



LETTER TO THE EDITOR

Trauma Informed Care

Dear Editor,

Re: A Case of Neurological Symptoms and Severe Urinary Retention on a Pediatric Ward: Is this Conversion Disorder? (*Journal of the Canadian Academy of Child and Adolescent Psychiatry* 22(1), February 2013, page 61)

Beyond well-conceived discussion in the article and its follow-up Commentary of the importance of interdisciplinary professional collaboration and the concept of diagnostic bias (re: behaviour disorders in children) this case might also be appropriately discussed under the importance of trauma informed practice. The diagnosis of developmental trauma disorder would subsume the diagnosis of conversion disorder and all the dysregulation of body, mind and affect related in the clinical vignette. This article gives us an opportunity for much needed discussion and awareness about the need for an integrative, trauma-informed model of pediatric case formulation and treatment. There is value in reviewing principles of trauma-informed developmental care, including but not restricted by the following:

- 1) at the most basic level, doing no harm;
- 2) having a purposeful therapeutic multidisciplinary approach;
- 3) recognition by health-care professionals of the pervasiveness of trauma *developmentally* (appropriate interventions which consider chronic trauma traversing various developmental periods), as well as based on 'developmental age' versus 'bone age';
- 4) a commitment to identify and address trauma in its early stages whenever possible;
- 5) seeking to understand the potential relationships(s) between presenting symptoms and previous traumas (present story/past story); and,
- 6) having a non-threatening screening approach (as this remains inconsistent in practice, resulting in improper diagnosis and/or inappropriate treatment).

There is building literature (Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005; Cloitre et al., 2009; Perry, 2006;

van der Kolk, 2003) on identifying developmental trauma disorder early and how to interview pre-adolescent children (Gabokwitz, Zucker & Cook, 2008), their parents/caregivers and their 'village' in order to rule in or out this important factor...beyond simply the child disclosing. With vulnerable populations as in this case presentation, an ecological framework, clinically viewing the children across various contexts, beginning with the family system and moving progressively outward, and allowing for consideration of trauma interactions. The recognition of need for trauma-informed care, training for staff, as well as clinical framework is unfortunately highlighted by this case.

On a separate commentary included in this journal we discuss the merit of recognizing developmental trauma disorder as a separate diagnosis in future revision of diagnostic systems such as the DSM and ICD.

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