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EDITORIAL

Introduction to the Special Section: Developmental Perspectives on Trauma Exposure and Posttraumatic Stress

Patricia K. Kerig[1]

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Abstract

This article provides an introduction and overview of the current special section devoted to developmental perspectives on trauma exposure and posttraumatic stress reactions. Although there have been many revisions to the posttraumatic stress disorder (PTSD) diagnosis in the four decades that have ensued since its inclusion in our diagnostic systems, and many decades of empirical and clinical work investigating the differential effects of traumatic stress on children and adolescents, a truly developmental perspective is still lacking in the diagnosis. In a call to address this gap, this article outlines principles of developmental psychopathology as applied to the phenomenology of trauma and points to potential developmental transformations in the expression of posttraumatic stress across developmental epochs. The introduction then goes on to describe the valuable contributions to the literature represented by the six teams of contributing authors to this present special section, in which they discuss stability and change in posttraumatic symptom expression across development, the current state of validation research on the proposed diagnosis of Developmental Trauma Disorder, complex symptom arrays in children who have been complexly traumatized, distinctions between Complex PTSD and emerging personality pathology, developmental perspectives on prolonged grief, and developmental considerations for understanding the intersection between trauma and moral injury. It is hoped that this collection of articles will serve to stimulate new research and inform effective interventions for young persons affected by traumatic stress.

Keywords Trauma · Development · Posttraumatic stress · PTSD · Developmental trauma · Complex PTSD · Grief · Moral injury

Since its initial inclusion in the diagnostic pantheon in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III; American Psychiatric Association, 1980), the diagnosis of posttraumatic stress disorder (PTSD) has gone through a series of significant revisions. The history of the diagnosis' evolution is a remarkable amalgam of scientific research and political activism, as veteran's groups, sexual assault advocates, and child maltreatment specialists rallied for expansion of the criteria to include traumatic experiences beyond those once narrowly and erroneously defined as being "beyond the realm of normal human experience" (Friedman et al., 2014). However, throughout this history, one group of scholars and clinicians has argued for a perspective that has had limited impact on the diagnostic compendia, and that is a developmental lens (e.g., Garber, 1984; Kerig 2017; Pynoos et al., 2009; Wolraich et al., 1997). Children and youth are not just a subspeciality within clinical science; rather, all humans begin life in childhood and the psychological, social, biological, and epigenetic processes that have their onset in early life are critical to understanding the adults we become (Kerig et al., 2012). To this end, this special section brings together a set of papers devoted to developmental perspectives on the phenomenology, assessment, diagnosis, and developmental psychopathology of PTSD and other trauma-related disorders.

✉ Patricia K. Kerig
p.kerig@utah.edu

[1] Department of Psychology, University of Utah, Salt Lake City, UT 84112, USA

Developmental Perspectives on the Definition of Trauma

To set the stage, it is important to consider that, from the earliest inception of the PTSD diagnosis, one significant point of contention has concerned the definition of what constitutes a "traumatic" event. In both the most recent versions of the DSM (DSM-5-TR; American Psychiatric Association 2022) and the International Classification of Diseases (ICD-11; World Health Organization, 2021) the experience of trauma a *sine qua non*—unlike most other psychiatric diagnoses (with the exception of those triggered by substance use), PTSD cannot exist without a clear precipitating event. But the definition of what comprises such an event has been ever-changing. Significant debates have pervaded our field as to whether the definition of trauma should be narrowed in order to avoid "criterion creep" (Spitzer et al., 2007), whether it should be eliminated altogether (Brewin et al., 2009), or whether it should be widened to accommodate the fuller spectrum of aversive experiences that either conceptually or empirically are purported to give rise to bona fide posttraumatic symptoms (e.g., Ayodeji et al., 2021; Hyland et al., 2021). Although DSM-5 (American Psychiatric Association, 2013) and ICD-11 were developed simultaneously, and in many cases with weigh-in from the same experts, the two systems arrived at different decisions on this point. Whereas the DSM-5 definition of a traumatic event was intentionally narrowed to include only actual or threatened physical harm or death, as well as sexual violence, ICD-11's definition encompasses a non-specified array of events that are deemed "horrific" or "threatening."

In this regard, it is noteworthy that in the developmental psychopathology literature, which is often siloed from PTSD scholarship, much attention has been given to refining and differentiating among types of childhood traumatic experiences. In contradistinction to the prolific literature utilizing the adverse childhood experiences (ACEs) measure (Felitti et al., 1998), which lumps together into one construct a wide variety of negative experiences, some of which are consistent with Criterion A and others of which are not (Amaya-Jackson et al., 2021), meta-analyses have shown that Criterion A-defined traumas have biobehavioral consequences distinct from more general adversities (Hosseini-Kamkar et al., 2021). Therefore, the distinction between trauma and adversity seems a meaningful one (Amaya-Jackson et al., 2021). Moreover, developmental psychopathologists have offered conceptual frameworks that differentiate among types of extreme stressors that profoundly threaten the development of the child, such as threat versus deprivation (McLaughlin et al., 2014), which partially overlap with but also supersede Criterion A definitions of trauma. What this literature reveals is that there is diversity in the types of developmentally-derailing experiences endured by young persons as well as in their subsequent consequences (Ellis et al., 2022). Even among Criterion-A defined traumas, such as childhood maltreatment, research is consistent in showing distinctive differences in the developmental consequences of, for example, physical abuse and sexual abuse (e.g., Guiney et al., 2022; Noll, 2021), particularly for adolescents (e.g., Putnam et al., 2020). Consequently, when viewed in the light of this research, childhood trauma exposure may need to be reconceptualized as a multidimensional construct. Moreover, traumatic experiences may act as a gateway or a transdiagnostic risk factor (Hostinar et al., 2023) for psychopathology; in other words, consistent with the developmental psychopathology construct of multifinality (Nolen-Hoeksema & Watkins, 2011), PTSD may be only one of the enduring outcomes that ensue when child development is disrupted by traumatic stress.

But, why might we need to take a specifically *developmental* perspective on Criterion A? First, it is valuable to consider the salience of cognition to the posttraumatic process, given that cognitive skills are well-known to change over the life course. As confirmed in a recent meta-analysis by Francis et al. (in press), there is poor correspondence between self-reports and objective (i.e., official records) measures of adverse and traumatic experiences in childhood; but, even more significantly, across studies, it is only subjective reports that are predictive of psychopathology. In samples with traumatic experiences ranging from earthquakes (Giannopoulou et al., 2006) to road accidents (Stallard et al., 1998), to a diverse set of Criterion A stressors (Verlinden et al., 2013), studies find that children's appraisals of events are more predictive of PTSD symptoms than are the severity of any other objective features of the event. Hence, appraisals are key in understanding risk and resilience in the aftermath of trauma exposure (Bovin & Marx, 2011; Bui et al., 2010), and this means that to understand the impact of potentially traumatic experiences on children and adolescents, we must perceive them from a child's-eye point of view (Kerig, 2017).

What is traumatic to a child? DSM-5 actually offers one clue in that, for children, the definition of Criterion A is tailored to provide that violence need not be a feature of any sexual abuse endured. Thus, to characterize an experience as traumatic to young persons, we need to go beyond physical threat. However, over and above the range of experiences to which Criterion A is limited in DSM-5, a developmental perspective requires that we acknowledge decades of attachment research which have shown definitively that reliable, loving care is essential to the psychological and physical well-being of children (Kerig et al., 2012). Even with all objectively necessary needs met for food, shelter and physical care, Spitz's (1947) observations showed that

young children deprived of loving caregivers failed to thrive and often withered away in foundling homes, suffering both emotionally and physically from what he simply and aptly termed "grief." Therefore, from a child's perspective, as Bowlby (1973/1988) argued, unavailability of a caregiver is as cataclysmic an experience as a classical Criterion A stressor such as war or natural disaster:

> Events that do not meet the A1 criterion for trauma among adults—for example, abandonment by a caregiver—may loom large when viewed from a child's point of view and when processed through a child's perceptual framework, and thus be interpreted as terrifying and even life-threatening (Kerig & Bennett, 2013, p. 432).

Beyond caregiver loss, other empirical research has confirmed that trauma looks different from a child's-eye point of view. For example, in a large-scale study of 1,420 children and adolescents, Costello et al. (2002) found that many youth construed as traumatic various experiences outside of the Criterion A definition, including unwanted pregnancy, losing a best friend, breaking up with romantic partner, moving, changing schools, parental arrest, and parental job loss. Similarly, in a community sample of children and adolescents, Taylor and Weems (2009) found that a significant proportion of the experiences youth defined as "traumatic" could not be classified into categories consistent with DSM, including separations from caregivers and exposure to media violence (with the latter expressly excluded from the DSM-5 definition of trauma). Youth also listed emotionally distressed states and behaviors that are typically thought of as *reactions* to traumatic events, such as nightmares, substance use, depression, and self-injurious actions, raising the possibility that, for young persons, what may be experienced as traumatic is not the event itself but its emotional aftermath (Taylor & Weems, 2009).

Tellingly, research further shows that many of these events that are inconsistent with Criterion A but deemed to be "traumatic" by young persons are associated with symptoms of posttraumatic stress. For example, using the same longitudinal dataset reported on by Costello et al., Copeland et al. (2010) found that non-Criterion A events were the most prevalent stressors experienced by children and adolescents; further, these experiences accounted for half of the cases in which youth exhibited significant PTSD symptoms, even when youth had no exposure to Criterion A events. Other prime examples include bullying which, despite not meeting Criterion A, is identified by children and adolescents as traumatic and is indeed associated with symptoms of PTSD (Idsoe et al., 2021). In addition, a significant literature has arisen recently regarding the need to recognize racism as a form of traumatic experience (Ayodeji et al., 2021; Bernard et al., 2020; Williams et al., 2021). Studies of young persons have confirmed that those who are subject to racism experience it as traumatic (Henderson, 2019) and evince symptoms of posttraumatic distress (Alvis et al., 2023; Bernard et al., 2021; Polanco-Roman et al., 2021).

Therefore, taking a truly developmental perspective into account calls for us to reconsider the definition of Criterion A, so as to encompass the range of experiences that are traumatic in the lives of children (and, perhaps, of some adults; see Dohrenwend 2010 and Hyland et al., 2021). Absent from the DSM-5 definition of trauma is an articulation of the underlying theoretical conceptualization that informs the restriction that the specific experiences specified—physical harm and sexual abuse—comprise the only sources of trauma. A better strategy might be to start with the question, "What makes an event *traumatic*?" and to go on from there to identify the kinds of events that qualify. Given that empirical research has demonstrated that children and adolescents deem a much wider range of experiences to be "traumas," identifying the common theme that underlies and unites those experiences might better lead us to the heart of the matter. Suggestively, many of the events identified by youth in these studies involve the potential for abandonment, loss of face, or social exclusion, all of which are inherently relational phenomena. The centrality of relationships to childhood—and especially the social world of peers in adolescence—cannot be underestimated by anyone with an understanding of young persons. Extrapolating from this observation, we might propose that the core of what makes an event traumatic across developmental periods may be that it is one that threatens the *loss of someone or something that is perceived to be essential to the physical or psychological integrity of the self*. Such a definition might better encompass the wide range of emotionally significant and psychologically harmful experiences that have been empirically demonstrated to result in posttraumatic stress during childhood and adolescence, in addition to those that are physically life-threatening. Consider, for example, the boy whose social world implodes when his classmates all join in humiliating and ostracizing him via a cyberbullying campaign; the preschooler who watches as her father is taken away for deportation by immigration authorities; the teenager whose family disowns and abases her when they learn of her pregnancy. Thus, rather than only threat of physical harm or sexual abuse, a developmental perspective on trauma must consider as traumatic those experiences that threaten to deprive one of that which a child feels to be critical to their going-on-being. In this regard, it is notable that Spitz's (1946) more formal term for the grief he observed in uncared-for children was *anaclitic* depression—literally, the loss of something on which one depends. In sum, a

psychologically- and developmentally-informed definition of trauma will need to encompass the wider range of non-Criterion A experiences that have been empirically demonstrated to result in symptoms of PTSD in childhood and adolescence. As Hyland et al. argue (2021), ICD-11's more open-ended definition of trauma might better accommodate such a psychological threat-centered perspective than DSM-5's more restrictive one.

Developmental Perspectives on Posttraumatic Symptoms

It should be acknowledged that the DSM-5 includes helpful text on the development and course of PTSD which offers some developmentally-specific symptom descriptions for children and adolescents; for example, avoidance is described as taking age-appropriate forms such as loss of interest in play in young children and reticence to engage in normative age-appropriate opportunities (e.g., driving, dating) in teenagers. There also is a separate set of diagnostic criteria for children under the age of six, which largely involve a reduction in the number of symptoms required and omission of cognitively complex symptoms that are not developmentally-appropriate for preschoolers (e.g., feelings of alienation or detachment). But these adaptations nonetheless fall short of a developmental conceptualization of how children are affected by trauma exposure. Beyond developmental refinements to the definition of Criterion A, therefore, a number of considerations are needed to guide us regarding the ways in which development comes into play in the expression of posttraumatic stress reactions across the life course (Kerig, 2017).

First, there are developmental differences in the ways that a given PTSD symptom typically is expressed, in keeping with children's emotional and cognitive developmental stages and capacities. For example, posttraumatic irritability may take the form of temper tantrums in preschoolers but of isolative behavior in teenagers (Kerig et al., 2012), just as hyperarousal may appear as separation anxiety in young children, but as risky behavior in adolescents (Kerig, 2017; Pappagallo et al., 2004; Pynoos et al., 2009). Development is also dynamic and ongoing, such that enduring effects of trauma exposure may emerge differently across time, in ways that reflect developmental transformations related to the child's maturation and increasingly complex transactions among the biological, cognitive, emotional, and interpersonal domains of development.

Development also comes into play in regard to the stage-salient issues that children are striving to navigate at each developmental epoch, such that the impact of trauma is heightened when it interferes with the mastery of those tasks (Becker-Blease & Kerig, 2016). Moreover, the concept of developmental cascades suggest that derailments of healthy trajectories at earlier points in the life cycle set the child up for failures in mastery of later stages and increase the risk for continuing disruptions to functioning over time (Masten & Cicchetti, 2010). From a biological perspective, there may be sensitive periods in development during which trauma exposure is particularly disruptive to neurobiological processes underlying capacities essential for self-regulation and healthy development, including brain plasticity and neurogenesis (McCoy, 2013).

In addition, as we noted in our discussion of appraisals, a young person's developmental level can impact their processing of a traumatic event which, in turn, influences the effect of that event on the child. Young children in particular are vulnerable to misapprehensions about traumatic events and it is this misunderstanding—rather than the actual circumstances of the event—that might be the genesis of posttraumatic distress (Kerig, 2017). Although with adolescence comes increasing cognitive sophistication and capacities for emotion regulation, agency, and self-protection, which can bolster resilience (Kerig, 2014), teenagers also may be stressed by adult expectations that they manage their distress self-sufficiently, as well as the unfortunate tendency for adults to attribute intentionality and blame to adolescents who endure traumatic experiences (Ryan et al., 2007).

Lastly, a developmental perspective on trauma is essential to informing effective treatment. Not only are there the usual considerations to keep in mind when providing therapeutic interventions to young persons, such as the challenges and benefits of including their caregivers in treatment, but treating trauma may involve some particularly developmental nuances. For example, O'Connor (2000) proposed that development may become "frozen" at the time of unresolved trauma. Thus, an adolescent who was a preschooler at the time of a traumatic event may comprehend the event at a preoperational level and revert to an earlier mode of functioning when triggered by trauma reminders, including those elicited in the context of therapeutic narratives and other forms of trauma processing. Therefore, "intervention techniques may need to be gauged at the level at which the child is processing the trauma as well as the child's current age" (Kerig, 2017, p. 46).

The Current Special Section

With these considerations in mind, the current special section was designed to bring together scholars who are blazing new trails by using developmentally-informed perspectives to understand the phenomenology of trauma exposure, posttraumatic stress, and related disorders. The special section

opens with a contribution by Weems et al. (2023), which utilizes the DSM-5 constellation of PTSD symptoms as a springboard to advance our thinking about the interface between trauma and development. As they point out, taking a developmentally-informed perspective requires appreciating development as a dynamic construct. Not only is development a matter of chronological time, but an interaction between the developing person and the stage-salient issues that come to the fore at each stage of the lifespan. For example, the lifetime effects of trauma exposure on an adolescent are distinguished not only by the teenager's current chronological age but also the point at which development was originally disrupted. The results of the authors' empirical research bears out this dynamic association of PTSD symptoms with age and time. Notably, specific symptoms were more likely to emerge over time in some age groups and to fade in others, reflecting age-related and temporal changes that have significant implications for the recognition and treatment of PTSD in adolescence and childhood. As the authors note, not only may two different youth meet criteria for PTSD by endorsing different symptoms but the same youth may meet criteria at two timepoints in different ways.

Given the diverse expressions of posttraumatic stress in childhood, Weems et al. also point to the importance of considering PTSD as a multifaceted, rather than a unidimensional construct. This is particularly the case due to the increased number of qualifying symptoms added to the DSM-5 version of the diagnosis, which surpass both the ICD-11 and earlier DSM definitions. These result in a wide array of different permutations of symptoms that all meet the diagnostic criteria; e.g., one youth may meet criteria for the hyperarousal cluster by evincing irritability and reckless/self-destructive behavior, whereas another might show only problems with concentration and sleep. Accordingly, scholars have begun positing the existence of discrete subtypes of PTSD in childhood and adolescence, with potentially different catalysts and consequences (e.g., Contractor & Weiss 2019; Kerig, 2019; Modrowski & Kerig, 2019; Weems, 2019). The present work adds a valuable undergirding to that proposition.

In the articles that follow, the contributions to this special section explore growing edges of the conceptualization of trauma beyond the DSM-5. In a seminal article, Ford (this issue) provides an update of an accumulated two decades of research devoted to validating the proposed diagnosis of Developmental Trauma Disorder (DTD), which describes a complex syndrome of childhood resulting from the combination of exposure to Criterion A trauma and inadequate or disrupted caregiving. The original report presented to the DSM-5 planning committee (van der Kolk et al., 2009) summarizing the need and accumulating evidence for this developmentally-sensitive diagnosis was a tour de force of scholarship and clinical insight. These scholars argued that DTD would benefit the field by encompassing the wide-ranging and cascading biological, emotional, cognitive, and interpersonal disruptive effects on the developing person of "failures in the average expectable environment" (Cicchetti & Valentino, 2006) that ensue when children are deprived of the kind of reliable caregiving that is essential to psychological health (van der Kolk et al., 2005). In addition, by placing apparently disparate symptoms under one umbrella based on their common etiology, the DTD diagnosis promised to meet the goals of parsimony and effective treatment planning (D'Andrea et al., 2012). Although ultimately DTD was included in neither the DSM-5 nor the ICD-11, scholarship has continued to be devoted to clarifying, assessing, and validating the diagnosis, which is incisively summarized here by Ford. Moreover, Ford offers a number of valuable insights into the ways in which the DTD concept can inform treatment by providing actionable interpretations of child and adolescent posttraumatic reenactments and challenging behaviors and attitudes toward others that otherwise might be mistakenly attributed to antisociality, hostility, or other disorders.

Continuing this theme, Tarren-Sweeney et al. (2023) provide an empirical examination of patterns of symptoms in a sample of maltreated children placed in long-term care. Importantly, these investigators went beyond either DSM-5- or ICD-11 PTSD-specific symptoms in order to investigate emotions, thoughts, and interpersonal behaviors associated with disruptions in the formation of a secure internal working model of attachment. Their results revealed strikingly different profiles characterized by varying patterns of symptoms associated with social instability and behavioral dysregulation, emotion dysregulation and distorted cognitions, as well as dissociation and other trauma-related symptoms. Consequently, when considering youth with histories of maltreatment and other attachment disruptions, they argue, in harmony with the DTD proposal, clinicians are advised to consider a broad range of affected developmental competencies beyond those specified in any one discrete disorder.

Although the developers of the DSM-5 and the ICD-11 concurred in that both failed to embrace the DTD diagnosis, the two systems diverged regarding Complex PTSD (CPTSD), an adult-oriented diagnosis developed to capture the unique symptom array that follows upon prolonged exposure to unescapable stressors. Beyond classical PTSD, symptoms associated with CPTSD include disruptions in affect regulation, self perception, and interpersonal functioning. Although not construed in a specifically developmentally sensitive manner, the CPTSD diagnosis is applicable to children and youth, particularly those subjected to ongoing interpersonal traumas such as childhood maltreatment.

Further, recent efforts to conceptualize, assess, and validate the diagnosis in young people have resulted in a growing body of empirical support (e.g., Kazlauskas et al., 2020; Redican et al., 2022; Sachser et al., 2022). A particular point of disagreement in the debates regarding the proposed CPTSD diagnosis was its apparent overlap with other syndromes, especially Borderline Personality Disorder (BPD) (Resick et al., 2012). Although a number of studies involving adult samples have now offered evidence for the distinguishability of CPTSD from BPD (e.g., Frost et al., 2020; Hyland et al., 2019; Powers et al., 2022), little has been done to clarify these distinctions across developmental epochs. To address this gap, in the present special section, Lawless and Tarren-Sweeney (2023) offer an empirical investigation of CPTSD and BPD symptoms in a sample of adolescents placed in foster care consequent to histories of severe maltreatment. The results echo those of this research group's companion study described earlier, in that the patterns of symptoms that emerged were highly complex and not readily subsumed under either diagnostic label. Intriguingly, these complexly traumatized youth were characterized by significant levels of attentional and behavioral dysregulation, which the discerning reader might note are both encompassed within the DTD diagnosis (see Ford). Accordingly, future research on this topic will benefit from considering DTD. Although advocates for DTD have not been deterred by its neglect in the official diagnostic compendia, and have continued to amass evidence in its support, as we have seen, it likely is the case that scientific progress has been deterred at least somewhat by the lack of official diagnostic status.

Although the ICD-11 and DSM-5 disagreed regarding inclusion of the CPTSD diagnosis, they both have long considered the possibility that prolonged or complicated grief might merit recognition in the trauma and stressor-related cluster. Indeed, prolonged grief disorder has been elevated to diagnostic status in the newly-published DSM-5-TR. Scaffolding this new understanding of maladaptive grief is multidimensional grief theory (Kaplow et al., 2019; Hill et al., 2019; Layne et al., 2017), a developmentally-informed model which describes how youth unable to move forward with a healing grief process may experience debilitating separation distress, loss of self, and preoccupation with the circumstances of the death. For this special section, Alvis et al. (this issue) elucidate a developmental perspective on the construct of grief, noting that loss of a loved one is a common form of traumatic experience in childhood, and describing how the manifestations of separation, identity, and circumstance-related distress might be expressed differently at discrete developmental stages. Consistent with a developmental understanding of trauma, these investigators point to the central role of caregiver-child relations in buffering young persons and enhancing their ability to adapt and be resilient in the face of traumatic loss. As the authors argue, the dearth of developmentally-sensitive criteria and measures to assess the disorder currently hinders our ability to fully apprehend its affects on children and adolescents; however, this team of researchers offers some promising advances.

The next paper in the special section addresses yet another potential expansion of the concept of trauma into the realm of what has been termed moral injury (MI), a construct which encompasses the effects of experiencing, witnessing, learning about, or perpetrating acts that violate one's moral code (Litz et al., 2009). Although originating in the study of adult military populations, MI recently has recently expanded to many other contexts. Most importantly for the current special section, scholars and researchers have begun investigating the ways in which disruptions of the moral compass have profound effects in childhood and adulthood (e.g., Chaplo et al., 2019; Haight et al., 2022; Kerig et al., 2016; McEwen et al., 2023; Wong, 2022). In Venn diagram fashion, the constructs of trauma and MI exhibit both partial overlap and independence—whereas not all traumatic events involve MI, and not all morally injurious experiences meet currently established definitions of trauma, those that are truly "high stakes" (Litz & Kerig, 2019)—for, example, a child who learns that her sibling is being sexually abused by their stepfather—may warrant consideration for both designations, especially when viewed through a child's-eye lens.

Consequently, it can be argued that the construct of moral injury has high relevance for researchers and clinicians who work with trauma and may in fact inform future diagnostic systems, particularly those with a developmental perspective. As Kidwell and Kerig (2023) point out, an understanding of the concept of MI is enhanced by considering its emergence in the context of developing self, cognitive, and moral systems, particularly as moral judgment and moral agency emerge in the context of attachment relationships across childhood and adolescence. Violations of the "social contract"—such as the expectation that adults should protect and care for children rather than harming or exploiting them—have been posited to underlie not only internalizing forms of distress, but also to fuel youth's engagement in vengeful and antisocial acts against the society that has betrayed their trust (Ford et al., 2006; Kerig & Becker 2010; Kerig, Wainryb et al., 2013). Accordingly, in this special section, Kidwell and Kerig (2023) provide an outline of a potential developmental model of MI, incorporating key developmentally-salient constructs such as attachment and betrayal, which are essential to the meaning-making processes by which youth come to terms—or fail to come

to terms—with harms they have endured, enacted, or witnessed.

Conclusion

The contributions to this special section illustrate the ways in which a developmental perspective enriches our understanding of the phenomenology of trauma exposure and posttraumatic stress. Development is a part of all lives—throughout childhood, adolescence, and adulthood—and so it only stands to reason that development is vital to consider in the investigation and treatment of trauma. With such a developmentally-enhanced understanding of trauma and its aftereffects, we are better equipped to use all our scholarly, scientific, and therapeutic tools to assist youth in achieving what Anna Freud (1965) deemed the essence of psychological wellbeing: the capacity to move forward in development.

Declarations

Conflict of interest I have no known conflicts of interest to disclose.

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