

ISTSS Guidelines Position Paper on Complex PTSD in Children and Adolescents



International Society
for Traumatic Stress Studies

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In view of definitional issues and, with very few exceptions, the absence of studies specifically designed to answer possible scoping questions, separate draft scoping questions on treatments for complex presentations of PTSD were not included for this revision of the ISTSS Treatment Guidelines. The ISTSS Board agreed that rather than the Guidelines Committee undertaking systematic reviews to address specific scoping questions, it would likely be more beneficial to undertake a narrative review of the current situation with respect to “complex PTSD”. This position paper is a key component of the ISTSS guidelines; it considers what ICD-11 Complex PTSD is in children and adolescents up to the age of 18, how it should be defined to enable the development of an evidence base of how best to treat it and makes recommendations to facilitate further research. A separate position paper considers the nature, evidence for and treatment of complex PTSD in adults.

Overview

For the past two decades, there has been substantial debate about whether there are qualitatively different symptom profiles that can develop in children from different types of traumatic events and life circumstances. The term “complex trauma” is often used to describe both the presumed causes and the consequences of exposure to traumatic stressors when the child has experienced other significant adversities and is manifesting more severe clinical presentations. The interest in an additional descriptive term or diagnosis has been fueled by trauma-focused treatment trials pointing to the fact that the experiences of many children involve more than the trauma and more than trauma-specific symptoms (e.g., children in foster care, residential treatment, juvenile justice). Efforts to classify these clinical presentations have included a proposed Developmental Trauma Disorder (Ford, et al, 2013).

The ICD-11 addresses the phenomenon through the adoption of a new diagnosis called Complex PTSD (CPTSD). The diagnosis of CPTSD requires the presence of a specific symptom profile and a traumatic experience but the type of traumatic event (e.g. complex trauma) is a risk factor rather than requirement for the disorder. CPTSD requires meeting the ICD-11 PTSD symptoms and three clusters that represent disturbances in self-organization (affect dysregulation, negative self-concept and disturbances in relationships). The clusters comprise severe and pervasive problems in affect regulation; persistent beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to the stressor; and persistent difficulties in sustaining relationships and in feeling close to others.

Developmental Overview

The three new clusters of symptoms/behaviors described in the ICD-11 definition of CPTSD (affect dysregulation, negative sense of self, impaired relationships) are recognized within child development and child psychopathology. In child development and child psychopathology they are not necessarily specifically linked to responses to traumatic events or the presence of PTSD as required by the ICD-11. Thus, when present in children they may or may not be related to trauma exposure. As well, some behaviors may be developmentally appropriate for different age groups. For instance, temper tantrums or difficulty regulating affect could be considered normal or pathological depending on the child's age. For this reason, it is important to evaluate CPTSD as it relates to traumatic exposure for appropriate attribution or differential diagnosis. Although it may be hard to assess when symptoms emerge in children, the Disturbances of Self Organization (DSO) symptoms must have emerged after a traumatic event and in concert with other symptoms clearly related to the trauma (nightmares, active avoidance, hypervigilance, etc.).

Developmental psychopathology is a widely accepted framework for understanding childhood onset disorders. The main premise is that psychopathology in children reflects normal developmental processes gone awry within the constraints of conferred biological risks. Diagnosing children with CPTSD must be undertaken very carefully and requires developmentally sensitive and comprehensive assessment. Distinguishing fluctuations or temporary departures from normal developmental pathways is critical because children are in continuous development. In addition, these symptoms and behaviors appear in other diagnoses that may better explain them and be more appropriate for treatment focus.

CPTSD Disturbances in Self-Organization in Children

The three clusters of symptoms and behaviors reflected in the ICD-11 CPTSD disturbances in self-organization clusters are not necessarily specific to CPTSD and can occur in other disorders. One or more of them may be present as part of other disorders that more parsimoniously explain them, they may reflect common co-morbidities and they may not be enduring patterns. This is especially true for children who are in a process of development. Classifying the presence of these clusters as disturbances of self-organization would require a thorough assessment that arrives at a formulation that the presence of the clusters reflects disturbances of self-organization related to trauma as the underlying construct.

Emotion dysregulation in children has a variety of causes. Biology is assumed to contribute although the exact mechanisms are not yet clearly understood. Early attachment experiences are believed to promote or impair children's capacities for self-regulation. Environmental context (e.g., neighborhood disadvantage) and adverse experiences such as trauma exposure, family dysfunction or instability will also likely

influence emotion regulation. In developmental psychopathology, severe and persistent dysregulation is described as a form of irritability and is often a feature of disruptive behavior disorders. It can be present as well in anxiety or depression. Recently a new DSM-5 diagnosis, Disruptive Mood Dysregulation Disorder (DMDD), was created to specifically capture severe and persistent emotion dysregulation difficulties. There continue to be controversies about the need for the disorder because of overlap with other diagnoses and the fact that intervention studies so far show that existing positive parenting interventions with modest adjustments or teaching coping skills are effective for children with extreme emotion dysregulation. In other words, even extreme emotional dysregulation can respond to the standard interventions for children. However, some adolescents may be so dysregulated that they require inpatient psychiatric treatment.

Negative sense of self. A persistent negative belief about self is a well-known clinical phenomenon among children. It may be a specific symptom of a psychiatric disorder (e.g., depression) or it may be an outcome of a psychiatric disorder. For example, children with disruptive behavior disorders sometimes have low self-esteem because their behaviors evoke negative reactions from others. For children with PTSD, a negative sense of self may develop from shame, guilt or failure related to a trauma as specified in the ICD-11 CPTSD.

Core beliefs of worthiness and unworthiness can arise early in development. In attachment theory children develop secure or insecure attachment styles based on early interactions with primary caregivers, specifically attunement and responsiveness to distress. Children with secure attachment tend to have a positive view of their self-worth, whereas, children with anxious/ ambivalent, or disorganized attachment styles may develop core beliefs of unworthiness. Attachment styles are conceptualized as adaptive strategies. They may generalize to new environments or may change over time in new caregiving environments.

There are evidence-based treatments that address the negative sense of self in children. Several proven treatments specifically address attachment insecurity in young children. Positive parenting programs for disruptive behavior enhance parental warmth and responsiveness and teach parenting skills which in turn improve self-worth in children. Standard treatments for childhood and adolescent depression and PTSD directly address unhelpful cognitions about self-worth.

Persistent difficulties in forming and maintaining relationships or feeling close to others. Relationship difficulties in a child can be explained by various causal mechanisms, including trauma and complex forms of traumatic exposure. Difficulties with caregivers may be conceptualized as attachment related. In many other cases these difficulties for children occur in the context of relationships with peers or

non-caretaker adults. For children with internalizing disorders such as anxiety or depression, or externalizing disorders such as oppositional defiant disorder or adolescent substance use disorders, relationship difficulties may be outcomes of the condition. Children may avoid relationships and interactions due to fear of rejection or may interact in ways that are not perceived positively by peers or other adults. Children with disruptive behaviors frequently have relationship difficulties because their behaviors are challenging and they lack social skills. Children who have been exposed to severe neglect, especially in the first two years of life, may show a problematic pattern of disregard for social boundaries (e.g., excessive familiarity with strangers) in the early years. A new diagnosis has been added to the DSM-5 in the Trauma and Stressor-Related Disorders domain, Disinhibited Social Engagement Disorder (DSED). DSED may represent an appropriate DSM-5 diagnosis for classifying severe childhood attachment-related interpersonal problems in young children.

Elements of proven treatments for anxiety, depression and PTSD (e.g., exposure, behavioral activation, cognitive restructuring) or specific social skills training are effective for addressing relationship difficulties in children and adolescents with internalizing disorders. Family systems, parent behavior management, and community reinforcement interventions are effective in helping children and adolescents with externalizing disorders to improve their relationships.

Summary - Disturbances of self-organization hypothesized to be CPTSD symptoms may also arise independent of trauma or be aspects of common co-morbidities with PTSD (depression, anxiety, behavior problems). Therefore, clinical assessment of the temporal and functional linkages between trauma exposure and symptoms should be done with great care, on a case-by-case basis, in order to effectively inform further clinical care. CPTSD is a disorder that reflects more generalized and persisting patterns of impairment in self-regulation, identity and relatedness for children with the re-experiencing, avoidance and increased arousal symptoms of PTSD. From a developmental perspective, it is not yet known how enduring the patterns are for children who are still in the continuous developmental process. Specific symptoms in the CPTSD self-organization clusters are expected to reflect disturbances associated with the developmental phase at which the trauma occurs and may change over time with development.

Evidence of CPTSD in children and adolescents

At this time there is only very preliminary evidence to support the existence of CPTSD in children and adolescents. In the only extant published study that specifically sought to determine CPTSD in children and adolescents, Sachser et al (2016) created an approximation of the ICD-11 definition of the non-specific symptoms of CPTSD reflecting disturbances in self-organization. The three clusters representing CPTSD symptoms were: emotion dysregulation, negative self-concept and interpersonal

problems. Each construct was represented by two items drawn from different measures used in a randomized trial of trauma-focused cognitive behavioral therapy (TF-CBT). Latent class analysis revealed two distinct classes, PTSD and CPTSD. Both groups in the TF-CBT condition significantly benefitted from TF-CBT, but the CPTSD children had higher distress at baseline and at post treatment. This study provides initial support for two distinct classes of PTSD in children.

Treatment Implications

To date, there is not enough evidence to recommend a particular treatment for CPTSD in children. However, there may not be a need for an entirely new or different treatment for CPTSD. Many trauma-focused treatments contain components that address both the PTSD symptoms and the CPTSD symptoms of negative self-concept, emotion dysregulation, and difficulties in relationships and show benefits on outcomes other than PTSD. It appears, that children classified as having PTSD or CPTSD can benefit by TF-CBT, an existing effective trauma-focused treatment, although the CPTSD children somewhat less so (Sachser et al, 2016). This is consistent with the general finding in child psychopathology that children and adolescents with more severe clinical presentations and co-morbidities tend to benefit less from standard evidence-based treatments (EBTs). Therefore, adaptations of trauma-focused EBTs for children and adolescents, or of EBTs for other disorders that involve internalizing or externalizing problems similar to those comprising CPTSD, may be needed in order to adequately treat CPTSD.

Future Directions

Measures of CPTSD in children need to be developed. The items used in the Sachser et al study were selected from the measures used for the treatment study to approximate the ICD-11 CPTSD non-specific clusters. They did not develop a specific measure of CPTSD. There are current efforts underway to further test measurement of ICD-11 PTSD and CPTSD in children and adolescents.

At this time it appears that standard effective treatments for PTSD such as TF-CBT are effective for children who meet criteria for CPTSD but not to the same degree. This suggests that these children may need something more to achieve better outcomes such as additional sessions that more specifically or intensively target the specific CPTSD symptoms. Research could investigate whether active or more parent involvement, more of certain components, different sequencing of components, booster sessions, or the addition of other as yet unspecified components could further improve outcomes for CPTSD.

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