

Developmental trauma disorder: An attachment-based perspective

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Abstract

Despite the evidence linking chronic early trauma with psychological distress, the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5) has excluded developmental trauma disorder from its taxonomy. This article considers developmental trauma from an attachment-based perspective and raises some of the difficulties professionals may experience conceptualising the trauma–attachment relationship. It explores the impact of the decision to exclude the diagnosis from DSM-5 on professionals, those who have had traumatic early experiences and their carers. Finally, it presents formulation as an alternative proposition which may better suit those who present to mental health services with attachment- and trauma-linked difficulties.

Keywords

Developmental trauma, attachment, DSM-5, diagnosis, formulation

In 2012, it was announced that the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) had been finalised and that publication was scheduled for 2013. As expected, developmental trauma has been excluded from the taxonomy. This piece seeks to examine the implications of such a decision for professionals and service users, as well as carers.

Despite my own view that we should exercise caution in diagnosing mental disorders in service users, both the literature and my clinical experience have shown me that there are advantages and disadvantages to the prevailing diagnostic system. I have sought to present these contradictory ideas while examining the impact of the exclusion of developmental trauma from DSM-5, using an attachment-based perspective.

Developmental trauma: The conceptual framework

The association between trauma-inducing experiences and psychological distress, including post-traumatic stress disorder (PTSD), has been well established (Cook et al., 2005). The symptoms of PTSD include re-experiencing the traumatic event, hyperarousal, rumination and emotional

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numbing (American Psychiatric Association, 2000). Secondary difficulties, such as substance misuse, anxiety, shame and sexual dysfunction, may serve to maintain the distress and further impair functioning (NCCMH, 2005). PTSD is diagnosed less often in young people, among whom co-occurring chronic trauma and adversity are more commonly experienced. The *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; DSM-IV-TR) classification was noted to be too narrow to incorporate this, and developmental trauma disorder (DTD), conceptualised as multiple, chronic or prolonged exposure to developmentally adverse interpersonal trauma in early life, has been proposed to fill this diagnostic gap (Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).

Although the experiences which result in trauma responses can vary widely, the proposers of DTD argue that they may all lead to adverse outcomes. Of 9500 adults who responded to a questionnaire relating to negative experiences, over half reported exposure in childhood to abuse, domestic violence and the consequences of parental substance abuse and mental disorder and a quarter reported experiencing two or more adverse early experiences (Felitti et al., 1998). Such experiences have been associated with a range of negative outcomes in adulthood, including sexual promiscuity, substance misuse, aggression and suicidality, as well as increased risk of psychosis (Felitti et al., 1998; Flannery, Singer, & Wester, 2001; Varese et al., 2012).

The role of attachment in developmental trauma

Although the proposed criteria for DTD do not specifically mention attachment, it is apparent that the proponents of the classification recognise the importance of consistent, appropriately protective caregiving (Van der Kolk et al., 2009). Children in care have repeatedly been found to have poorer mental health than their peers in the general population (Burns et al., 2004; Cappelletty, Brown, & Shumate, 2005; Pilowsky, 1995). In a recent study of 347 4–11 year-olds in care, a third demonstrated psychopathology consistent with existing mental disorders and a further 20% manifested complex attachment- and trauma-related difficulties that could not be adequately conceptualised by the current taxonomy (Tarren-Sweeney, 2013). It is clear that such difficulties exist, and we know that they have enormous repercussions: neglect, estimated to be the most common form of childhood maltreatment (Sedlak & Broadhurst, 1996), has a substantially detrimental effect on cognitive, emotional and behavioural development (Hildyard & Wolfe, 2002). Such difficulties continue well into adolescence and adulthood and have a significant negative effect on social interaction and academic ability, as well as increasing the risk of offending (Hildyard & Wolfe, 2002). Maltreated children are also up to four times as likely to develop disorders of personality than their non-abused or non-neglected peers (Johnson, Cohen, Brown, Smailes, & Bernstein, 1999; Johnson, Smailes, Cohen, Brown, & Bernstein, 2000).

The model proposed by Van der Kolk (2005) acknowledges that exposure to trauma may result in adverse outcomes but that these outcomes will be affected by the quality of the child's attachment to their caregivers. Thus, positive attachment relationships can mediate the degree to which young people are affected by trauma experiences. Conversely, the absence of secure attachments is likely to result in poorer outcomes and, it is suggested, trauma perpetrated by those the child sees as caregivers will amplify these poor outcomes further (Van der Kolk, 2005). Children who are maltreated by their primary caregivers are often unable to find an alternative source of security which will enable them to modulate their arousal; they will eventually learn that the external world is both dangerous and unable to meet their needs and that they are incapable of regulating their own internal world. Such individuals may become fearful of relying upon others, while also experiencing their own emotional states as intolerable. Typically, they will demonstrate poor understanding of boundaries, mistrust of others and difficulty in understanding other people's emotions, and they

may act in ways perceived as helpless, blaming or rejecting (Cook et al., 2005). Many of the behaviours they exhibit can be conceptualised as attempts to minimise threats to their integrity while simultaneously managing their own distress, but these attempts to maintain personal and emotional security are often interpreted as oppositional or antisocial (Van der Kolk, 2005).

The absence of DTD from DSM-5 raises questions about how trauma and attachment can be conceptualised. Although the construct of reactive attachment disorder (RAD) already exists and has been extended in the updated DSM, it simply describes children who, due to emotional neglect or deprivation, do not seek comfort when distressed and who demonstrate a lack of positive affect. It is of note that RAD may be separated into two distinct disorders: RAD, as per its current classification, and Disinhibited Social Engagement Disorder, to indicate features of RAD with associated socially inappropriate disinhibited behaviour around unfamiliar adults, for which the criteria include unstable caregiving (Lawler, Hostinar, Milner, & Gunnar, 2014). Despite the proposed expansion of the diagnostic criteria, RAD does not make any mention of the effect of domestic violence, nor does it recognise the physiological manifestations of emotional disturbance or the possibility of functional impairment. It appears that the taxonomy has not adequately taken into consideration the scientific literature and that children who do experience multiple chronic traumas, particularly at the hands of caregivers, will continue to fall through the diagnostic net.

The proposition to include developmental trauma as a diagnostic classification

Given the high prevalence of early adversity and the range of poor outcomes which may result, the existing diagnostic classification relating to trauma in young people is insufficient (Van der Kolk, 2005). Most children who have been abused receive diagnoses related to anxiety rather than trauma, and often present as impulsive and aggressive (Ackerman, Newton, McPherson, Jones, & Dykman, 1998). The absence of an appropriate diagnosis may act as a barrier to effective treatment being offered: while the disturbance may manifest itself as an anxiety disorder, treating the child for anxiety focuses on symptoms, rather than addressing underlying distress. This appears to be borne out given that early trauma is strongly associated with a constellation of negative outcomes in adulthood (Romano & De Luca, 1997; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Widom & Maxfield, 1996). Similarly, the absence of a diagnostic label may preclude individuals from accessing psychological intervention. Without an appropriate diagnostic classification, research is impeded and evidence-based treatment guidelines cannot be formulated.

The existing diagnosis of PTSD does not account for disturbance related to affect or attachment, nor for somatic difficulties. The classification of PTSD requires 'perceived or actual threat to the person's own life or physical integrity' (American Psychiatric Association, 2000). It does not, therefore, account for witnessing domestic violence, loss of attachment figures or chronic bullying. Thus, a child who demonstrates PTSD-like symptoms may not receive a diagnosis if he or she has not been exposed to danger deemed by health professionals to be 'life-threatening'.

The proposed DTD criteria (Van der Kolk et al., 2005) account for behaviours which may be seen as oppositional, while considering the potential impact of trauma on thinking and attachment styles, coping strategies and self-attributions. The authors note that many children who experience trauma receive either no diagnosis or an incorrect diagnosis and that the behavioural manifestations of trauma-induced disturbances are often inadequately addressed. Despite this, the new edition of DSM has simply increased the number of PTSD clusters from three to four and attends more to behavioural symptoms, although it has been stated by the DSM-5 Task Force that the diagnosis is now more developmentally sensitive (Grohol, 2012).

Implications for the exclusion of 'developmental trauma' as a diagnostic classification

The decision to exclude DTD from DSM-5 will have considerable ramifications for professionals, those affected by early traumatic experiences and those who care for them.

The impact upon professionals

The necessity of diagnosis. For many clinicians, the 'top-down' diagnostic approach is reductionist and does little to explain the constellation of difficulties that many service users experience. Although it may serve as a tool for classification, the extent to which this classification is useful is debatable. Finally, a diagnosis may be meaningful as a descriptive term but generally fails to provide any reasons for the person's presentation; it fails to ask 'why?'. The formulation-based approach, in contrast, seeks to understand why service users present as they do and uses this understanding to consider how the individual's relationships with staff teams may be affected. Grounded in established theory and the scientific literature, good formulation is evidence based, collaborative and individualised (British Psychological Society (BPS), 2011). It can also integrate a life-span perspective, crucial in the case of presentations such as developmental trauma.

Generally, for a client to be referred for trauma-focused work, he or she will have had to have been given a diagnosis. Here, the very question of diagnostic validity is raised. Much has been written about the poor reliability of diagnoses (Kutchins & Kirk, 1999), but the construct of a classification system such as the DSM, in all its incarnations, has generally been supported by proponents of the biomedical model. In recent years, however, dissent has been increasing and the results of the DSM-5 Field Trial suggest that this is not without good reason. We have known for some time, for example, that even classifications as weighty as schizophrenia and bipolar affective disorder are not the discrete disorders that the DSM suggests they are, and that medication does not necessarily reduce symptomatology or distress (Bentall, 2010).

The failure of diagnostic systems. The results of the recent Field Trials provide significant support for those who are sceptical of the very nature of pathologising human experiences (Jones, 2012). The kappa statistic for PTSD in children using the DSM-5 criteria is 0.34, while the statistic for disruptive mood regulation disorder is 0.25. In adults, the reliability is little better; generalised anxiety disorder demonstrates a kappa of 0.20 and even schizophrenia, a label which has been much criticised for its broad criteria, still has a kappa of only 0.46. It appears that questions relating to the utility and applicability of DSM-5 criteria are both fair and necessary. This is perhaps best illustrated when considering the classification of mixed anxiety–depressive disorder, which has a kappa of −0.004 (Freedman et al., 2013). The current criteria for the DSM-5 Field Trials results would be concerning enough if they were directly comparable with the data relating to earlier Field Trials. Unfortunately, however, they are not. Historically low kappa statistics are common when ascertaining the reliability of DSM classifications (Kraemer, Kupfer, Clarke, Narrow, & Regier, 2012), and the thresholds have recently been further reduced: when compared to the previous thresholds, the reliability of DSM-5 labels is actually lower than has been reported. Indeed, even the chair of the DSM-IV Task Force has stated that DSM-5 is 'deeply flawed', 'clearly unsafe' and 'clinically unsound' (Frances, 2012) and has advised clinicians not to follow it.

These results may well persuade proponents of the psychosocial approach to emotional distress that diagnosis is irrelevant to them, and shortly after DSM-5 was finalised, the BPS released a position statement arguing that the biomedical approach is insufficient to understand distress (BPS, 2013). Health and social care professionals who do not have a medical background are not

trained to diagnose, and although many models of intervention use diagnostic labels, there is a plethora of trans-diagnostic models and interventions at our disposal. Alternatives to the medical model have always existed but support for such alternatives appears to be increasing: even those who do believe in the utility of diagnosis have shown much caution at the latest incarnation of the 'diagnostic bible'. On the contrary, this could be the moment at which the case for an alternative is accepted by a range of professionals within the field of mental health, and this will be explored in due course.

Enabling access to services. The exclusion of DTD from DSM-5 presents a significant dilemma for clinicians: in the current UK climate of spending cuts, with an emphasis on clinical outcomes and payment by results, how can children who do not meet the threshold for a psychiatric diagnosis gain access to services in the statutory sector? There appear to be two options: either those children will be diagnosed inadequately or incorrectly, or they will be rejected from the service and advised to seek help elsewhere. Given the increasing focus upon a system of formulation, rather than diagnostic classification, this may pose a significant ethical dilemma for professionals. Mental health professionals are trained to try to reduce distress and are bound to be able to justify their decision-making on ethical grounds, but those employed by the National Health Service (NHS) operate within a medicalised system based upon diagnosis, treatment and recovery. If professionals are to be able to provide interventions to children who have experienced chronic trauma responses, they need to be able to successfully bridge the gap between the need for treatment and the absence of a diagnosis which may act as a gateway to that treatment. With ever-stricter criteria being used to assess eligibility to services, we already have to make decisions about whether we can provide service users with the treatment they may desperately need, even if they do not meet the minimum threshold for the service.

The impact upon service users

Access to services. DTD has no place in DSM-5, and in the present system, this could well be a barrier to traumatised individuals accessing appropriate interventions. Although it could be argued that this will simply result in no change to the status quo, it is my view that in light of the overwhelming evidence relating to the impact of multiple early traumas, this perspective is unacceptable. Service users who have experienced significant trauma should be able to access care that is appropriate to their needs. In the event that they are unable to access care from statutory services, they will have little option but to go elsewhere. Traditionally, the private and voluntary sectors have filled the gaps in services left by government funding and, considering the impact of the UK Health and Social Care Act (2012), which allows 'any qualified provider' to tender for services, there is now greater provision for this in Britain than ever before. A number of private providers have been awarded NHS contracts for services and this has been particularly true of services for children and adolescents. The problem of access remains, however: if a service user cannot be diagnosed appropriately, interventions may be ineffective and treatment outcomes will be diminished. Payment by results is designed to reward services for good outcomes, and it is unlikely that a provider which seeks to make a profit will accept referrals for individuals who may be so complex that those profits are placed at risk. Evidence from international data bears this out; a number of countries, most notably the United States, require individuals to provide details of their health insurance provider prior to receiving assessment or treatment. A 2010 Congressional investigation found that at least one in seven applicants was refused health insurance based on his or her pre-existing medical conditions and that over 210,000 claims by those already insured were denied (Waxman & Stupak, 2010). When both government and insurance companies fail to ensure access

to care, the only providers which remain are those in the voluntary sector. Many charitable organisations provide low-cost counselling, psychotherapy and cognitive-behavioural therapy for those unable to afford the fees of private providers. Waiting lists, however, can be long, and there is no guarantee that the interventions offered will meet the needs of all service users.

The effect on service users from minority backgrounds. Assaultive violence has been implicated in around 40% of PTSD cases and has also been associated with being of an ethnic minority background, as well as poorer education and low income (Breslau & Kessler, 1998). Although it is a myth that those from financially secure backgrounds do not experience adverse early life events and that abuse and violence only affect certain social groups, it is also clear from the literature that access to mental health services is partially dependent on sociodemographic variables. Evidence from research conducted globally indicates that ethnic minorities and the less affluent rarely present to mental health services (Andrulis, 1998), despite their increased risk of developing a mental disorder (Costello & Compton, 2003). Similarly, trauma experiences are common among the lesbian, gay, bisexual and transgendered communities (Brown & Pantalone, 2011), but these populations often describe negative experiences related to their minority status (Avery, Hellman, & Sudderth, 2001) and may be reluctant to approach services. As clinicians, we already fail to provide appropriate services to those in need, but these people are the least likely to be aware of alternative service providers, or to be able to afford those services. To suggest that the private and voluntary sectors should do what public health providers cannot or will not is to implicitly agree that a two-tier health system is appropriate, but for many professionals, this position is untenable. State health providers should provide a 'comprehensive service, available to all', 'based on clinical need, not an individual's ability to pay' (Department of Health (DoH), 2012), and while they may not explicitly stop any group from receiving services, certain people simply fall under the radar. The exclusion of DTD from DSM-5 will, at the very least, maintain this problem at existing levels, and may exacerbate it substantially.

Pathologising human experiences. Despite the recent proliferation of cases of 'mental disorder' among young people (Green, McGinnity, Meltzer, Ford, & Goodman, 2004), many feel that diagnosing children and providing them with pharmacological 'treatments' is stigmatising and unnecessary. DSM-5 has been criticised generally for its inclusion of 'binge eating disorder' and for its relaxation of the criteria for 'major depressive disorder' to include an element related to bereavement. We already diagnose substantial numbers of children with disorders ranging from attention-deficit hyperactivity disorder to bipolar affective disorder, and it is relatively common for medical professionals to prescribe such children medication (Crisma, Bascelli, Paci, & Romito, 2004; LeFever, Dawson, & Morrow, 1999). The literature suggests that many traumatised children who do not meet the criteria for PTSD are prescribed sedatives and antidepressants to help them manage 'emotional disturbance' (Van der Kolk, 2005), but this is not a viable long-term 'solution'.

Equally, the extent to which the proposed classification for a diagnosis of DTD meets the criteria for psychiatric diagnosis can be called into question. 'Mental disorders require an individual to present to professionals with distress or disability, neither of which should be an expected or culturally appropriate response to an experience (Kutchins & Kirk, 1999). In my view, a young person who experiences chronic neglect, abuse, loss or bereavement would be very much expected to present with behavioural or somatic difficulties, or to re-experience the adversity in some manner. Indeed, it is likely that any child who had experienced those circumstances but who failed to exhibit any kind of distress would be seen as having difficulties acknowledging what they had been through. The same can be said for a number of 'disorders': I once worked with a gentleman diagnosed with paranoid schizophrenia. After several weeks of exploration of his current experiences

and early history, it transpired that he had been bullied by his peers and that his father had been a violent man, who constantly beat and humiliated him. After he had disclosed this, I asked if, given that he had spent much of his early life waiting for someone to threaten or belittle him, he thought it unusual that he was now hyper-vigilant to any perceived threat from others. After giving the question some thought, he conceded that it seemed a logical outcome. This person had become more and more isolated since his first breakdown 15 years earlier, but it was not until we began working together that he was able to gain any understanding of why he felt persecuted. His medication had many side effects, but it seemed somewhat ineffective when it came to reducing distressing thoughts which impacted so enormously on his life. A diagnosis of paranoid schizophrenia did not help him in any meaningful way; it simply served to make him feel stigmatised. Our work did not eliminate his persecutory ideas, but it did allow him to place them in some kind of context.

By its very nature, the diagnostic system focuses on deficits, often conceptualised as an inability to carry out the activities of everyday living. While it is important to recognise the difficulties that service users and those who care for them have and to work towards negotiated goals, each service user will have strengths they can draw on to aid their own recovery. The biomedical approach ignores these strengths and perpetuates the myth that 'recovery' comes in the form of a capsule. Indeed, the rate at which children are being prescribed psychotropic drugs in the United Kingdom is increasing, despite the fact that few of these drugs are licensed for use by children (NCCMH, 2005).

The trauma–dysfunction relationship. It is a myth that those born into privilege do not experience trauma; it is also a fallacy that those who have been neglected, abused or bereaved will automatically become deeply damaged adults. While those with histories of trauma are over-represented in the criminal justice system and forensic settings (Widom, 1989), it is demonstrably the case that a substantial number of such individuals function well without input from services and that they have a generally good quality of life. Receiving a diagnosis of DTD in early life may actually diminish positive outcomes, particularly in light of the stigma associated with the term 'developmental trauma'. It can be difficult to shake off a label once it has been applied, and this may be particularly pertinent when considering academic and professional careers. Many positions require occupational health clearance and even relatively common diagnoses such as 'depression' can cause applicants much anxiety. Such individuals are faced with the decision to falsify information which, if discovered, may result in disciplinary action or dismissal, or disclosing and risking never being offered the position simply because of difficulties which may have occurred many years earlier. The term 'developmental trauma disorder' indicates that the individual experienced early trauma, and this may be wrongly interpreted as significant sexual abuse, or something equally severe. From discussions with colleagues, I am aware that diagnoses carrying far less stigma have caused them considerable anxiety when applying for jobs in mental health and that they fear they will be thought of as too unstable or fragile to be able to work with those in distress. While it is perhaps to be expected that diagnoses such as anxiety and depression are common among mental health professionals, I wonder how many have hidden more stigmatising labels; it is well known that Rufus May¹ only disclosed his psychiatric history post-qualification. Although as professionals we claim to be understanding towards mental health problems in ourselves as well as those we work with, prospective employees seem more sceptical.

The impact of a diagnosis of any kind affects more than one's professional life, of course. Telling friends or a partner that you had a 'difficult' childhood is likely to be readily accepted – as we have seen, adversity is common in early life – but attributing a disorder to oneself may result in those relationships cooling off or disintegrating. The stigma of common disorders remains great; those seen as more 'serious' can seriously affect social and familial networks. I have worked with

a number of individuals whose families have rejected them following a breakdown and many have told me of the difficulties associated with disclosing their histories to friends or potential partners. It is not the place of those working in mental health to create even more labels which would exacerbate this issue, but that does not negate our potential to work with problems as and when they arise to improve people's quality of life.

Reducing risk to children. DTD is an emotive label, and any young person warranting such a diagnosis would likely trigger a safeguarding alert, if not full procedures. At present, a child who suffers multiple 'smaller' trauma responses may not be flagged up as being at risk because there may be no direct, discrete risk to their physical or emotional safety. This may keep that child in a situation which could cause them substantial harm over time. If nothing else, this indicates that our dependence on labels and classifications is in itself a risk, and given the absence of DTD from DSM-5, we may need to employ clinical judgement more and reduce our reliance on structured assessments. While such tools have clinical utility, they are not sensitive in the way that clinical teams can be, and when procedures fail, good clinical judgement is key.

Reducing risk to society. It is clear that for some individuals exposed to trauma in early life, outcomes are poor. The proliferation of mental disorders in prisons and the burgeoning population in secure forensic settings suggests that we are inadequately addressing disturbance early in life. Furthermore, some people are denied intervention until they affect society so adversely that we are compelled to lock them up, at enormous financial and social cost. Essentially, we are failing to intervene at the critical point and the result is that we are substantially increasing the risk of violent offending and adult mental disorder. Again, this raises the question of when services should intervene. Is it necessary to do so when an adolescent is noted to be truanting and misusing substances, or is that seen as a poor use of limited resources? Should we wait until they have engaged in criminal activity and, if so, how can we balance that with the ineffective punitive culture of the criminal justice system? More to the point, how do we convince those who have to agree funding that this is indeed an area which warrants attention? Diversion from the criminal justice system can be effective in reducing offending (Bradley, 2009; James & Harlow, 2000) and it is economically prudent (Marsh & Fox, 2008), but is this compatible with the current political opinion of being 'tough on crime'? In my view, the problem is that many offenders, whether committing crime in the context of a mental disorder or not, have already experienced too much difficulty. We know that incarceration in prisons is likely to result in reoffending and reconviction (Marsh & Fox, 2008); perhaps it is time we changed our approach to be more understanding and rehabilitative. Unfortunately, incorporating that into an electoral manifesto is unlikely to make any political party more popular.

The impact upon carers

If we are failing to provide adequate care and support to children who are traumatised, it is likely we are failing to adequately support those who care for them. Although much early trauma occurs within the home, not all will, and caring for a young person can be a strain on the system in which they live (Sanders & Morgan, 1997). This strain may well persist past childhood; the child who develops serious mental health or substance misuse problems in later life may still be cared for by parents, siblings or his or her own children; the person who is not able to work may receive financial assistance from friends and family. While the positive contributions of these networks should not be downplayed, the potential negative effects on those

who have been placed in a position of caring cannot be underestimated. How do we support carers effectively if we cannot give the traumatised person a diagnosis which will enable them to access services? It is likely that such work will have to be co-ordinated by the voluntary sector by way of drop-in and counselling services. Such services already exist, but they too have been affected by the economic climate and their resources can only be stretched so far.

As carers age, they themselves will require more support, in all domains. As life expectancies for those experiencing psychological distress increase, many of those whose lives have been severely affected by trauma will outlive those who care for them, and it is probable that the state will become the *de facto* carer. The financial implications are likely to be huge, and this again poses the question of whether we intervene when individuals are young, or whether we wait until they require more intensive support, possibly over a period of decades. In short, do we play the long game or do we react to mental health needs as they arise? Historically, governments are wary of playing the long game; I would suggest that this failure of long-term thinking has created an explosion in rates of mental illness and offending and that continuing to take this position is defensible neither financially nor morally.

An alternative proposition

As we have seen, there are myriad problems associated with a diagnosis of DTD, as with all psychiatric disorders. Equally, the exclusion of the disorder from DSM-5 raises a number of issues. There are, however, alternatives. Although the psychiatric profession favours diagnosis as a way of describing distress, it is apparent that the labels currently in use are not fit for purpose and that, by extension, neither is the diagnostic system as we know it.

Not all mental health services are based on diagnosis. My first job in mental health was at a therapeutic community which worked with individuals who had experienced extremely adverse early experiences. Despite the majority being diagnosed with a personality disorder (often comorbid) by psychiatrists in secondary services, our assessment process was based upon formulation and considered the circumstances each individual had experienced, rather than simply the symptoms they exhibited. Although risky and maladaptive behaviours such as self-injury were common among this very complex group, they were viewed by staff as a result of the person's history, rather than being typical of someone with, for example, 'a borderline personality disorder'. Intervention was based upon the person's needs and personal goals, while taking account of their strengths. Individuals with a diagnosis of personality disorder have traditionally been deemed 'hard to treat' and excluded from mental health services (NIMHE, 2003); in contrast, this formulation-led approach resulted in significantly improved outcomes (Chiesa & Fonagy, 2000, 2003). If formulation can be effective for those whose distress warrants intensive treatment in specialist services, it can be as effective, if not more so, for individuals who present with lower levels of risk to themselves and others.

In recent years, formulation has moved from the psychological sphere to being an approach that has gained wider acceptance among colleagues in other professions. Similarly, despite the production of clinical guidelines relating to those presenting with simple problems, the majority of clients seen in secondary and tertiary mental health services are often more complex, and for clients such as these, there are no appropriate clinical guidelines. As such, clinicians often tailor interventions to the client, rather than sticking rigidly to a model which may be ineffective when compared to an integrative approach. At present, this allows them the flexibility to operate outside the constraints of diagnosis, but the envisaged changes to the NHS may require them to provide more limited, structured interventions.

Conclusion

The proposal to include DTD in DSM-5 has provoked significant debate but little has been resolved. It is clear that the authors of DSM-5 felt that there was inadequate rationale for including the classification in the updated taxonomy, but this decision is likely to form a vicious circle – the diagnosis does not exist, so investigation into its epidemiology and treatment will be impeded; without an empirical base, there may be insufficient evidence to include DTD in the next version of DSM. Researchers wishing to investigate the effect of multiple, chronic trauma on development may be forced to create their own disparate criteria for what constitutes developmental trauma and the potential problems with this approach are plain.

More saliently, we as clinicians are now faced with a situation in which we know that diagnosis is problematic, that the effects of trauma can be significant and long term and that intervention may be difficult to obtain without a diagnosis. The question is whether professionals choose to continue to work within the constraints of the traditional approach or whether we decide that our skills and knowledge can be applied in a way which is more suited to our clients and which will, it is hoped, result in more positive outcomes. This is likely to be a challenge at all levels, from the clinician working in primary care to the working parties at the Department of Health. Developments in areas such as formulation have shown that there are realistic alternatives to the biomedical approach and that these alternatives can inform and alter current practice. The publication of DSM-5 has raised serious questions about the validity of diagnosis, and we must use this opportunity to highlight the alternatives and what they can achieve. Mental health professionals should be able to advocate on behalf of service users and carers; fundamentally, issues related to risk management and access to services are issues of principle. The Department of Health has stated explicitly that there is 'no health without mental health' and that emotional wellbeing is key to overall functioning; it is time for clinicians to capitalise on this, to mobilise, and to change a system that we know fails some of the most vulnerable in society.

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Note

1. Rufus May is a clinical psychologist working in the United Kingdom's National Health Service. He was diagnosed with a psychotic disorder in his teens and detained under the Mental Health Act on three occasions. He later trained as a clinical psychologist but did not declare his history of contact with mental health services until he had completed training.

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