Trends in Research

Over the past several years there has been a significant amount of new research regarding the effects of maltreatment on the brain, later development, and interpersonal relationships. There has also been much promising work done in the area of assessing and treating Complex Post Traumatic Stress Disorder (CPTSD). There has been less research regarding the effects of various treatment methods and modalities on the attachment system and attachment relationships. This article will provide you with a very brief summary of some of this material…as such it is incomplete and I urge my colleagues to write material for this Newsletter on the topics I have omitted or neglected to discuss. A note on definitions. In this article the term "maltreatment" refers to various types of abuse and neglect. The term "treatment" refers to both psychotherapeutic interventions provided by a licensed mental health provider and therapeutic parenting approaches; usually provided with the support and guidance off the mental health professional. These definitions are the same as the ones used in the ATTACh White Paper on Coercion.

Recently there has been an increasing recognition that there are differences in the nature and quality of the effects of discrete trauma (Post Traumatic Stress Disorder [PTSD]) and early chronic trauma (Complex Post Traumatic Stress Disorder). Furthermore, it appears that treatment may need to be somewhat different for CPTSD than for PTSD. The children most of us work with seem to be best characterized by the concept of CPTSD.

CPTSD is "caused" by early chronic maltreatment. The results of CPTSD are impairment in six critical domains:

1. Attachment
2. Biology
3. Emotional Regulation
4. Dissociation
5. Behavioral Regulation
6. Self-concept

As a result of impairment in attachment, we find problems with relationship boundaries, lack of trust, social isolation, difficulty perceiving and responding to other's emotional states, and lack of empathy. Impairment in the biology domain is seen in sensory-motor developmental dysfunction, sensory-integration difficulties, somatization, and increased medical problems (See the CDC's Adverse Childhood Experiences research for more on this). Impairment in emotional regulation is seen in poor affect regulation, difficulty identifying and expressing emotions and internal states (under-developed reflective function), and difficulties communicating needs, wants, and wishes. Dissociation is seen in such behaviors as amnesia, depersonalization, discrete states of consciousness with discrete memories, affect, and functioning, and impaired memory for state-based events. Behavioral regulation difficulties are seen in problems with impulse control, aggression, pathological self-soothing, and sleep problems. Problems in the Cognition domain are seen in such things as difficulty regulating attention, problems with a variety of "executive functions" such as planning, judgment, initiation, use of materials, and self-monitoring, difficulty processing new information, difficulty focusing and completing

tasks, poor object constancy, problems with "cause-effect" thinking, and language developmental problems such as a gap between receptive and expressive communication abilities. Difficulties in the Self-concept domain are seen in a fragmented and disconnected autobiographical narrative, disturbed body image, low self-esteem, excessive shame, and negative internal working m models of self.

Since the effects of chronic early maltreatment (CPTSD) are so pervasive, treatment must necessarily be multi-modal. In other words, treatment must address each domain of impairment. One very important caveat from the treatment of trauma, generally, applies here. Above all else and first, there must be safety. It is vital that the child experience a safe, secure, welcoming, nurturing, and inviting environment. SAFETY first. Without an experienced sense of safety, nothing else can occur; no growth, no healing, no improvement. A second very important caveat is that "symptoms" serve important survival and adaptive functions. A necessary and essential part of treatment is being able to see the adaptive and survival basis for these problem behaviors so that the child is approached with empathy, which is a critical component of creating safety; the secure base that is needed for effective treatment.

The National Child Traumatic Stress Network has published an excellent White Paper, "Complex Trauma in Children and Adolescents, White paper from the National Child Traumatic Stress Network, Complex Trauma Task Force, 2003 (www.NCTSNet.org) This paper outlines the core components of CPTSD treatment as:

1. Safety
2. Self-regulation
3. Self-reflective information processing
4. Traumatic experience integration
5. Relational engagement
6. Positive affect enhancement.

There were three outcome or follow-up studies regarding Dyadic Developmental Psychotherapy(DDP) that appeared in peer-reviewed professional publications. In each instance there was a control group who received "usual care" (meaning individual, family, play or other forms of treatment at other centers for other providers). Both groups of children had scores in the clinical range on the outcome measures uses prior to treatment. The studies found that one year and four years after treatment ended, the children with received DDP had scores in the normal range and that there were clinically and statistically significant reductions in symptoms on the outcome measures. The children in the control group showed no changes after one year and statistically significant worsening of several scale scores after four years, despite having received an average of fifty therapy sessions during that time period.

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