

Complex Post Traumatic Stress Disorder: Definition, Assessment, Treatment.
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Complex Post Traumatic Stress Disorder (CPTSD) is a clinical formulation (which may be included in the proposed DSM-V expected out in 2011) that refers to the results or outcomes of four simultaneous factors:

1. Chronic
2. Early
3. Maltreatment
4. Within a care-giving relationship

Maltreatment refers to abuse or neglect. Early, meaning occurring in early childhood; within the first several years of life. Chronic meaning a pervasive pattern, no a single or discrete event. Very important is that all the above occurs within a care-giving relationship. It is this last factor that makes the chronic early maltreatment so insidious and that leads to such pervasive negative effects on later development and impairment in so many domains of functioning.

The domains of impairment include the following:

1. Attachment
2. Biology
3. Emotional regulation
4. Dissociation
5. Behavioral control
6. Cognition
7. Self-concept

As a result of pervasive impairment, assessment must be multimodal and comprehensive in nature. This is important since “symptoms,” can have many causes and it is the cause that is the primary focus of treatment not the surface symptom. For example, anxiety can be caused by an anxiety disorder, brain trauma, PTSD, or various medical conditions. A comprehensive assessment of a child who has CPTSD must include, at a minimum, a review of all previous records, clinical sessions with the parents and with the child, and the use of various psychometric instruments to screen for a variety of issues. The areas that a thorough assessment must cover include: mental health differential diagnosis, sensory-integration screening, a screening for neuro-psychological issues, screening for executive function problems, attachment, developmental screening, consideration of Alcohol Related Neurological Dysfunction (ARND), and consideration of the nature and quality of the family’s interpersonal, emotional, and psychological constellation.

Children and adolescents with complex trauma require a multimodal approach (Cook, et. al., 2005), (Cook, Blaustein, Spinazzola, van der Kolk, 2003, Cook, Spinazzola, Ford, Lanktree, et. al., 2005). These authors identify six core components of complex trauma interventions, which are the following: “safety, self-regulation, self-reflective information processing, traumatic experience integration, relational engagement, and positive affect enhancement” (Cook, Spinazzola, Ford, Lanktree, et. al, 2005 p. 395).

Safety, actual safety and the client’s perception of safety, is vital for the creation of a secure base and a healthy attachment. At a minimum this must

include the absence of physical danger, emotional and psychological maltreatment, and other threats to the physical, emotional, psychological, and interpersonal integrity of the child. One aspect of this includes creating an environment in therapy and at home in which coercive and shaming interactions are reduced and eliminated (Becker-Weidman, 2005).

Self-regulation is achieved in treatment by focusing on helping develop and enhance the capacity to modulate arousal in a variety of domains such as emotional, behavioral, physiological, and interpersonally. Children who have experienced chronic maltreatment and complex trauma have difficulty with self-regulation, especially with affect regulation. They can become dysregulated quite easily. The co-regulation of affective states through experiences of parent-infant attunement necessarily precedes the ability to self-regulate such states (Schore, 2001). Such attunement experiences were very infrequent for most of these children. In one relevant approach, Dyadic Developmental Psychotherapy, the practitioner expends a considerable amount of attention and energy to dyadically regulating the child's level of arousal much like the responsive and attuned parent does (Hughes, 2007). The therapist functions to maintain a "therapeutic window" (Briere & Scott, 2006). The therapist actively works to avoid either inadequate or overwhelming activation of affect during treatment. If dysregulation occurs, the therapist acts swiftly to re-regulate the child, repair the relationship, and achieve emotional safety and balance.

Self-reflective information processing is achieved in treatment by developing and maintaining the shared affect, attention, and intentions that

characterize intersubjectivity (Hughes, 2007). Through these intersubjective experiences the therapist and caregiver assist the child in exploring past events again so that the experience of them can be reorganized. With these additional perspectives of the event, the child is much more able to reflect on it with new meaning and less terror and shame.

Traumatic experience integration can be achieved in treatment by using such techniques as the judicious use of psychodramatic re-enactments, role-playing, and the reading of relevant historical documents such as police reports (Becker-Weidman, 2006). Again, these interventions are only employed within the intersubjective context, with the need for psychological safety remaining primary.

Relational engagement is achieved in treatment by its emphasis on acceptance and by developing and maintaining a therapeutic alliance with all family members. The child's frequent avoidant or controlling behavioral patterns are likely to decrease when these are also met with acceptance. These defensive patterns are understood as viable coping strategies when the child has not been able to turn to attachment figures for safety. Engaging the child in a reparative relationship therapeutically and at home is an important dimension of complex trauma treatment.

Positive affect enhancement is achieved in treatment by the playful attitude of the therapist. In addition, the therapist's acceptance of the caregiver's and child's feelings and motives and the development of a deep level of empathy enhances self-worth. The positive regard with which the practitioner of Dyadic

Developmental Psychotherapy holds the family underscores their intrinsic worth as valued and valuable, as loved and loveable individuals (Becker-Weidman & Shell, 2005), (Hughes, 2007).

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