perpetrator relationship
- Disclosure history and responses
- Prior treatment

2. Attachment Profile

- Primary caregiver patterns
- Current relational functioning
- Reflective functioning capacity

3. Neurobiological Impact

- Arousal dysregulation baseline
- Dissociative features
- Somatic presentation

4. Developmental Impact

- 7-domain assessment (Cook)
- Cognitive/EF profile
- Academic functioning

5. Resilience Factors

- Secure relationships available
- Community and cultural supports
- Child strengths and interests

6. Risk & Safety

- Current safety status
- Ongoing abuse / adversity
- Disclosure risk and protection

Treatment & Integration

Evidence-Based Approaches, Cultural Lens & Case Application

"Recovery is not about 'getting rid' of problems. It is about seeing people beyond their problems – their abilities, possibilities, interests and dreams – and recovering the social roles and relationships that give life value and meaning"

- Slade, 2010

The Therapeutic factors

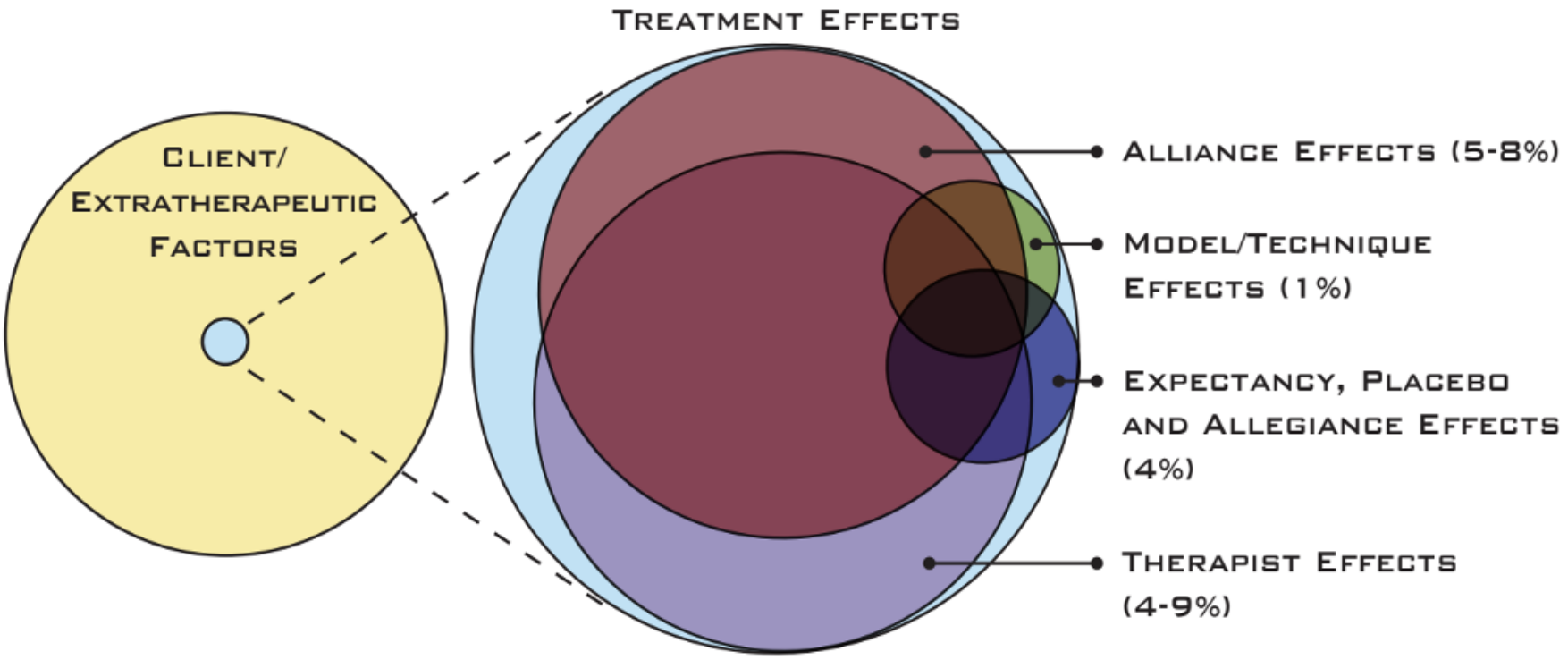


Figure 1

PTSD Recovery

- Majority of people with PTSD have symptoms even after undergoing “gold standard” of treatment
- Symptoms tend to worsen after major life stressors, worsening symptoms lead to more stressors, and it often takes months or even years to return to baseline functioning after a symptom flare up
- Stress reactivity, stress generation, ans stress persistence may reflect individual mechanisms that account for chronic PTSD symptoms

Ringwald, W. R., Feltman, S., Cloutson, S. A., Mann, F., Ruggero, C., Bromet, E., ... & Kotov, R. (2025). Stress dynamics that maintain posttraumatic stress disorder across 20 years. *Psychological medicine*, *55*, e151.

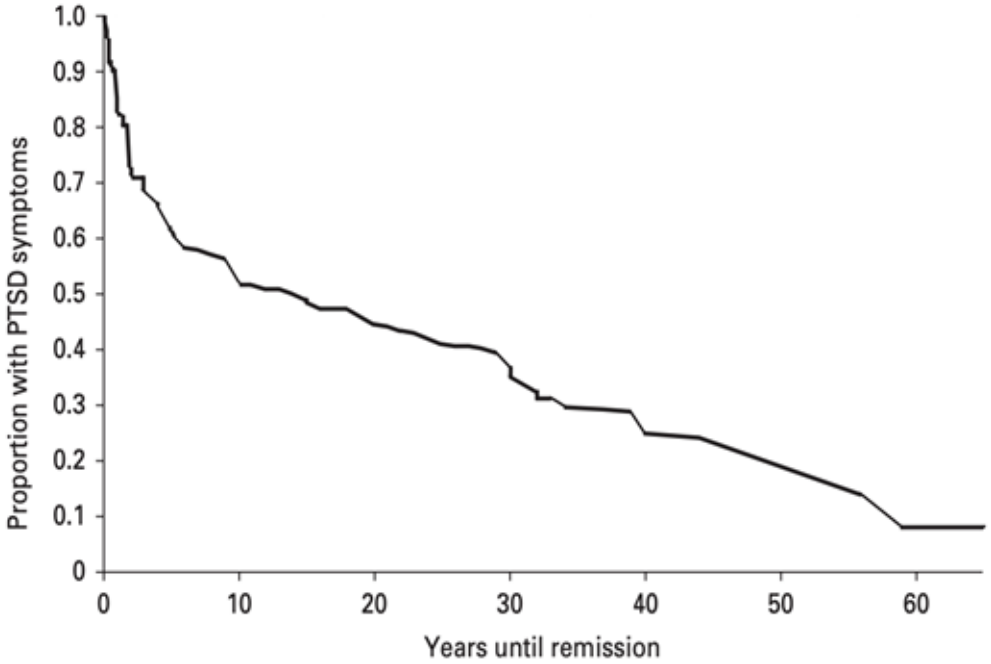


Fig. 1. Survival curve indicating years after onset until remission from post-traumatic stress disorder (PTSD) in the population.

Chapman, C., Mills, K., Slade, T., McFarlane, A. C., Bryant, R. A., Creamer, M., ... & Teesson, M. (2012). Remission from post-traumatic stress disorder in the general population. *Psychological medicine*, *42*(8), 1695-1703.

Treatment in the First Five Years

The Most Impactful Clinical Window

Primary Modality: The Caregiving Relationship

At ages 0–5, individual child therapy is insufficient. The caregiver IS the treatment environment. All effective 0–5 interventions work through the dyad. CPP, Theraplay, PCIT, and Watch-Wait-Wonder all involve the caregiver as co-therapist.

Neuroplasticity Window

The brain is at peak malleability 0–5. Hippocampal, amygdala, and PFC development are active. Intervention in this window produces larger, more durable gains than at any later age. This is the strongest evidence base for early investment.

Co-Regulation Before Self-Regulation

Infants and toddlers cannot regulate without a regulated caregiver. Every successful self-regulation is built on thousands of co-regulation experiences. The first treatment goal is always caregiver regulation, then dyadic co-regulation.

Play as Primary Healing Modality

Spontaneous, child-led play within a safe therapeutic relationship is the most powerful healing agent for young children. It provides: narrative processing, somatic discharge, relational repair, and mastery experiences simultaneously.

Phase-Based Treatment of Trauma

Herman (1992) — Safety, Mourning, Reconnection

Phase 1

Weeks to months (longer for developmental trauma)

Safety, Stabilization & Skill-Building

Establish physical and psychological safety. Build the therapeutic alliance. Develop regulatory capacity. Build a repertoireof coping skills. DO NOT begin trauma processing until this phase is solid.

Phase 2

After Phase 1 is consolidated

Trauma Processing & Mourning

Titrated exposure to traumatic material within the therapeutic window. Narrative construction. Integration of fragmented memories. Grief work for lost childhood, lost relationships, lost self. Includes TF-CBT trauma narrative, EMDR processing, CPT.

Phase 3

Ongoing, often throughout treatment

Integration & Reconnection

Consolidate gains. Build future orientation. Strengthen identity narrative. Re-engage with community, school, peers. Grief and meaning-making. Prepare for healthy separation from therapy.

Critical warning: Trauma processing in Phase 2 before Phase 1 is established can be retraumatizing and destabilizing. Safety first is not caution — it is evidence.

Stage (phased)-Based Treatment

- **Debated as to the merit**
  - Phase-based treatment recommended for Complex PTSD by the International Society for Traumatic Stress Studies (ISTSS)

- **Phase 1 - Safety and Stabilization [14]**
  - Not needed for every client (don't encourage avoidance)
  - Focused on creating coping skills
  - Emotional regulation
  - Sobriety
  - Goals
    - Ensure client safety
    - Improve expression of emotion
    - Increase positive beliefs about self
    - Address feelings of guilt shame
    - Improve interpersonal functioning


EMOTIONAL REGULATION
DISTRESS TOLERANCE
DBT
MINDFULNESS
INTERPERSONAL EFFECTIVENESS

TEMPERATURE

Change your body temperature. Splash your face with cold water, hold an ice cube, let car AC blow on your face, take a cold shower

INTENSE EXERCISE

Do intense exercise to match your intense emotion. Sprint to the end of the street, do jumping jacks, push ups, intense dancing

PACED BREATHING

Try Box Breathing: Breathe in for 4 seconds, hold it for 4 seconds, breathe out 4, and hold 4. Start again, and continue until you feel more calm.

PAIRED MUSCLE RELAXATION

Focus on 1 muscle group at a time. Tighten your muscles as much as possible for 5 seconds. Then release & relax. Repeat with other muscle groups.

S.T.O.P SKILL
DISTRESS TOLERANCE

Helps us to react in a less impulsive way when we're upset or in need of support

S STOP! Don't react impulsively!!!

T Take a step back from the situation and breathe!

O Observe your internal bodily sensations, thoughts and feelings. Connect with your 5 senses and the present. What are others saying or doing?

P Proceed mindfully by acting with awareness. Think about your long term goals. Which actions will make the situation better or worse?

@I.A.M.MINDFUL_

Stage (phased)-Based Treatment

- **Phase 2 – Exposure for PTSD/ CPTSD**
  - Focuses on review of trauma
  - Aim is re-experiencing traumatic events in which the client feels safe
  - Evidenced based protocol (APA Guidelines)
    - TF-CBT
    - CPT
    - Prolonged Exposure Therapy

TF-CBT

Trauma-Focused CBT (TF-CBT)

Cohen, Mannarino & Deblinger — The Most Evidenced Trauma Treatment for Children

P — **Psychoeducation**
About trauma and its normal impacts

R — **Relaxation**
Regulation skills before processing

A — **Affective Modulation**
Identify, tolerate, manage emotions

C — **Cognitive Coping**
The triangle: thoughts / feelings / behaviors

T — **Trauma Narrative**
Telling the story, integrating affect and cognition

I — **In-vivo Mastery**
Graduated exposure to avoided reminders

C — **Conjoint Sessions**
Child and caregiver together

E — **Enhancing Safety**
Safety skills, future orientation, healthy relationships

TF-CBT: Evidence Base & Honest Limitations

What the RCTs Tell Us — and What They Don't

Strong Evidence ✓

- 20+ RCTs across multiple countries, trauma types, and cultural contexts
- Robust reductions in PTSD, depression, anxiety, and behavioral problems
- Caregiver component doubles effectiveness — this is a family treatment
- Average treatment length: 12–25 sessions — accessible, time-limited
- Web-based clinician training (tfcbt.org) makes dissemination feasible
- Evidence extends to abuse, IPV, complex trauma, and refugee populations

Honest Limitations ✗

- Most RCTs designed for single-incident or abuse-related trauma — less evidence for severe developmental trauma / C-PTSD
- Dropout rates higher in complex presentations — PRACTICE components may need extension or modification
- Requires a non-offending supportive caregiver — not always available in foster/adoption contexts
- Cultural adaptations needed — original development was primarily in North American/Western contexts
- Trauma narrative component may destabilize highly dissociative children — must be titrated carefully

EMDR

EMDR for Childhood Trauma

Shapiro (1989) — Evidence, Adaptations & Honest Debate

What EMDR Is

Eye Movement Desensitization and Reprocessing. 8-phase protocol. Client holds traumatic memory in mind while therapist delivers bilateral stimulation (eye movements, taps, or tones). Aimed at reprocessing traumatic memories and reducing their emotional charge.

Evidence Base

WHO (2013) and ISTSS guidelines endorse EMDR for adult and child PTSD. Multiple RCTs support effectiveness comparable to TF-CBT. EMDR-IGTP (group protocol) shows promise for trauma in humanitarian settings.

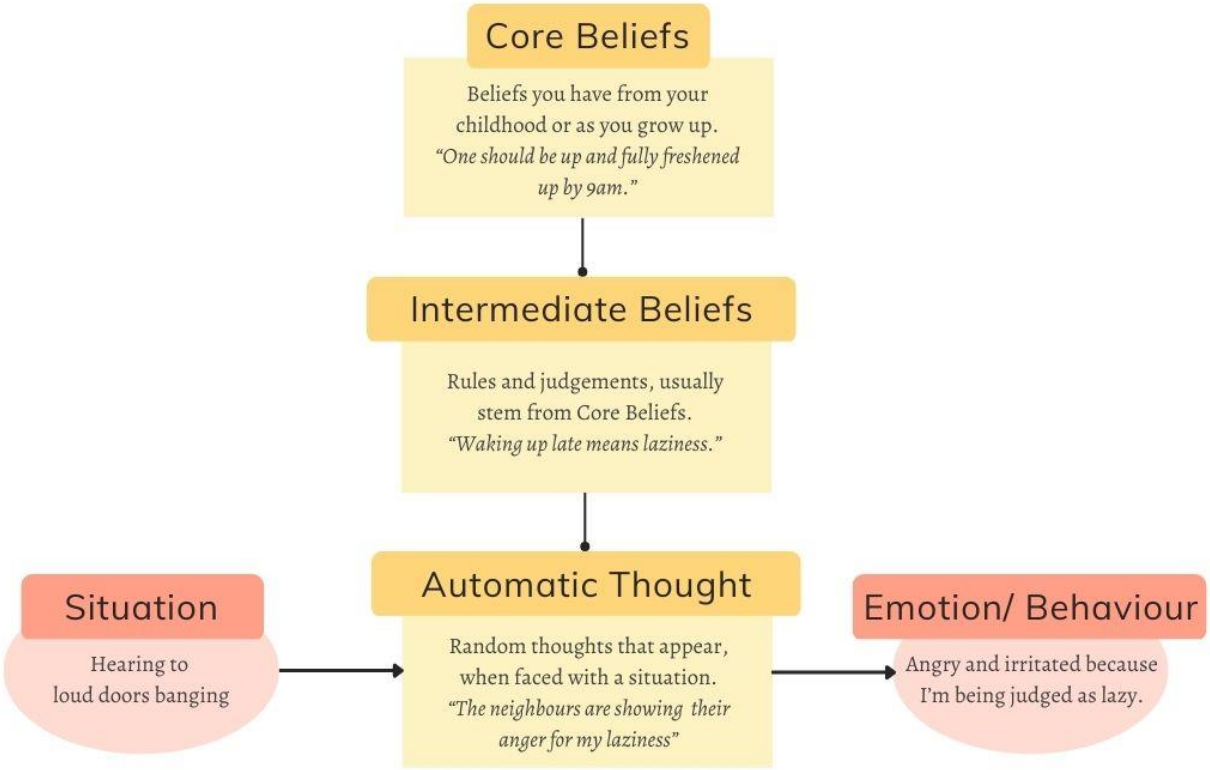
The Mechanism Debate

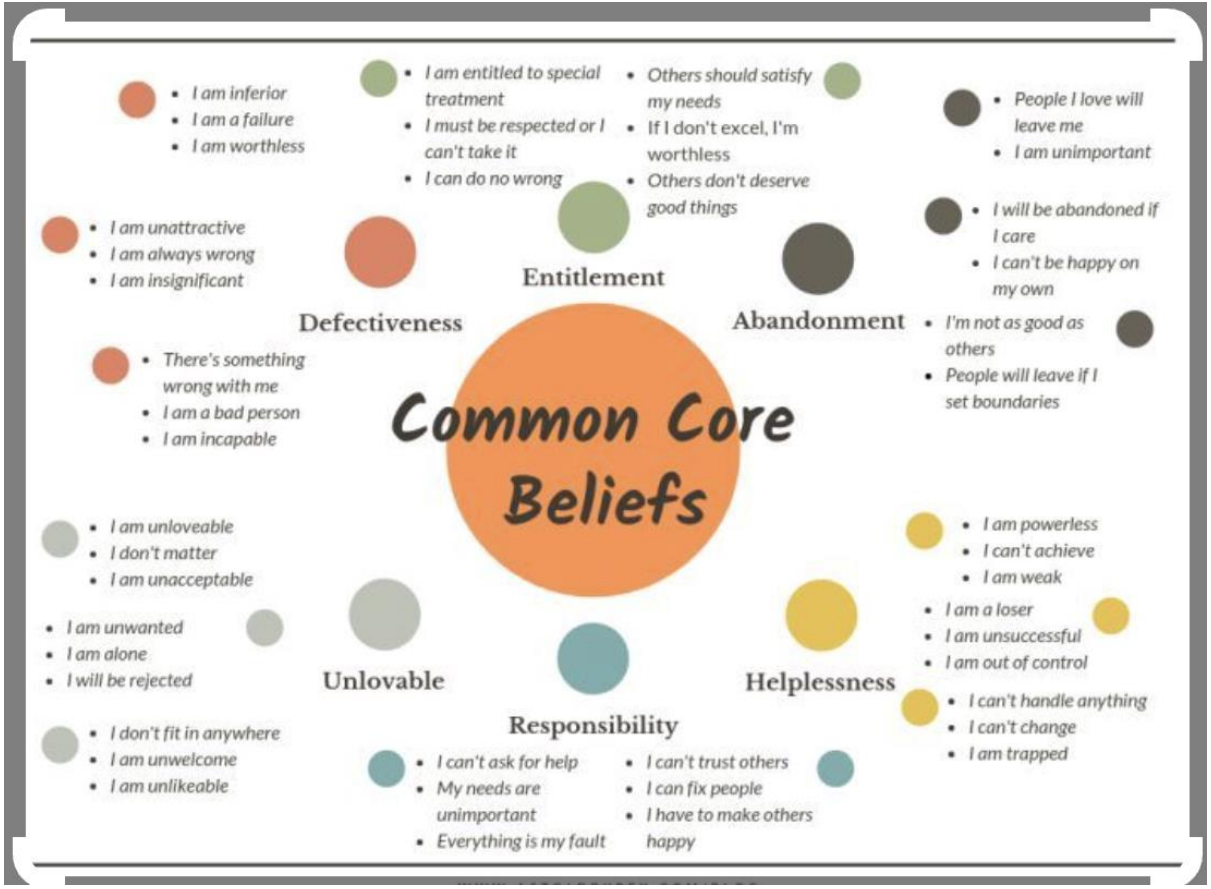
The role of eye movements specifically remains contested. Several meta-analyses show no difference between EMDR with and without bilateral stimulation — suggesting eye movements may be incidental. The effective components may be exposure + cognitive processing.

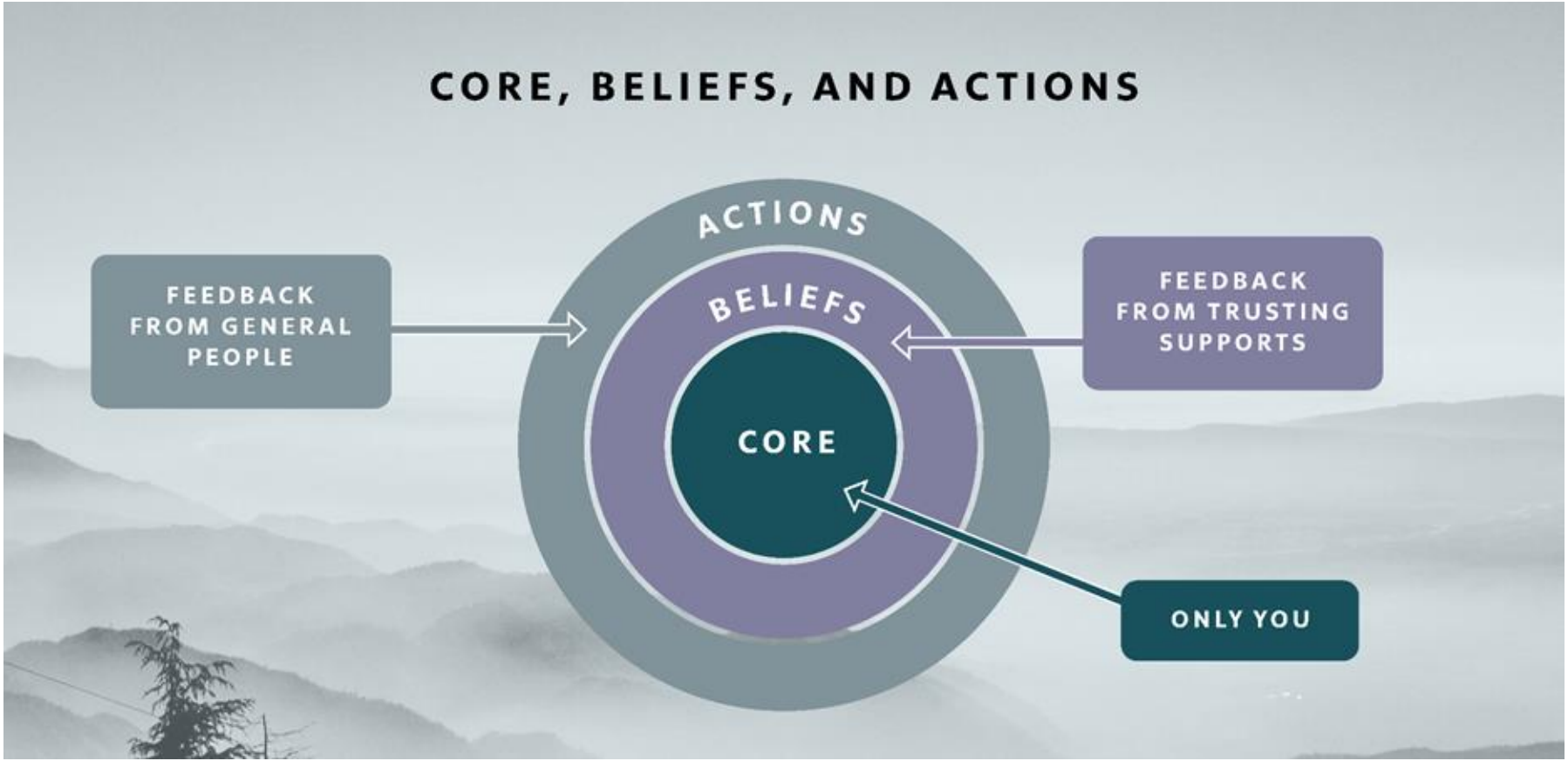
Developmental Adaptations

EMDR-Play therapy integration for young children (ages 3+). Modified installation phases for complex trauma. Stabilization resources must precede targeting in developmental trauma. Caution with severely dissociative presentations.

Clinical position: EMDR is a well-supported, evidence-based treatment for PTSD in children. Mechanism uncertainty does not diminish clinical utility. Ensure Phase 1 stabilization before trauma targeting.


Core Beliefs
Beliefs you have from your childhood or as you grow up.
"One should be up and fully freshened up by 9am."
Intermediate Beliefs
Rules and judgements, usually stem from Core Beliefs.
"Waking up late means laziness."
Automatic Thought
Random thoughts that appear, when faced with a situation.
"The neighbours are showing their anger for my laziness"
Situation
Hearing to loud doors banging
Emotion/ Behaviour
Angry and irritated because I'm being judged as lazy.
schizowarriors.com


Common Core Beliefs
Defectiveness
I am inferior
I am a failure
I am worthless
I am unattractive
I am always wrong
I am insignificant
There's something wrong with me
I am a bad person
I am incapable
Entitlement
I am entitled to special treatment
I must be respected or I can't take it
I can do no wrong
Others should satisfy my needs
If I don't excel, I'm worthless
Others don't deserve good things
Abandonment
People I love will leave me
I am unimportant
I will be abandoned if I care
I can't be happy on my own
I'm not as good as others
People will leave if I set boundaries
Unlovable
I am unloveable
I don't matter
I am unacceptable
I am unwanted
I am alone
I will be rejected
I don't fit in anywhere
I am unwelcome
I am unlikeable
Helplessness
I am powerless
I can't achieve
I am weak
I am a loser
I am unsuccessful
I am out of control
I can't handle anything
I can't change
I am trapped
Responsibility
I can't ask for help
My needs are unimportant
Everything is my fault
I can't trust others
I can fix people
I have to make others happy


CORE, BELIEFS, AND ACTIONS
ACTIONS
BELIEFS
CORE
FEEDBACK FROM GENERAL PEOPLE
FEEDBACK FROM TRUSTING SUPPORTS
ONLY YOU

Stage (phased)-Based Treatment

- **Phase 3 - Transition back to everyday life**
    - Goal is to reinforce the emotional, social, and relationship skills of the client
    - Positive psychology is the science of what is needed for a good life.
    - Assessment (Slade, 2010)
        - 1. Deficiencies and undermining characteristics of the person
        - 2. Strengths and assets of the person
        - 3. Lacks and destructive factors in the environment
        - 4. Resource and opportunities in the environment

ELSEVIER

Journal of Affective Disorders

Volume 251, 15 May 2019, Pages 227-230

Positive mental health as a predictor of recovery from mental illness

Matthew Iasiello [a b], Joseph van Agteren [a c], Corey L.M. Keyes [d], Eimear Muir Cochrane [b]

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https://doi.org/10.1016/j.jad.2019.03.065

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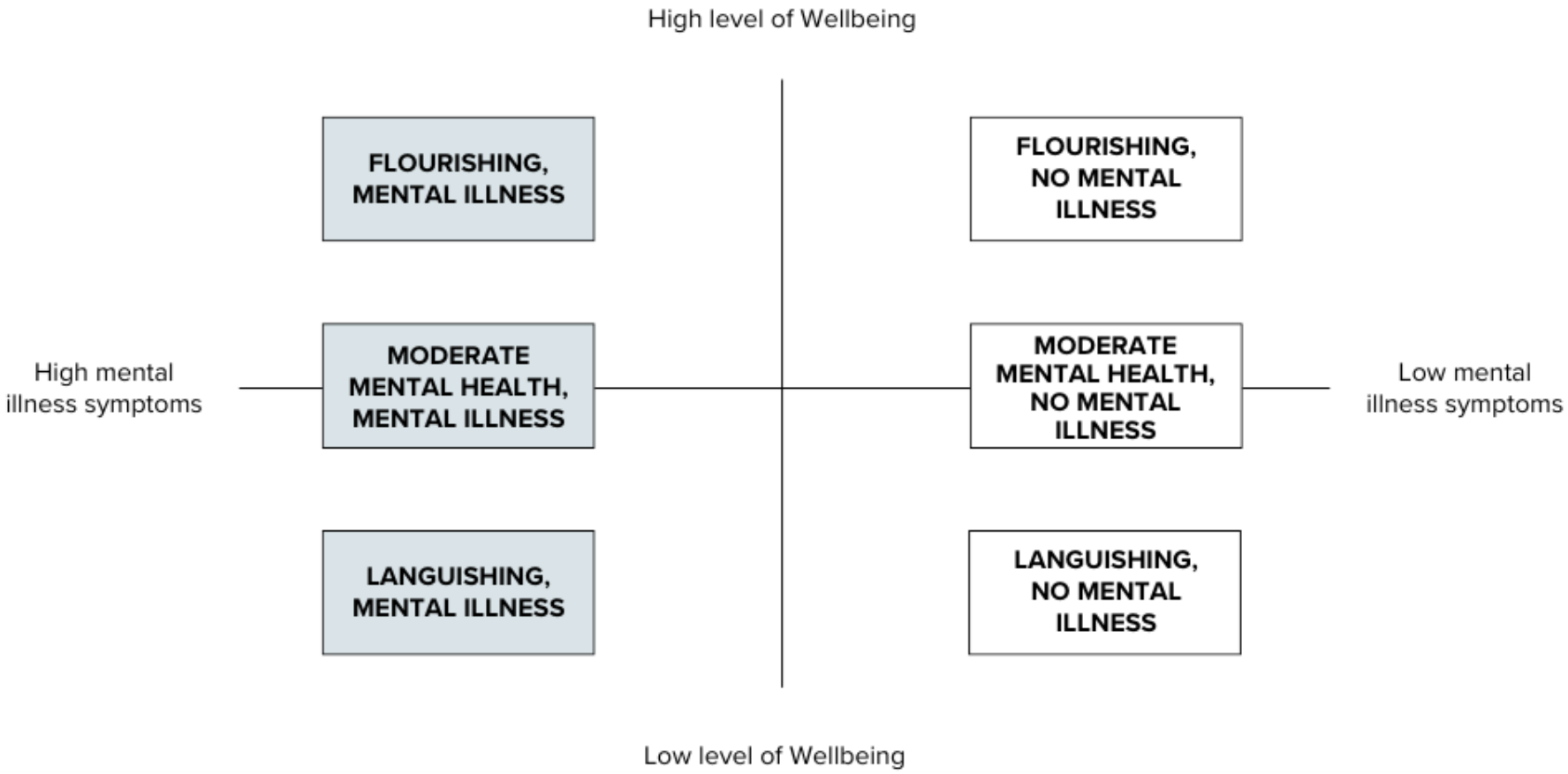
Highlights

- Individuals who gain or maintain high levels of positive mental health are much more likely to recover from an affective disorder than those with low positive mental health.
- Positive mental health and mental illness are separate constructs, and both should be included in the assessment of patients interacting with mental health care systems.
- Improving and maintaining positive mental health may be an important strategic focus for reducing the burden of mental illness.
- Mental health care systems should explore offering of services designed to improve positive mental health in addition to reducing mental distress.


High level of Wellbeing
FLOURISHING, MENTAL ILLNESS
FLOURISHING, NO MENTAL ILLNESS
High mental illness symptoms
MODERATE MENTAL HEALTH, MENTAL ILLNESS
MODERATE MENTAL HEALTH, NO MENTAL ILLNESS
Low mental illness symptoms
LANGUISHING, MENTAL ILLNESS
LANGUISHING, NO MENTAL ILLNESS
Low level of Wellbeing

Posttraumatic Growth

Tedeschi & Calhoun (1996) — When the struggle with trauma becomes a source of transformation

> *"PTG is not the absence of suffering — it is positive psychological change that emerges from the struggle with highly challenging life circumstances. The growth comes through the struggle, not despite it."*
>
> — Tedeschi & Calhoun, 1996; Tedeschi, Park & Calhoun, 1998

Personal Strength

A revised sense of oneself as a survivor — discovering resilience and capability not known before. 'I am stronger than I thought.'

Relating to Others

Deeper, more authentic connections. Greater empathy and compassion. A shift from surface relating to genuine intimacy.

New Possibilities

Opening of new paths — often unexpected. New interests, roles, or directions that would not have been pursued without the trauma.

Appreciation of Life

Renewed appreciation for living — changed priorities, greater gratitude, awareness of what truly matters.

Spiritual / Existential Change

Deepened spiritual life or engagement with questions of meaning — not necessarily religious.

Important nuance: PTG and distress coexist — growth does not mean the trauma stops hurting. It is not a required outcome or a clinical goal to impose. Tedeschi & Calhoun (2004); Zoellner & Maercker (2006)

Mentalization & Reflective Functioning

Fonagy et al. — The 'Mind-Mindedness' of Caregiving

> *"Mentalization is the capacity to perceive and interpret human behavior in terms of intentional mental states — to hold the child's mind in mind. When a parent can do this, the child learns to do it for themselves." — Fonagy et al. (2002)*

Why RF Matters for Attachment

Fonagy: the most powerful predictor of infant secure attachment is the parent's own Reflective Functioning (RF) — ability to think about the child's internal world. High RF breaks the intergenerational cycle even when the parent has their own trauma history.

What Low RF Looks Like

Parent responds to the behaviour, not what's behind it. 'He's just doing it to annoy me.' Cannot imagine the child has feelings different from their own. Misattributes intentionality to child's regulatory failures.

MBT-C and MBT-F

Mentalization-Based Treatment for Children (MBT-C) and Families (MBT-F): directly targets RF through curiosity about mental states, validation of child's subjectivity, and exploring misunderstandings collaboratively. Evidence growing.

Building RF in Caregivers

Practical approaches: wondering aloud about the child's mind, validating the child's perspective before correcting behavior, 'catch them feeling' before 'catch them being good.' These translate RF into daily caregiving moments.

PSYCHOEDUCATION

Psychoeducation for Families & Caregivers

What Every Caregiver Needs to Understand

Trauma Is Not Manipulation

Reframe child's behavior neurobiologically. 'When your child freezes, refuses, or explodes — their alarm brain is activated. They are not choosing this. This is a nervous system response, not a character flaw.'

Your Nervous System Regulates Theirs

Co-regulation is the most powerful tool a caregiver has. Your calm presence, warm voice, and predictable responses literally shift your child's physiology. This is biology, not indulgence.

The Three Rs: Regulate, Relate, Reason

Regulation must precede reasoning. When a child is activated, skip the lecture. First: calm the nervous system (regulate). Then: reconnect relationally (relate). Only then: address the behavior or teach (reason).

Triggers Are Not Misbehavior

Help caregivers identify their child's specific triggers. Sensory triggers, anniversary reactions, transition triggers, and relationship triggers are predictable — and predictable triggers are preventable.

Healing Takes Time

Set realistic expectations. Healing is non-linear. There will be good weeks and regression weeks. Progress is not the absence of symptoms — it is the gradual widening of the Window of Tolerance.

You Are the Intervention

The research is unambiguous: caregiver engagement doubles treatment effectiveness. Their daily responses provide hundreds of co-regulation opportunities that therapy can only simulate. They matter more than the clinician.

TREATMENT OUTCOMES

What Does Healing Look Like?

Realistic Outcomes and How to Measure Them

Expected Improvements

Widened Window of Tolerance; reduced PTSD symptom severity; improved sleep; less reactive aggression; increased capacity for trust and relational risk; better school functioning; reduced shame.

Non-Linear Trajectory

Progress is never a straight line. Regression during transitions, anniversaries, developmental leaps, and life stressors is normal. Regression is not failure — it is information about what still needs support.

What We Measure

TSCC/TSCYC repeat at 6-month intervals. BRIEF-2 parent/teacher. Observed quality of attachment behaviors. School functioning data. Caregiver report of daily regulatory capacity. ProQOL for clinician.

Relationship Quality as Outcome

For children with early relational trauma, the quality of the therapeutic relationship IS the primary outcome measure. Can this child trust, repair ruptures, and return to connection? That is healing.

Honest limits: For the most severe early developmental trauma, treatment does not produce full 'recovery' — it produces a life more fully lived within the reality of the trauma. The goal is integration, not erasure. Adequate neurobiological healing is possible when treatment is early, intensive, relational, and sustained.

Epigenetic Resilience: Turning the Tide

The Biology of Healing Can Be Inherited Too

"The same epigenetic plasticity that makes children vulnerable to adverse environments is also the mechanism of their recovery. The molecular signature of adversity can be written — and it can also be revised." — Weaver et al. (2004); Meaney (2010)

Caregiving Reverses Methylation

Weaver et al. (2004): nurturing maternal care in rats reverses adverse methylation patterns established by early stress — and these reversals are transmissible. Good caregiving has molecular consequences.

Neuroplasticity Window

The same neural plasticity that makes early trauma so damaging makes early intervention so powerful. Environments rich in co-regulation, safety, and responsiveness can literally rebuild the neurobiological architecture of regulation.

Breaking the Cycle

When we help a parent resolve their own attachment trauma — through CPP, MBT-F, or therapy — we do not just help that parent. We alter the epigenetic trajectory of their child. The intervention's impact extends to the next generation.

Message for Families

'The trauma your child has experienced is real and it has biological consequences — but those consequences are not permanent. With consistent safety, responsive care, and support, children's brains can heal. You have the power to be part of that.'

KEY MESSAGES

Key Take-Home Messages

What to Carry Into Your Practice from Today

01

Attachment is the infrastructure of development

Everything — cognition, emotion, relationships, identity — is built on the foundation of early attachment. Early is not everything, but it matters most.

02

Developmental trauma is not DSM-PTSD

It requires its own conceptual framework: complex, relational, multi-domain, phase-based treatment. Do not apply a single-incident model to a chronic relational injury.

03

Regulate first. Always.

The PFC cannot process what the amygdala is screaming. Regulation is the prerequisite to every other therapeutic intervention. Safety before processing.

04

The therapeutic relationship IS the treatment

For children with early relational trauma, the corrective relational experience of therapy is not the vehicle for healing — it is the healing.

05

Hold PVT as a useful metaphor, not settled science

Use its clinical wisdom. Acknowledge its contested neuroanatomy. Maintain scientific humility in how you communicate it.

06

Healing is possible. The biology says so.

Epigenetic reversibility, neuroplasticity, and the power of consistent safe caregiving mean we have genuine reasons for evidence-based hope.

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