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When a child's development is adversely impacted by past or current victimization such as abuse, neglect, trafficking, hate crimes, war, genocide, or family, community, or peer violence, the child's body and brain experiences the world as dangerous and relationships as insecure and untrustworthy, and adapts by prioritizing **survival** instead of openness to **learning** (Ford, 2020).

Developmentally traumatized children's automatic shift into **survival mode** fundamentally changes how they **self-regulate** in every aspect of their functioning, including their *bodies, emotions, attention* and *thinking*, and *behavior*, and as a result, how they engage in *relationships* and ultimately how they develop a sense of *self/identity* (D'Andrea et al., 2012). Instead of self-regulating adaptively, this shift into survival mode causes the child to become **dysregulated** in each of those key areas of physical, psychological, and relational functioning (Ford, 2023).

There are fifteen **features or symptoms** of biopsychosocial dysregulation that clinicians and researchers have identified as the fundamental **targets** for assessment and therapeutic treatment with developmentally traumatized children (Ford et al., 2013 2018, 2022; Ford, 2023).

Emotion and/or Somatic Dysregulation

1. B1: Emotion dysregulation: extreme distress or difficulty in modulating distress
2. B2: Somatic dysregulation: incapacitating physical problems not medically explained
3. B3: Impaired access to emotions or body awareness/functioning
4. B4: Impaired ability to recognize/express emotions or somatic feelings/states

Attentional/cognitive and/or Behavioral Dysregulation

5. C1: Hyper/Hypo-Vigilance: Attention bias toward or away from threat
6. C 2: Impaired self-protection (risk-taking, recklessness, or intentional provocation)
7. C 3: Maladaptive self-soothing
8. C4: Non-suicidal self-injury
9. C5: Impaired ability to initiate or sustain goal-directed behavior

Relational- or Self/Identity-Dysregulation

10. D1: Self-loathing (self viewed as irreparably damaged and defective)
11. D 2: Attachment insecurity and disorganization
12. D 3: Betrayal-based relational schemas (betrayal, coercion, exploitation, rejection)
13. D4: Reactive verbal or physical aggression
14. D5: Impaired psychological boundaries (enmeshment or craving for reassurance)
15. D6: Insufficient or excessive interpersonal empathy

Ford, J. D., Spinazzola, J., van der Kolk, B., & Chan, G. (2022). Toward an Empirically-Based Developmental Trauma Disorder (DTD) Diagnosis and Semi-Structured Interview for Children: The DTD Field Trial Replication. *Acta Psychiatrica Scandinavica, 145*(6), 628-639. https://doi.org/10.1111/acps.13424

Ford, J. D. (2023). Why We Need a Developmentally Appropriate Trauma Diagnosis for Children: a 10-Year Update on Developmental Trauma Disorder. *Journal of Child & Adolescent Trauma, 16*(2), 403-418. https://doi.org/10.1007/s40653-021-00415-4

Knefel, M., Karatzias, T., Spinazzola, J., Shevlin, M., & Ford, J. D. (2023). The relationship of posttraumatic stress disorder and developmental trauma disorder with childhood psychopathology: A network analysis. *Journal of Anxiety Disorders, 99*, 102766. https://doi.org/10.1016/j.janxdis.2023.102766

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Developmental Trauma Disorder Screening and Assessment Instruments

New: **Developmental Trauma Disorder *Youth Self-Report (DTD-SR)* and *Parent-Report (DTD-PR)* Questionnaires**

The **Stress Coping Strategies Questionnaire (SCopeS)** enables youths and parents/caregivers to describe the youth's DTD symptoms without an extensive interview. Separate versions (with questions that are worded appropriately for the youth (DTD-SR) and the parent/caregiver (DTD-PR) provide an independent perspective from the youth and from their parent(s)/caregiver(s).

The SCopeS is designed as an initial screening tool and **not** a clinical diagnostic instrument.

In order to reduce the understandable reluctance to disclosing sensitive personal problems that might be perceived as stigmatizing or pathologizing, the questionnaires are entitled, and the instructions and questions do not use psychiatric terminology or refer to trauma. Instead non-technical and non-pejorative terms are used to refer to how the youth copes with stress.
Each item is rated for its *frequency* in the *past week,* ranging from "Never" (scored as 0), to "1 Day" (scored as 1), to "2-3 Days" (scored as 2) to "Most Days" (scored as 3).

Item #26 provides information about whether the symptoms occurred during the *past month,* as a basis for comparison to the symptoms of PTSD (which often are assessed for the past month because they must occur during the past month in order for a PTSD diagnosis to be applicable)

Finally, item #27 identifies functional domains that may be impaired by the symptoms, including peers, school, and family.

The questionnaires have 25 questions that correspond to the 15 DTD symptoms, because 10 of the DTD symptoms involve two possible manifestations. If a total symptom score is calculated, only the score for the option that is rated as occurring most frequently should be counted. The total possible symptom score therefore is 15 x 3 = 45.

Numerical scores also may be calculated for each of the three DTD symptom domains. The domain in which each question belongs is shown in the column on the far right of each item.

Affective/Somatic Dysregulation (symptoms B1-B4) Total = 0-12
Attentional/Behavioral Dysregulation (symptoms C1-C5) Total = 0-15
Relational/Self Dysregulation (D1-D6) Total = 0-18

However, in addition to numerical scoring, for clinical purposes it is important to consider **both** potential manifestations of each DTD symptom, not just the one that occurs most frequently.

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Stress Coping Strategies Questionnaire (SCopeS)

Your Name: _____ **(circle) Male / Female** **Age:** _____ **Today's Date:** _____

INSTRUCTIONS

These questions ask about how you cope with stress. Please think about how you have been thinking, feeling, or acting in the **past week** when answering the questions. Circle or check your answer to say how often you use each coping strategy.

	0 None	1 1 Day	2 2-3 Days	3 Most Days	
1. If you felt scared, mad, sad, or frustrated, how often did these feelings get so big that you blew up or just totally shut down.	☐	☑	☑☑	☑☑☑	B1a
2. When you felt upset how often were you unable to calm yourself down or unable to get over feeling totally shut down emotionally?	☐	☑	☑☑	☑☑☑	B1b
3. How often did you feel that you couldn't stand to have anyone or anything touch you, or that everything had to be totally quiet?	☐	☑	☑☑	☑☑☑	B2a
4. How often did you feel that your body was really messed up or hurt all the time or just wouldn't work right?	☐	☑	☑☑	☑☑☑	B2b
5. How often did you feel like nothing mattered, like you didn't have any feelings at all except just being bored with everything?	☐	☑	☑☑	☑☑☑	B3a
					B3b
6. How often did you have no feeling at all in parts of your body, like feeling numb if it's really cold, *even though it wasn't really cold*?	☐	☑	☑☑	☑☑☑	
7. How often were you feeling really strong emotions, like crying or shouting, but you didn't know how to say what you were feeling?	☐	☑	☑☑	☑☑☑	B4
8. How often did you have feelings in your body that you couldn't understand or that you felt too confused to be able to describe?	☐	☑	☑☑	☑☑☑	B4b
9. In the past week, how often did you feel like all you could think about was really bad things that you were worried will happen?	☐	☑	☑☑	☑☑☑	C1a
10. How often did you try really hard not to think or talk about really bad things that you were worried will happen?	☐	☑	☑☑	☑☑☑	C1b
11. How often did you do dangerous things like get into a bad fight or drive too fast or jump from high places or go places where people get attacked?	☐	☑	☑☑	☑☑☑	C2a
12. How often did you go looking for trouble, like starting fights on purpose, or confronting people like a parent, police, teacher, coach, or gang leader?	☐	☑	☑☑	☑☑☑	C2b
13. If you felt upset or bored, how often did you things to try to feel better that got you laughed at or into trouble, or that were bad for your health?	☐	☑	☑☑	☑☑☑	C3

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	None	1 Day	2-3 Days	Most Days	
14. How often did you hurt your body on purpose because you felt bad or because it helped you vent or feel better for a while?	☐	☑	☑	☑	C4
15. How often was it hard for you to get started on activities or finish the unless someone else reminded you or made you do it or did it for you?	☐	☑	☑	☑	C5
16. How often did you feel like you were dirty, disgusting, horribly ugly, all messed up, or like no one could ever like you?	☐	☑	☑	☑	D1
17. How often did you try to take care of people who should be taking care of you, or try really hard to help them feel better or not make them unhappy?	☐	☑	☑	☑	D2a
18. How often did you feel really upset or angry with someone taking care of you because they went away or left you alone, even if they did come back?	☐	☑	☑	☑	D2b
19. How often did you feel you couldn't trust close friends or family, or people you used to look up to (like a teacher, coach, priest, or rabbi)?	☐	☑	☑	☑	D3a
20. In the past week, how often did you feel like people are always pushing you around or taking advantage of you?	☐	☑	☑	☑	D3b
21. How often did you attack someone because they were being unfair or disrespectful or mean or trying to hurt you or someone else?	☐	☑	☑	☑	D4
22. How often did you try to get people you know or strangers to show you they care about you, like by making them hug you or going off with them, even though you know not to do that with strangers?	☐	☑	☑	☑	D5a
23. How often did you feel like you couldn't calm down or feel better when you were upset unless someone paid a lot of attention to you or told you everything would be okay?	☐	☑	☑	☑	D5b
24. How often did you feel angry or disgusted with people who say they need help or are hurt because they seem stupid or like whiny babies?	☐	☑	☑	☑	D6a
25. How often did you feel so sad or upset or guilty that you couldn't cope, because someone you know felt upset or hurt or needed help?	☐	☑	☑	☑	D6b

26. Have you had these problems some of the time for **at least the past month**? **NO** **YES** E

27. When you have these reactions or feelings, does this make it harder for you to… (*Circle all that are true for you*)

a.	make or keep friends?	**NO** **YES**	F1
b.	get along with other kids your age?	**NO** **YES**	F2
c.	do schoolwork?	**NO** **YES**	F3
d.	get along with your teachers?	**NO** **YES**	F4
e.	get along with people you live with?	**NO** **YES**	F5
f.	get your chores or other work done?	**NO** **YES**	

THANK YOU, YOU ARE FINISHED

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Stress Coping Strategies Questionnaire (SCopeS)

Your Child's Name: _____ **(circle) Male / Female** **Age:** _____ **Today's Date:** _____

INSTRUCTIONS

Please circle the answer that best describes how often in the **past week** your child has felt or acted in the following ways.

	0 None	1 1 Day	2 2-3 Days	3 Most Days	
1. If your child felt scared, mad, sad, or frustrated, how often did these feelings get so extreme that s/he blew up or just totally shut down?					B1a
2. When your child felt upset how often was s/he unable to calm down or get over feeling totally shut down emotionally?					B1b
3. How often did your child act like s/he couldn't stand to be touched or like s/he couldn't stand any noise—even soft touch or sounds?					B2a
4. How often did your child act like s/he felt her/his body was really messed up, or hurt all the time, or just wouldn't work right?					B2b
5. How often did your child act like s/he didn't have any feelings or care about anything, or like s/he was bored with everything?					B3a
6. How often did your child act like s/he couldn't feel anything in her/his body, or like parts of her/his body were completely numb?					B3b
7. How often did your child seem to have strong emotions but s/he couldn't understand or express in words how s/he was feeling?					B4
8. How often did your child seem to have body feelings s/he could not understand or felt too confused to be able to describe?					B4b
9. How often did your child act like all s/he couldn't stop thinking or worrying about really bad things that s/he was afraid will happen?					C1a
10. How often did your child seem to try avoid talking or thinking about really bad things that s/he was afraid will happen?					C1b
11. How often did your child do dangerous things like get into a bad fight or drive too fast or jump from high places or go where people get attacked?					C2a
12. How often did your child seem to be looking for trouble, like starting fights or confronting parents, police, teachers, coaches, or gang leaders?					C2b
13. If your child felt upset or bored, how often did s/he do things to try to self-soothe (feel better) that were immature or socially inappropriate?					C3
14. How often did your child hurt her/his body on purpose when s/he felt upset (like cutting, burning, punching walls or head-banging)?					C4

CONTINUE ON NEXT PAGE

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	None	1 Day	2-3 Days	Most Days	
15. How often was it hard for your child to get started on or finish activities without a lot of reminders or help, or someone else doing it for her/him?	☐	☑	☑	☑	C5
16. How often did your child seem to feel that s/he was horribly ugly, disgusting, worthless, or completely rejected and uncared-for?	☐	☑	☑	☑	D1
17. How often did your child try to take care of people who should be taking care of her/him, or to comfort and not upset them if they were unhappy?	☐	☑	☑	☑	D2a
18. How often did your child seem unable to emotionally tolerate being left alone or separated from someone they counted on to take care of them?	☐	☑	☑	☑	D2b
19. How often did your child seem unable to trust close friends or family, or people s/he used to look up to (like a teacher, coach, priest, or rabbi)?	☐	☑	☑	☑	D3a
20. How often did your child seem to feel like people were treating her/him unfairly, pushing her/him around, or taking advantage of her/him?	☐	☑	☑	☑	D3b
21. How often did your child attack someone because s/he thought they were disrespectful or trying to hurt her/him or someone else?	☐	☑	☑	☑	D4
22. How often did your child try to get inappropriately physically close to strangers or go off with them without telling a parent/caregiver?	☐	☑	☑	☑	D5a
23. How often did your child seem unable to calm down or feel better when upset unless given a lot of attention or reassurance?	☐	☑	☑	☑	D5b
24. How often did your child seem emotionally cold and uncaring, or angry and disgusted, when someone else was upset or needed help?	☐	☑	☑	☑	D6a
25. How often did your child get so upset when someone else was hurt or upset—or s/he was afraid they would be--that s/he couldn't cope?	☐	☑	☑	☑	D6b

26. Has your child had these problems at least some of the time for at least the past month?	**NO**	**YES**	E

27. When your child acts or feels in these ways, does this interfere with her/his ability to … (*Circle all that are true*)

a. make or keep friends?	**NO**	**YES**	F1
b. get along with other kids her/his age?	**NO**	**YES**	F2
c. do schoolwork?	**NO**	**YES**	F3
d. get along with teachers?	**NO**	**YES**	F4
e. get along with people in your home?	**NO**	**YES**	F5
f. get her/his chores or other work done?	**NO**	**YES**	

THANK YOU, YOU ARE FINISHED

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Developmental Trauma Disorder Semi-structured Interview (DTD-SI)

The 15-item ***DTD Semi-structured Interview (DTD-SI)*** is a semi-structured clinical interview with detailed questions and follow-up probes assessing symptoms of Developmental Trauma Disorder. The DTD-SI is designed to be administered following a trauma history interview such as the Traumatic Events Screening Inventory (TESI-PRR or TESI -CRF) (https://www.nctsn.org/measures/traumatic-events-screening-inventory) or the Traumatic Antecedents Questionnnaire (https://www.complextrauma.org/resources/diagnostic-tools/).

The DTD-SI has three sections, corresponding to the three domains of DTD:

- Criterion B in the DTD-SI includes four items that assess the emotional or somatic features of dysregulation (inability to recover from extreme states), dissociation (absence of awareness of affect/bodily feelings), and numbing (alexithymia or inability to describe bodily states).
- DTD-SI Criterion C includes five items, representing symptoms of attentional or behavioral dysregulation: attention bias toward or away from threat; risky behavior; self-harm; self-soothing; difficulty initiating or sustaining goal-directed behavior).
- DTD-SI Criterion D includes six items, representing symptoms of self- and relational-dysregulation: self-loathing, attachment insecurity and disorganization, expectancy of betrayal and abandonment, reactive aggression, impaired self-other boundaries, diminished or excessive empathy).

Obtaining the DTD-SI

The DTD-SI may be obtained for clinical or research purposes at no cost by requesting at: https://www.complextrauma.org/resources/diagnostic-tools/

Administering the Developmental Trauma Disorder Semi-structured Interview (DTD-SI)

(1) Before the interview, ask parent(s) (or in the case of an older adolescent or young adult child, ask the youth) about their impressions on how their child/the youth will experience and react to the interview. From this conversation, interviewers may learn that the child/youth need breaks, can't sit still for long, etc. During the conversation, ask what kind of activities during the interview help the child/youth to be as relaxed as possible; e.g., for younger children, stuffed animals, coloring books, rubiks cube, a ball to squeeze, something to doodle with, juice or water and a healthy snack; for adolescents, periodic breaks to check their cellphone or to listen to their music.

Develop a collaborative plan for (a) IF, (b) and for how long, the child/youth should be included in the interview, and whether to interview the child (especially teens) alone. The DTD-SI may be conducted with the parent(s) and child **separately or together**.

- If the parent(s) and child are interviewed together, rapport with each participant is important to maintain throughout the interview (e.g., by consistently checking with the other person(s) to get their input when one person initially answers a question). It also is important to accept differing answers by the participants in a nonjudgmental manner (e.g., "So you see/remember this somewhat differently, I'll be sure to remember both/all of your answers because each of you has a valuable contribution to make to helping me understand how things are going").

- If the parent(s) and children are interviewed separately, their responses should be recorded independently. If a single final rating is necessary for interview items, this should reflect the most clinically significant information (e.g., if a child denies a symptom but a parent describes it as present and causing impairment, a single cumulative rating for that item should be based on the parent's response; this would be equally the case if the responses were reversed and it was the child who described the symptom as present and causing impairment).

(2) Begin the interview with a 10-20 minute open-ended discussion of the child and parent's current family, living arrangements, activities, achievements, strengths, and resources) followed by an open-ended discussion of the child's and family's primary difficulties, concerns, and problems with health, behavior, emotions, and relationships.

(3) During the interview, if a child/youth (or parent) seems angry, squeamish, anxious, dysregulated, withdrawn, distractible, tangential initially or as the interview proceeds:

- Acknowledge the participant's discomfort/reluctance nonjudgmentally without directly pointing to any individual participant (e.g., "This kind of talk can be stressful, so let's do everything we can to make it okay for all of you") and ask each participant individually what would be most helpful for them.
- Give a withdrawn/uncommunicative participant explicit permission to not have to answer questions unless s/he would like to do so. If this occurs in an interview with one participant solo, accept non-answers nonjudgmentally as a "pass." If this occurs with multiple participants, focus the discussion on participants who are willing to actively participate and check-in frequently with the withdrawn or reluctant participant so that it is clear s/he is not being ignored but also not pressured or forced in any way to join the discussion unless s/he wishes to.
- Always offer a non-communicative child the option of talking privately with you unless their parent has already indicated this is not acceptable; if a parent objects to having their child interviewed separately, help the child take a break (with adult supervision for younger children) and privately hear out the parent about their reservations. Accept the parent's decision ultimately, but offer to take precautions to forestall reactions by the child that concern the parent (e.g., "I will make sure that if your son begins to show any of those signs of upset we will take a break until he seems relaxed and says he's ready to resume the questions—or I will offer to stop entirely and we will stop if he continues to seem on the verge of distress or says he doesn't want to answer any more questions").
- If it appears that the child/youth wants to be in the interview, with or without the parent, be prepared to shift to helping the child/youth comfortably/securely pause the interview and take a break. Be especially alert to escalating child/ youth distress/dysregulation when doing a trauma history and DTD symptoms, and be prepared to calmly help the child leave the interview with the message that s/he has done a great job and deserves a break—or to end the questions because it's okay to stop after s/he has done such a good job. The child's mental, emotional, and behavioral state should be the guide to the interviewer, and moving preventively rapidly (i.e., taking the child out of the interview) is better than trying to keep the child in the interview for as long as possible.

(4) if the child/youth is too young (i.e., 10 years old or younger) or too reactive/ disorganized or withdrawn/disengaged to be interviewed alone, do a conjoint interview

- (a) focus mostly on the parent, with regular "checking" with the child to invite (but not require) her/his views/input briefly, and then resume primarily as a dialogue with the parent;
- (b) help the child comfortably leave and take breaks or do other tasks (with an interviewer monitoring/helping) at the first signs of restlessness or distress.

Identifying Clinical Significant (Threshold) and Severe Symptoms with the DTD-SI

When a symptom is judged by the interviewer to be present, in order to determine if the symptom is clinically significant (i.e., "threshold"), the interviewer should use closed- and open-ended probes to determine if there is impairment in that self-regulatory competence compared to what is developmentally expectable for a child/youth at that age).Sample probes are provided in the shaded area on the right side of the interview guide.

For each symptom, consider three factors in determining whether a symptom is clinically significant (threshold):

1. Have observable behaviors consistent with the symptom actually occurred?
2. Are the behaviors clearly different from normative developmental expectancies for a child/youth of this age, background, culture, and community?
3. Do the behaviors result in definite problems in functioning for the child/youth in relationships (family and/or peer), school (academics and/or citizenship), or other important activities?

Rating symptoms as "severe" over and above the clinically significant threshold is optional. This may be done in order to clinically characterize more extreme symptom manifestations as a guide to treatment or to calibrate progress monitoring in treatment (where partial remission from "severe" to "threshold" reflects real progress).

Note that all symptom items have check-boxes in the Severity Rating section for the interviewer to indicate whether a symptom is accompanied by either "DISTRESS/CRISES" and/or "SHUT-DOWN (i.e., emotional numbing, dissociative depersonalization or derealization, social detachment/withdrawal, significantly reduced executive function/problem solving/decision-making).

The Severity Rating section also provides interviewers the opportunity to identify symptoms as present or threshold for (a) the **past month or a worst month in the past year**, or if this is not the case, for (b) ever in the child/youth's **lifetime**.

B. Affective/Physiological Dysregulation. *Impaired developmental competencies: affect or arousal regulation.* ***Approximate normative developmental expectancies:***

- 8-11 years old – knows and can describe and express her/his own feelings with a limited vocabulary and range of behaviors, including occasional tantrums, meltdowns/shut-downs or confusion, from which s/he recovers with support from adults or passage of time. Manages and can describe in colloquial terms ordinary body functions with occasional problems but no evidence of paralysis or infantile/complete failure of bodily functions or inability to recognize/describe them.

- 12-14 years old – can describe and autonomously manage specific emotion and body states/functions, albeit often with embarrassment and self-consciousness. May become angry, disgusted, sad, or frustrated and "pout" or react impulsively, but is able to independently recover (more quickly with adult or peer support, but not exclusively relying upon external support). Has occasional but not chronic physical complaints, unless experiencing expectable symptoms of a medically diagnosed illness or recovery from a physical injury that expectably requires a lengthy recovery period.

- 15-17 years old – can express a range of emotions and recover autonomously (with periodic assistance from peers or adult mentors) from dysphoria while having episodes of irritability, impatience, sadness,

worry, or frustration consistent with hormonal changes, sleep deprivation, and cognitive leaps. Manages bodily functions with no more than temporary breakdown (due to occasional illness, injury, over-shooting of physical capacities, or medically expectable recovery from serious illness/injury).

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

B.1a. Extreme Negative Affect States

□ **Threshold** *Experiences frequent or ongoing states of severely impairing negative affect/distress*

□ **Severe** *Loss of conscious awareness*: loses consciousness (blackouts, fainting, periods of complete amnesia)
Loss of Body Functions: paralysis, loss of muscle control, inability to perform ordinary body functions
Dissociative shifts in self-state: depersonalization, extreme or unrecognizable alteration in personality state

B.1b. Impaired Recovery from Extreme Negative Affect States

□ **Threshold** *Frequently or consistently cannot recover from persistent distress despite substantial help*

□ **Severe** *Extreme Negative Affect: Is (a) Continuously Present (b) Cyclically Recurs (c) Escalates over time:* unable to change emotion state from extreme negative affect (a) all the time, (b) recurrently,(c) increasingly over time

B. 2. Inability to modulate, tolerate, or recover from extreme bodily states

B.2a. Aversion to Touch

□ **Threshold** *Cannot tolerate even incidental or gentle/sensitive physical touch without extreme distress*

□ **Severe** *Loss of conscious awareness*: loses consciousness (blackouts, fainting, periods of complete amnesia)
Loss of Body Functions: paralysis, loss of muscle control, inability to perform ordinary body functions
Dissociative shifts in self-state: depersonalization, extreme or unrecognizable alteration in personality state

B.2b. Aversion to Sounds

□ **Threshold** *Cannot tolerate even mild noises or periods of quiet/silence without extreme distress*

□ **Severe** *Loss of conscious awareness*: loses consciousness (blackouts, fainting, periods of complete amnesia)
Loss of Body Functions: paralysis, loss of muscle control, inability to perform ordinary body functions
Dissociative shifts in self-state: depersonalization, extreme or unrecognizable alteration in personality state

B.2c. Aversion to Interoceptive/Kinesthetic Sensations

□ **Threshold** *Cannot tolerate some body states/sensations without extreme persistent distress*

□ **Severe** *Loss of conscious awareness*: loses consciousness (blackouts, fainting, periods of complete amnesia)
Loss of Body Functions: paralysis, loss of muscle control, inability to perform ordinary body functions
Dissociative shifts in self-state: depersonalization, extreme or unrecognizable alteration in personality state

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

B.3a. Unawareness of or Confusion about Emotions

□ **Threshold** *Complete absence of any felt emotions most or all of the time*

□ **Severe** *Machine-like Detachment:* shows absolutely no signs of human emotion (including frustration, confusion)
La Belle Indifference: appears completely unaware of or unaffected by own or others' suffering or pleasure
Dissociatively emotionally overwhelmed: becomes depersonalized/derealized/amnesic if any emotion begins to occur

B.3b. Physical Anaesthesia or Body Depersonalization

□ **Threshold** *Repeated or chronic total absence of awareness or sense of ownership of some body parts*

□ **Severe** *Machine-like Detachment:* shows absolutely no signs of awareness of own body except as a tool/machine
La Belle Indifference: appears completely unaware of or unaffected by own bodily pain/injury/responses
Dissociative anesthesia: becomes depersonalized/derealized/amnesic if begins to be aware of bodily feelings/functions

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

B.4a. Alexithymia.

□ **Threshold** *Completely at a loss for words to describe feelings and blocked or unable to find them*

□ **Severe** *Phobic of Revealing Emotions:* experiences terror at the thought or suggestion of disclosing any emotion
La Belle Indifference: describes own emotions as if they belong to somebody else

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Dissociative alexithymia: depersonalizes/derealizes/amnesic when attempts to put emotions into words

B.4b. Somatic Alexithymia.
 Subthreshold *(Skip to C.1a.) Unsure of how to express body feelings but sometimes accurately does so*
 Severe *Phobic of Revealing Bodily Feelings:* experiences terror at the thought.suggestion of disclosing bodily feelings
La Belle Indifference: describes own bodily feelings as if they belonged to somebody else
Dissociative alexithymia: depersonalizes/derealizes/amnesic when attempts to put bodily feelings into words

C. Attentional and Behavioral Dysregulation: ***Impaired attentional or behavioral responses to threats.***

Approximate normative developmental expectancies:

- 8-11 years old – can sustain attention sufficiently to complete most structured or independent activities, despite occasional episodes of distraction, boredom, interruption by salient cues/activities/people. Able to recognize and make adjustments in behavior to manage most problems, with help from older individuals when demands/pressures/threats are beyond the expectable for similar age/context children. Self-soothes in socially acceptable private ways, but not in a compulsive or public manner or with behaviors characteristic of young children (e.g., thumbsucking). Relies on others to determine when to initiate or how to complete complex activities, but is able to initiate and sustain simpler activities autonomously consistently.

- 12-14 years old – recognizes problems proactively and seeks help or develops autonomous coping tactics. Thinks ahead about problems or dangers, although coping tactics often are only partially effective and may lead to temporary worsening of problems or emotional distress. Clearly knows the difference between being safe and being in danger, and generally chooses to avoid or get help if danger is possible. Able to self-soothe with routine comfort behaviors (e.g., socializing/activities with friends, normal sleep, predictable activities). Generally is able to initiate and sustain multi-part or multi-person activities with some help from older individuals, and fully autonomously with well practiced complex activities.

- 15-17 years old – knows how to maintain focused attention even when distracted, although can become distractible by "attractive nuisances" or salient opportunities (e.g., to socialize, compete, enjoy exciting activities). Able to maintain own safety and to help others (e.g., siblings, other family members, and peers) maintain safety without assuming full adult responsibility except in emergencies. Able to self-soothe by interacting with peers without relying upon sexual behavior, over/under-eating, drug use, or public display of ordinarily private acts to achieve tension reduction. Able to initiate and complete complex activities autonomously with some coaching and support.

C. 1. Attention-bias toward or away from potential threats.

C.1a. Preoccupation with Dread
 Threshold *Loses track of everything when preoccupied with even remotely possible threats*
 Severe *Phobic of Unpreparedness:* terrified of any sign that s/he is not completely prepared for any possible danger
Ruminates about Unpreparedness: cannot stop thinking about preparing for any possible danger
Dissociative preoccupation w/vigilance: involuntarily shifts awareness frequently to a preoccupation with preparedness

C.1b. Inability to Recognize/Trust Safety Cues
 Threshold *Systematically confuses and mis-reads threat and safety cues.*
 Severe *Indifferent to Being Safe:* appears to be completely unaware of signs of being safe
Ruminates about Being Safe: cannot stop thinking about how to be safe
Dissociative preoccupation w/safety: involuntarily shifts awareness frequently to preoccupation with safety

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

C.2a. Dangerous Risk Taking
 Threshold *Systematically exposes self or others to extreme danger with inadequate preparation/coping*
 Severe *Indifferent to Extreme Risks:* appears unaware or uncaring about exposing self/others to extreme danger
Compulsively takes Extreme Risks: seems to be driven by a need to expose self or others to extreme danger
Dissociative harm seeking: dissociates when seeking to expose self or others to extreme danger

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C.2b. Disregard for <u>Causing Injury to Self/Others</u>

 Threshold *Systematically exposes self to severe interpersonal or health dangers*
 Severe *Indifferent to Injury/Reprisals:* <u>appears unaware or uncaring about causing injury/attack to self/others</u>
Compulsively seeks Injury/Reprisals: <u>seems driven by need to cause self/others to be injured or attacked</u>
Dissociative <u>seeking of injury/Reprisals</u>: <u>dissociates when seeking to cause self/others to be harmed/attacked</u>

C. 3. Maladaptive attempts at self-soothing

 Threshold *Cannot stop using unhealthy, isolative, regressive or exhibitionistic ways of self-soothing*
 Severe *Ex/implodes if Impeded :* <u>becomes aggressive toward self/other if blocked in attempts to self-soothe</u>
Purposively seeks stigma : <u>states/acts out intent to punish/humiliate/embarrass self by publicly engaging in self-soothing</u>
Dissociative shifts in self-state: <u>becomes depersonalized/derealized/amnesic when engaging in self-soothing behavior</u>

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

 Threshold *Compulsively self-harms to relieve/focus pain/distress*
 Severe *Wants to Damage Body:* <u>states/acts out intent to punish/injure self by inflicting damage to own body</u>
Purposively seeks stigma: <u>states/acts out intent to punish/humiliate/embarrass self by publicly engaging in self-harm</u>
Dissociative self-harm to self-soothe: <u>becomes depersonalized/derealized/amnesic if engaging in self-harm behavior</u>

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

 Threshold *Systematically avoids ignores or sabotages opportunities to initiate or complete activities*
 Severe *Expects self to fail:* <u>states/acts out expectation of chronic personal failure</u>
Compulsively shifts responsibility: <u>seems driven to blame others for own failures to initiate/sustain behavior</u>
Dissociative passivity: <u>becomes passive and depersonalized/derealized/amnesic when should be initiating/sustaining</u>

D. **Self and Relational Dysregulation**. **Impaired competencies in personal identity and relational involvement**

Approximate normative developmental expectancies:

- 8-11 years old – feels guilt or shame when fails to meet family/community standards for behavior, but can recover with support from caregivers/mentors. Cares and occasionally worries about the well-being and emotional approval/availability of caregivers, but generally feels secure with/about them. Generally trusts and is cooperative toward others, with occasional doubts/fears/selfishness/noncompliance. Feels/acts angry at times when feeling frustrated/criticized by others but rarely if ever lashes out verbally/physically and is genuinely remorseful if this occurs. Enjoys affectionate/friendly physical contact with others s/he knows well, and seeks their reassurance periodically but generally feels confident in self. Interested in others' feelings and sympathetic when they are distressed or hurt, but generally confident they will recover fully.

- 12-14 years old – feels guilt or shame when fails to meet own internal standards for behavior, but can recover with support from peers or caregivers/mentors. Generally takes the well-being and emotional approval/availability of caregivers for granted, generally feeling secure with/about them. Generally trusts and is cooperative toward others, with occasional doubts/fears/selfishness/noncompliance. Feels/acts angry at times when feeling frustrated/criticized by others but rarely if ever lashes out verbally/physically and is genuinely remorseful if this occurs. Enjoys affectionate/friendly physical contact peers and privately with adult caregivers. Seeks reassurance periodically from peers (and less often, usually privately, from adult caregivers) but generally feels confident in self. Interested in others' feelings and motivated to help when they are distressed or hurt, but generally believes that other people can/should take care of themselves.

- 15-17 years old – consciously experiences self-doubts and self-criticism when fails to meet own/peers' standards for behavior, but can recover with support from peers and public acknowledgement of own achievements (e.g., grades in school, athletic/artistic accomplishments). Acts indifferent to the well-being and emotional approval/availability of caregivers, relies on them to create a general home/neighborhood environment that is secure and dependable. Generally trusts and is cooperative toward others, with occasional doubts/fears/selfishness/insensitive assertiveness. Feels/acts disgusted at times when feeling frustrated/criticized by others but rarely if ever lashes out verbally/physically and is genuinely remorseful if this occurs. Enjoys affectionate/friendly physical contact with peers s/he knows well, and seeks their reassurance periodically but generally feels confident in self. Concerned about injustice/unfairness if other people seem to be treated badly and are distressed or hurt, but generally expects people to be self-reliant.

D. 1. **Persistent extreme negative perception of and emotion reaction to self, including (a) self-loathing, and (b) viewing self as damaged, helpless, ineffective, or defective.**

D.1a. ***Self-Loathing***

□ **Threshold** *Ruminates persistently about self as permanently deformed, dirty, and disgusting*
□ **Severe** *Punishes Self:* states/acts out intention to harm/humiliate self due to hatred of or disgust with self
Attempts to Cleanse by Defiling Self: states/acts out intention to harm self in order to remove/erase deformity/badness
Dissociative self-loathing: becomes depersonalized/derealized/amnesic when thinking of own deformity/badness

D.1b. Perception of Self as Damaged

□ **Threshold** *Ruminates persistently about self as permanently damaged, defective, and inadequate*
□ **Severe** *Punishes Self* states/acts out intention toinflict harm/damage on self as a punishment for perceived defects
Attempts to Correct by Eliminating Self: states/acts out intention to get rid of parts/all of self to correct perceived defects
Dissociative self-condemnation: becomes depersonalized/derealized/amnesic when ruminating about self as damaged

D. 2. **Compensatory adultified (precocious) attempts to take on the role of caregiver/protector for own caregiver(s) and difficulty tolerating reunion with caregivers after separation**

D.2a. Parentified Protectiveness of Caregivers

□ **Threshold** *Compulsively role-reverses with caregivers despite their competent attempts to give care*
□ **Severe** *Feels Overburdened:* states/acts out sense of exhaustion/unfairness while caring for/protecting caregivers
Devalues Legitimate Caregivers: states/acts as if legitimate caregivers are abusive/abandoning/betrayers
Dissociative parentification: becomes depersonalized/derealized/amnesic when caring for/protecting caregivers

D.2b. Attachment Insecurity

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 Threshold *Persistently reacts to available caregivers as if they are undependable, uncaring, unworthy*
 Severe *Feels Chronically Rejected/Abandoned:* states/acts out belief that s/he will always be left/rejected by caregivers
Devalues Legitimate Caregivers: states/acts out belief that people actually offering her/him meaningful care are worthless
Has Severe Crises when Separated from or Reunited with Real or Perceived Caregivers: becomes suicidal, self-harming, psychotic, substance abusing, violent, or otherwise in crisis when separated from or reunited with caregiver(s)

D. 3. **Extreme persistent distrust, defiance or lack of reciprocal behavior in close relationships**

D.3.a. Sense of Betrayal in Close Relationships
 Threshold *Persistently defiant, aggressive or withholding, distancing when disappointed*
 Severe *Projective Identification of Betrayal:* states/acts out blame of others for betraying her/his trust while actually behaving in a manner toward those other persons that is untrustworthy or betrays their trust
Devalues Healthy Relationships: states/acts out belief that relationships which objectively involve caring, respect, and mutuality, and the people in those relationships, are inadequate, deserving of severe criticism, or worthless
Dissociative isolation: becomes depersonalized/derealized/amnesic when distancing/withdrawing from relationships

D.3b. Sense of Coercion/Exploitation in Relationships

 Threshold *Persistently reacts with oppositional defiance to non-coercive help, requests, or guidance*
 Severe *Projective Identification of Coercion:* views others as consistently overcontrolling/demanding/coercive while treating them in an over-controlling/demanding/coercive manner
Projective Identification of Exploitation: views others as consistently taking advantage of/burdening her/him while treating them as if they should meet all her/his needs/wants without consideration of their needs/point of view
Dissociative resistance to control: becomes depersonalized/derealized/amnesic when perceives others as attempting to make her/him act/think/feel in ways that s/he does not choose to

D.3c. Inability to Trust People Who are Trustworthy
 Threshold *Persistently reacts trustworthy individuals/relationships with extreme distrust*
 Severe *Hostile/Punitive toward Trustworthy Others:* verbally/physically attacks/criticizes/demeans people who are objectively trustworthy in their relationships with her/him
Trusts only Coercive/Exploitive/Rejecting Others: seeks out and preferentially relies upon/defers to people who are objectively coercive/exploitive/rejecting toward her/him

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

 Threshold *Persistently reacts with extremely intense defensive or self-protective aggression*
 Severe *Dangerously aggressive:* verbally/physically assaults/attacks/lashes out in ways that cause serious harm
Indifferent to causing harm: states/acts out an attitude of uncaring indifference to own acts that harm others
Dissociative defensive aggression: : becomes depersonalized/derealized/amnesic when reacting aggressively in response to perceived threats/attacks/harm by other persons

D. 5. **Inappropriate (excessive or promiscuous) seeking of intimate contact (including sexual or physical intimacy), or excessive reliance on peers or adults for safety and reassurance**

D.5a. Disinhibited Social Engagement

□ **Threshold** *Persistently violates personal boundaries with intrusively intimate behavior*
□ **Severe** *Sexually Intrusive/Promiscuous:* violates others' personal space/boundaries or own well-being/safety/self-respect when pursuing sexual involvement with other persons
Harmfully Intrusive: violates others' personal space/boundaries with hurtful/critical/demanding statements/acts that cause serious physical or emotional harm to others
Dissociative neglect of boundaries: : becomes depersonalized/derealized/amnesic when intrusively engaging with others

D.5b. Compulsive Reassurance Seeking
□ **Threshold** *Persistently demands reassurance in ways that lead others to feel burdened/alienated*
□ **Severe** *Incapacitated unless reassured:* becomes paralyzed/severely regressed/overwhelmed if not given reassurance
Help seeking/rejecting: consistently rejects/devalues/ignores legitimate help that is given when s/he requests help
Dissociative desperation: : becomes depersonalized/derealized/amnesic when seeking reassurance/help from others

D. 6. **Impaired capacity to regulate empathic arousal: (a) lacks empathy for, or intolerant of, expressions of distress of others, or (b) excessive responsiveness to the distress of others**

D.6a. Inability to Feel Empathy or Compassion
□ **Threshold** *Persistently views any need for help in self or others as unjustified and burdensome*
□ **Severe** *Enraged by Vulnerability: :* becomes enraged if others show signs of emotional/physical vulnerability
Contemptuous of Distress: states/acts out attitude of contempt/disgust when others show/express distress
Dissociative dismissal of others: becomes depersonalized/derealized/amnesic when expressing indifference toward others

D.6b. Excessive Emotional Responsiveness to Distressed Others
□ **Threshold** *Compulsively attempts to rescue anyone who is perceived as distressed*
□ **Severe** *Pathological Enabling:* sacrifices own needs/wellbeing/safety in order to meet others' needs/wants/demands
Pathological Enmeshment: takes on suffers and others' distress contagiously, as if it was her/his own distress
Dissociative affective enmeshment: becomes depersonalized/derealized/amnesic when consciously reacting sympathetically to others' distress or when unconsciously experiencing others' distress as her/his own suffering

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Frequently Asked Questions about the DTD-SI
(with answers in blue font)

How do we access a severe rating without probing (when the child does not explicitly endorse)? Many sections seem to require further questioning so that the interviewer is not missing something.
Sample probe questions for the Severe ratings are provided in the DTD-SI righthand margin.

Often, scoring seeming to be linked to distress but questions are linked to functional behavior.
Actually both the questions and the ratings should be based on evidence of distress *and* altered functioning.

The title indicates that this is a structured interview but it seems to be semi-structured.
Yes, this is a semi-structured interview, not completely or exactly scripted.

If administered with parent and child together – do you administer/score only one DTD interview or both parent and child ones? We figure you just administer and score the parent one (please confirm if this is correct), but weren't sure how to handle discrepant responses from parent and child. There is no place to report parent and child responses.
Correct, just use the parent version.

Is it OK to read the child DTD interview to the parents if we find the wording of the parent one to be too complex? We found the child version to illustrate the questions more concretely. Absolutely fine.

Can you provide examples for questions: B.2c and D.1b? Also for D.1b is says attempts but you are not actually coding attempts to kill self or remove part of self, just a desire? Please clarify. Correct, the intention/desire is scored, not just actual acts.
B2c: Stomach growling interpreted as becoming horribly ill. Heart beating interpreted as heart going to explode or stop entirely. Feeling tired interpreted as body not being able to move at all (paralysis, not just fatigue). Feeling dizzy interpreted as blacking out.
D1b: I'm a total idiot. I'm so ugly no one can stand to see me. Everything I do hurts other people. The sound of my voice makes me/others want to run away. There's nothing I like about myself, I'm a total failure/mess. I'm evil. I'm the nastiest person in the world when I get mad. No one could ever love me, I deserve to be alone.

Specific DTD Interview Item Questions

1. On the DTD interview, "one time per week" is not an option for a frequency rating. If someone says "once per week" do we default to "less than once per week" or "2-3 times per week"?
Corrected on the most recent version attached, please replace prior versions with these (they are what we're sending you in the box of paper copies).

2. For rating "Not present" through "Severe"' it seems like we will not get this information

without probes outside of the structured format. Are we able to clarify or ask further questions? **Yes, you should use any of the probe questions on the right hand side of the interview protocol that seem appropriate for the interviewees.**

3. On item B.3.a (regarding dissociation), the client stated that she "turns her feelings off" when she feels like it, and when probed, she simply stated that she just doesn't feel anything because she can shut her feelings down. Although it implies much more intent not to feel, does this capture the dissociation that you are trying to assess with this question?

Her statement that she doesn't feel anything is sufficient to consider dissociation likely; people sometimes believe they can "shut down" or "turn off" their feelings when it actually is happening involuntarily (gives a sense of control when fear of loss of control is strong). I could have asked her to tell me more about what happens and how she feels (or doesn't) in those instances, but for the sake of time I accepted the statement that she doesn't feel anything as sufficient for this symptom.

4. We would like help with part C. Attentional and Behavioral Dysregulation: The child exhibits impaired developmental competencies for attentional or behavioral responses to threats: C.1a. This sentence sounded confusing: "Have you ever felt so worried about something terrible that you were afraid would happen, that you couldn't think about anything else except how to be ready for it or to get away from it?" We ended up asking this one instead: "Have you ever felt afraid that something terrible would happen and worried so much that you were thinking about getting ready for it or getting away from it and you couldn't think of anything else?"

That's a good alternative phrasing, feel free to use it if it works better.

5. C.2. Impaired capacity for self-protection, including extreme risk-taking or thrill-seeking. C.2b. We weren't clear if the question was emphasizing the words "on purpose". Is this asking if the child is intending to challenge social norms out of rebellion rather than compulsivity? In the "Subthreshold" option, it says "copes effectively". Since we are not asking about coping, how will we get this information?

Yes, 2b. refers to risk taking intentionally (including seeking to get hurt as well as to challenge norms) rather than the non-intentional (which may be accidental or due to carelessness as well as to compulsivity) risk taking of 2a.

Copes effectively is shorthand for being able to cope with consequences when they are negative; if this is not clear a probe such as "How do you handle (the consequences, e.g., being suspended, getting into fights)?" could be used.

On item C.2a (regarding putting self in harm's way), the mock client stated that she often went into unsafe situations with her brother because she knew her brother was there to protect her and therefore, she did not feel that she was truly in harm's way or unsafe. Upon further query, she also stated that she does not go to such places without her brother because she knows it is unsafe. How would you code this? I view this as risky behavior because it's not at all clear that her brother really can protect her – again, her view minimizes the potential danger (which she implies with the many statements she makes obliquely referring to violence, especially gang-related).

6. C3. Maladaptive attempts at self-soothing. "Have you ever done things in order to try to feel good, or make yourself feel better, even though they were unhealthy, got you in

trouble, or other people made fun of you? This sentences reads like a rapid fire series of questions. There's a lot in there--pleasure-seeking, self-soothing, punishment, teasing. We were wondering if we should pause for at each comma.
Definitely pause at each comma.

7. C.4. Habitual (intentional or automatic) or reactive self-harm. "Have you tried on purpose to hurt your body? . . ." How does on self-harm "unintentionally" as in "Subthreshold"? Is the goal of the self-harm important? For example, harming out of self-loathing rather than self-soothing.
If it happens due to accidents, carelessness, recklessness this would be unintentional.
The subjective motivation is important clinically but the functional objective of intentional harm is "soothing" in the form of arousal/distress/tension reduction – even if it backfires and increases distress (e.g., self-loathing).

8. There are sometimes opposites in the in same sentence. For example in B.1a. Extreme Negative Affect States, it says, "Do you ever blow up or shut down totally"? Should we treat these differently as we go through. I found myself treating them as two different kinds of events and having to specify what emotions went with either blowing up or shutting down rather than grouping them together. We'd like help on how to ask this.
Good point: because these adaptations often are dialectical they often involve opposite paths to a single goal, e.g., managing extreme uncontrollable emotions by blowing up or shutting down. I'd suggest noting briefly if either or both are endorsed and coding as present if either manifestation (or both) is endorsed.

9. C.5. Inability to initiate or sustain goal-directed behavior. In "Severe" it says, Expects self to fail. How would we know this without probing for it? Yes, you can ask (if not already clear): "Do you not do stuff or not finish what you're doing, because you think you aren't good enough to do it right/well?"

10. Do we ever ask D.2 questions in the presence of a parent? D.2. Compensatory adultified (precocious) attempts to take on the role of caregiver/protector for own caregiver(s) and difficulty tolerating reunion with caregivers after separation.
This should be done with caution: the child might be reluctant to answer with parent present.

11. What is an example of "dissociative parentification" (referred to in the "Severe" categories of Sections D? Is it episode-specific like dissociating while taking care of parents? **Exactly.**

12. In D.3a. we weren't really getting at separation and reunion so the ratings seems unrelated. We would like help with how to ask this.
Good catch, that's a typo: should be "emotional disappointments" not "separation and reunion"!

13. In the video, you probed for some feelings (in yellow) but not all listed. Should we be probing? Specific feelings or in general? **Ideally probe briefly for each feeling.**

14. If a client endorses part "a" then do we need to ask about "b"? For example, in the video the client endorsed B.1.a and then you briefly asked about B.1.b (not in the detail that you asked for "a") and then moved on to section C.
Ideally ask both parts, even though the symptom will be counted as present if one part is present.

15. C.4. you want to know the what, not the why, correct? So, what the client is doing to self-harm (it at all) rather than why. **Exactly.**

16. D.3.a. asks about feelings but scoring is based on behavior endorsement. Can you clarify?
I'm using "felt" colloquially here, to reference a belief (distrust, insecurity) that manifests in the behavior described in the ratings.

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Table 1

Self-Regulation Developmental Competencies

Affective/Bodily Self-Regulation

- Recognizing, labeling, and expressing discrete emotions
- Recognizing and experiencing positive affect states
- Selectively enhancing or reducing affect states
- Maintaining affect intensity within a tolerable "window"
- Recognizing somatic state-markers (e.g., tension/relaxation, energy/fatigue, pain/comfort)
- Maintaining physical arousal within a tolerable "window"
- Utilizing bodily states for meta-self-regulation (to inform and guide affective, cognitive, behavioral, interpersonal and identity self-regulation)

Cognitive/Behavioral Self-Regulation

- Focusing and sustaining attention selectively
- Encoding information in and retrieving information from procedural/situational and verbal/declarative/narrative memory
- Organizing and reconstructing information in working memory
- Formulating and evaluating the enactment and outcomes of goals and plans with optimism and willingness to disengage from unattainable goals
- Reflectively observing thought processes—"mentalizing" (Fonagy & Target, 2006)
- Sustaining goal-directed behavior (task persistence)
- Shifting task focus and action strategy flexibly
- Error monitoring
- Inhibiting impulsive and aggressive behavior

Interpersonal/Identity Self-Regulation

- Forming and sustaining prosocial relationships
- Resolving interpersonal conflicts safely and constructively
- Modulating interpersonal empathy
- Maintaining personal boundaries without detachment or enmeshment
- Developing and sustaining secure attachment bonds
- Developing and evolving a coherent sense of self
- Developing and evolving an integrated psychosocial identity

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Developmental Trauma Assessment Targets and Measures

1. Assess developmental trauma history using developmentally-validated self- and caregiver report.
   - Traumatic Events Screening Instrument (Daviss et al., 2000; Ford et al., 2000)
   - UCLA PTSD Reaction Index (Steinberg, Brymer, Decker, & Pynoos, 2004)
   - Dimensions of Stressful Events (Fletcher, 1996)
   - Parent-Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998)
2. Assess affect regulation and dysregulation using norm-referenced measures.
   - Five Factor Personality Inventory for Children (Branje, van Lieshout, & van Aken, 2004; Kroes, Veerman, & De Bruyn, 2005; Markey, Markey, & Tinsley, 2004)
   - Minnesota Multiphasic Personality Inventory for Adolescents (Stokes, Pogge, Sarnicola, & McGrath, 2009)
   - Personality Inventory for Youth/Personality Inventory for Children-Revised (Kline, Lachar, & Gdowski, 1992; Lachar & Gruber, 1993; Negy, Lachar, Gruber, & Garza, 2001)
   - Affect Intensity and Reactivity measure for Youth (Jones, Leen-Feldner, Olatunji, Reardon, & Hawks, 2009)
   - Abbreviated Dysregulation Inventory (Mezzich, Tarter, Giancola, & Kirisci, 2001)
3. Assess cognitive regulation and dysregulation using norm-referenced measures.
   - Attentional focusing/shifting (Langenecker, Zubieta, Young, Akil, & Nielson, 2007)
   - Working memory (Mangeot, Armstrong, Colvin, Yeates, & Taylor, 2002)
   - Verbal/declarative and procedural memory (Camos, 2008; Poreh, 2005; Prehn-Kristensen et al., 2009; Wilhelm, Diekelmann, & Born, 2008)
   - Narrative memory (Miniscalco, Hagberg, Kadesjo, Westerlund, & Gillberg, 2007)
   - Higher order conceptual thinking and problem solving (McGee, Schonfeld, Roebuck-Spencer, Riley, & Mattson, 2008; Miniscalco et al., 2007); Poreh, 2005)
   - Adult-rated executive dysfunction: Achenbach System of Empirically Based Assessment (Achenbach et al., 2008); Behavior Assessment System for Children-2 (Doyle, Ostrander, Skare, Crosby, & August, 1997; Kamphaus et al., 1999); Personality Inventory for Youth/Personality Inventory for Children-Revised (Kline et al., 1992; Lachar & Gruber, 1993; Negy et al., 2001)
   - Abbreviated Dysregulation Inventory Cognitive Scale (Mezzich et al., 2001)
   - Social information processing vignettes (Dodge, Greenberg, & Malone, 2008; McGee, Bjorkquist, Price, Mattson, & Riley, 2009)
   - Child Dissociative Checklist (Wherry, Neil, & Taylor, 2009)
   - Adolescent Dissociative Experiences Scale (ADES; (Brunner, Muller, Parzer, & Resch, 2008; Martinez-Taboas, Canino, Wang, Garcia, & Bravo, 2006; Sho et al., 2009)
   - Trauma Symptom Checklist for Children (Wolpaw, Ford, Newman, Davis, & Briere, 2005), Trauma Symptom Checklist Young Children (Briere et al., 2001) dissociation sub-scales
4. Assess behavioral regulation and dysregulation using norm-referenced measures.

- Five Factor Personality Inventory for Children Conscientiousness scale (Kroes et al., 2005)
- Achenbach System of Empirically Based Assessment Social Competence scale (Achenbach et al., 2008).
- Behavior Assessment System for Children-2 Activities of Daily Living, Adaptability, Leadership, Functional Communication, Social Skills, and Study Skills scales (Doyle et al., 1997; Kamphaus et al., 1999)
- Perceived Competence Scales for Children (Harter & Pike, 1984; Harter & Whitesell, 2003; Schuengel et al., 2006)
- Abbreviated Dysregulation Inventory, Behavior Scale (Mezzich et al., 2001)
- Trauma Symptom Checklist for Children (Wolpaw et al., 2005), Trauma Symptom Checklist Young Children (Briere et al., 2001) Sexual Concerns and Anger/Aggression sub-scales
- Child Sexual Behavior Inventory (Friedrich et al., 2001)

5. Assess somatic regulation and dysregulation using norm-referenced measures.
   - Achenbach System of Empirically Based Assessment Somatic Distress scale (Achenbach et al., 2008).
   - Behavior Assessment System for Children-2 Somatic Complaints scales (Doyle et al., 1997; Kamphaus et al., 1999)
   - MMPI-A Hypochondriasis and Hysteria scales (Stokes et al., 2009)
   - Personality Inventory for Youth/Personality Inventory for Children-Revised Somatic Concern scale (Kline et al., 1992; Lachar & Gruber, 1993; Negy et al., 2001)
   - Trauma Symptom Checklist for Children (Wolpaw et al., 2005), Trauma Symptom Checklist Young Children (Briere et al., 2001) Somatic Complaints sub-scale