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TREATMENT OF CHILDREN WITH COMPLICATED POSTTRAUMATIC STRESS REACTIONS

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Complicated or complex posttraumatic stress reactions in children typically indicate a history of protracted trauma and often include both a greater number of symptoms with heightened severity as compared with children experiencing single-incident traumas. Complicated traumatic stress responses in childhood are usually more difficult to treat than less complex ones. Characteristics of the traumatic event as well as mediating and moderating variables, which can render the child susceptible to a complicated trauma reaction, are delineated in this article. Interventions are presented to address the diverse difficulties presented by children with a complicated trauma reaction, including safety planning, grief work, family therapy, cognitive–behavioral individual treatment, and utilization of various systems of childhood (e.g., school).

Diagnostic Criteria for Posttraumatic Stress Disorder in Children

The emerging consensus on the method by which posttraumatic stress disorder (PTSD) manifests in childhood has gradually evolved from observations of the symptom patterns found among adults afflicted with PTSD. Early on, it was noted that while the clinical picture in children with PTSD was similar to that of PTSD in adults, it also consistently exhibited departures from adult manifestations. Consequently, the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–IV*; American Psychiatric Association [APA], 1994) cited diagnostic criteria for PTSD specific to children.

These differences in PTSD in children extend to the very definition of trauma that constitutes Criterion A of the diagnostic criteria for PTSD. For example, in contrast to the adult definition of trauma, which is explicitly limited to threatened or actual violence or injury, the *DSM–IV* broadens the definition of trauma for children to include developmentally inappropriate sexual contact, whether or not it is accompanied by the overt threat of physical violence (APA, 1994, 2000). Further, the *DSM–IV* specifies that in children, the fear, helplessness, and terror that PTSD diagnostic Criterion A delineates must be associated with the traumatic event and may take the form of disordered or chaotic behavior.

Similarly, the *DSM–IV* elucidates the method in which the intrusive symptoms that compose Criterion B of the PTSD diagnosis displayed by children are commonly divergent from the forms they assume in adulthood. Reexperiencing of the traumatic event, in children, may present as recurring play with trauma themes. Analogously, while the content of nightmares for adults diagnosed with PTSD is trauma specific, for children, frightening content without a specific theme satisfies this criterion (APA, 1994, 2000). Additionally, in children, the flashbacks of traumatic events typically reported or observed with adults may appear in the form of behavioral reenactment of the traumatic incidents. For instance, it is common for sexually victimized children to engage in sexual or sexualized behavior with other

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children (APA, 1994, 2000; Faust & Kelly, 1999).

As has been observed among adults, child clinicians and researchers have discovered that the presentation of PTSD in childhood can vary dramatically with respect to the severity, chronicity, and number of symptoms expressed (Faust & Furdella, 2002; Norman-Scott & Faust, 2002). These variations in symptom characteristics may be determined by the nature of the trauma itself, by individual differences between clients, and by contextual variables such as the buffering impact of social support. Factors such as these can either ameliorate traumatic effects or complicate the trauma reaction, in turn affecting amenability to treatment intervention.

Complicated Trauma Reactions

It has been postulated that the long-term effects of multiple traumas are not effectively captured in the symptoms listed in the *DSM–IV–TR* (text revision; APA, 2000) definition of PTSD (Herman, 1992). After facing an ongoing trauma, children sometimes do not display "overt diagnosable disorders," yet they "profoundly distrust people, expect betrayal, and lose faith that life holds any justice or meaning" (Williams & Sommer, 2002, p. 227). While it has long been recognized that single-event traumas contribute to the formation of PTSD symptomatology, it has only been in the past 10 years that this diagnostic category has been broadened to include the effects of multiple traumas, including ongoing physical and sexual abuse. Review of the literature reveals the distinction between the impact of circumscribed and repeated or ongoing trauma; this distinction can be observed by the range of designations, such as acute versus chronic trauma, Type I versus Type II trauma (Terr, 1991), and simple versus complex trauma reactions (Herman, 1992). Lack of awareness of the markedly different impact of single versus chronic traumatization among practitioners has often resulted in failure to focus on the most relevant areas for intervention in victims of multiple traumas. Misdiagnosis in the form of conduct, depressive, and attention deficit disorders frequently occurs, often resulting in the core traumatic issue never being fully examined or treated (Terr, 1991).

To address this problem, Terr (1991) has delineated separate categories of catastrophic events that she labels *Type I trauma* and *Type II trauma*. Type I trauma consists of unanticipated single events that usually meet the *DSM–IV–TR* (APA, 2000) definition of trauma captured by Criterion A for diagnosing PTSD. The classic PTSD symptom clusters of repetition, avoidance, and increased arousal usually accompany this type of traumatic event.

In contrast, Type II trauma represents "long standing or repeated exposure to extreme external events" (APA, 2000, p. 15). Terr (1991) maintained that while children affected by Type II trauma will often present with the classic signs of PTSD, as is the case in Type I trauma, those with Type II trauma, because of repeated trauma exposure, will experience other psychological sequelae. In contrast to Type I trauma, Type II trauma is characterized by massive denial, psychic numbing, and personality problems.

Terr (1991) postulated that after repeatedly being confronted with traumatic experiences, the child earnestly attempts to protect the psychological self when he or she perceives that the physical self cannot be saved. These attempts to save the psychological sense of integrity include self-hypnosis and denial of distress (i.e., dissociation), which can later manifest as rage. This rage usually has no outlet, save toward the self, because most often the child's aggressor is someone who is trusted and more powerful than the child.

Herman (1992) also examined the effects of Type II trauma, which she referred to as *complex trauma*. Herman proposed that the considerably more diverse consequences of complex trauma require a more comprehensive diagnosis than PTSD typically observed in single-event trauma. She argued that complex trauma routinely results in major alterations in several fundamental areas of functioning such as affect regulation, consciousness, self-perception, and relations with others. Herman used the term *complex PTSD* to designate this varied but consistently observed constellation of difficulties that stem from prolonged traumatization.

Herman (1992) maintained that it is only when the treatment provider addresses these multiple areas of impairment that the client is able to effectively confront the traumatic origins of his or her symptoms. As survivors of complex trauma become aware that their psychological difficulties stem from their extensive traumatic background, they are less likely to attribute their symptoms to an inborn defect in the self. Herman

argued that by failing to include a diagnosis that subsumes the wide range of difficulties resulting from complex traumatization, the *DSM* conceptually fragments the effects of trauma. For example, somatic complaints that frequently are experienced by survivors of complex trauma are diagnosed as somatic disorders; their interpersonal problems often are categorized under the borderline personality diagnosis; changes in consciousness are demarcated as a dissociation diagnosis; and intrusive thoughts about and recollections of traumatic events are categorized under the current heading of PTSD (Herman, 1992). The consequence of diagnosing complex trauma survivors with these multiple divergent syndromes is that the traumatic origins of their varied difficulties are obscured. This, in turn, renders the adverse effects experienced by them as inconsequential, fostering self-blame and stigmatization by others.

Some of the effects of research, examining the divergent manifestations of circumscribed versus repeated trauma, have received limited recognition in the *DSM–IV* (APA, 1994). The *DSM–IV* committee charged with defining PTSD responded to empirical findings documenting the complex reactions that occur in response to repeated traumatization by tentatively proposing a diagnostic category labeled *disorders of extreme stress not otherwise specified* (DESNOS), a term often used interchangeably with Herman's (1992) designation, *complex PTSD.* Some considerations for assessing complex trauma reactions and DESNOS have been added in the "Associated Features and Disorders" section of the PTSD diagnosis (APA, 1994, p. 488). Similarly, the framers of the ICD-10 (World Health Organization, 1992) developed a completely separate category to delineate enduring personality changes after traumatic experiences (F62.0). These psychological manifestations include permanent hostility and distrust, social withdrawal, feelings of emptiness and hopelessness, increased dependency and problems with modulations of aggression, hypervigilance, and feelings of alienation (World Health Organization, 1992).

Investigations based on data from the *DSM–IV* field trials concluded that people traumatized at an early age seemed to experience a spectrum of problems that was neatly encapsulated within the DESNOS category. In fact, it was found that the longer the duration of exposure to trauma and the less protection received from the effects of the trauma, the greater the prevalence of DESNOS rather than of PTSD alone (Pelcovitz et al., 1997; Van der Kolk, Perry, Pelcovitz, & Mandel, 1993). These studies also concluded that ongoing trauma led to the most extreme effects when it occurred during the first 10 years of life.

Tremblay, Hebert, and Piche (2000) used comparison groups to show that Type II trauma is prevalent within a sample of sexually abused children. This particular group of children displayed more anxiety and depressive symptoms than the medically compromised and community sample groups. Parents of sexually abused children also reported that their children experienced more dissociative symptoms than the other groups.[1] The sexually abused group manifested more aggressive behaviors and used avoidant coping strategies more frequently than the two comparison groups.

In a sample of sexually abused children, Hall (1999) found that those who were diagnosed as meeting full criteria for PTSD and who experienced the greatest cumulative number of negative events scored the highest on a measure of complex trauma symptoms. In this study, *negative events* were defined as multiple incidents of interpersonal trauma. Hall concluded that the complex-trauma model explains why some children develop PTSD while others do not develop the constellation of symptoms. Hall also mentioned that this model shifts the perspective away from a "stimulus–response paradigm" to a "broader systems' view," which can help identify possible moderating and mediating variables of multiple trauma (p. 66).

Hall's (1999) advocacy of a systemic approach to understanding the impact of chronic traumatization has been echoed by researchers in the adult PTSD area such as Gold (2000), who argued that trauma exposure in and of itself is not sufficient to explain the wide-ranging symptom presentation in individuals exposed to prolonged trauma. These researchers have identified mediating and moderating or risk and protective factors that aid in clarifying both trauma expression and its amenability to treatment. In fact, the severity, length, and number of exposures to the trauma may not be the primary factor that dictates long-term psy-

[1]The term *parent* throughout the text refers to any primary caretaker of a child.

chological difficulties in survivors of prolonged trauma; there may be a number of variables external to the traumatic event itself that affect the traumatic response. Gold (2000), for example, provided evidence that children who are subjected to ongoing abuse often grow up in chaotic and ineffective family environments that in themselves contribute to chronic maladjustment in adulthood.

Risk and Protective Factors in Youth Trauma Reactions

Child research has demonstrated a host of variables, which can mediate or moderate the psychological impact of life events. Investigators have identified factors that impact children's resiliency or that buffer the impact of trauma or stressful life events. For example, in the pediatric psychology literature, it has been found that children with supportive peer relationships adjust better to their chronic illnesses and concomitant complex medical regimes than those children without such peer relationships (Reiter-Purtill & Noll, 2003). Studies have also highlighted the importance of family support, parent and family organization, and reduced family conflict in determining children's general adjustment. Researchers have begun to identify protective and risk factors that impact children's reactions to trauma. In fact, some have noted that problems commonly found in children traumatized by abuse may be influenced more greatly by risk factors than the maltreatment experience itself (e.g., McClellan, Adams, Douglas, McCurry, & Storck, 1995). Faust and Norman-Scott (2000), for example, discovered that the greater the family conflict and the lower the level of family organization, the more severe the trauma reaction in sexually abused children.

There are less data available that identify mediating and moderating variables in the expression of PTSD in children. However, the literature that does exist indicates that the protracted potency of the expression of trauma symptoms may be influenced by maternal adjustment, level of family cohesiveness, support, and conflict (e.g., Runyon, Faust, Kenny, & Kelly, 1997). By extrapolating from the general child adjustment and coping literature, one can discover that variables important in protecting or buffering trauma symptoms in children that have not been well researched include not only family variables but a number of competencies, including peer relationship and academic skills (La Greca, 2002; Reiter-Purtill & Noll, 2003).

If children's adjustment is contingent upon these factors, then the less available these buffering variables are and the greater the presence of risk factors, the greater the potential for symptom severity and symptom duration, and hence the more complicated the overall trauma reaction becomes. It is likely that children with the greatest severity and complexity of symptoms and the least resources and buffering factors will present the greatest treatment challenges. While treatment-outcome research lags significantly behind basic research and adult research in general, there is an even greater delay in the progression of science in child treatment outcome. The treatment outcome research that does exist, although scant, identifies the utility of cognitive–behavioral therapy (CBT) and family systems therapy (FST) for children with PTSD who have been exposed to sexual abuse (Faust, in press).

While empirical treatment-outcome data have begun to illuminate the efficaciousness of treatments in general, such data typically do not identify nonresponders, the active ingredients that account for treatment efficacy, or individual-difference factors. Applicability of these findings to individual cases is therefore often limited. This is especially the case with children experiencing complex trauma reactions, since empirical treatment outcome studies tend to be reductionistic in design, employing exclusionary criteria that eliminate multiple problem cases and limit samples to those meeting criteria for PTSD. In this respect, studies routinely attempt to maximize reliability at the expense of ecological validity. Alterations of manualized, empirically based treatments for PTSD are needed for children presenting with complex trauma reactions, who frequently come from environments with scarce protective factors and numerous risk factors. To determine an appropriate plan of intervention in these cases, the clinician must consider a number of operative factors.

Treatment of Complicated Trauma Reactions

Irrespective of how one defines a more severe, protracted, and complex trauma reaction, the professional must modify treatment accordingly to effectively address this appreciably more involved variation on PTSD. The practitioner must

take into account real-world variables and those previously identified in the literature that have the propensity to complicate the trauma reaction and render it less amenable to direct treatment. Key factors that must be considered include the following.

1. Safe Environment/Survival

With respect to the practical consideration of real-world variables, primary survival is the overriding priority. Hence, the practitioner first must assess whether the child has been removed from the traumatizing stimuli and has been subsequently placed in a safe environment. If not, child protective services agencies, law enforcement personnel, or the judiciary (for some cases that are already in the system) must be involved. Not only does exposure to unremitting traumatizing events place the child in danger, but such a situation also renders trauma treatment moot if the child is living in an environment where traumatization continues. Unfortunately, there are some situations that arise in which the practitioner may not know that the child is continuing to live in traumatizing circumstances even while being treated. Owing to the existence of such cases, the practitioner must monitor treatment progress with this question in mind. Should the child continue to exhibit trauma symptoms throughout treatment, one must consider that one possible explanation for this is that the trauma is being perpetuated or repeated.

2. Safe Relocation

The next priority after safety has been established is to address secondary survival needs. Prior to commencing treatment or during treatment, it is not uncommon for changes in residences to occur, especially when working with traumatized, maltreated children. Home placement and the children's adjustment to home placement will be a key consideration prior to targeting the existence of new forms of traumatization. Immediate safety concerns for children and adolescents must be addressed and monitored closely as these youth will be impervious to treatment if they are concerned about their safety in their new environment. That is, worries about food, shelter, and safety are frequently present in response to relocation.

In addition to removal from their residence and relocation in a new placement to ensure their safety, children may also lose their residence because of adverse events and natural disasters. Together with the loss of this shelter, the destruction of their home environment entails forfeiting personal items that help provide an identity for children such as photographs, home movies, and special stuffed animals. Unfortunately, in some cases, death of a caretaker or pet can complicate the trauma reaction.

3. Grief Reactions

In cases of complex trauma, a child often loses someone close to him or her—(a) by being removed from the family environment, (b) because a primary relative in the home had to relocate out of the home, or (c) by the death or destruction (e.g. fatal accident, domestic violence, natural disaster) of a close individual. Such losses can raise issues related to survival instincts as well as of mourning and grief. Grief work must be conducted prior to addressing the posttraumatic stress reaction, and the processing of grief should be revisited periodically as it emerges throughout the course of treatment.

4. Risk and Protective Factors

Age may be a factor in children's response to traumatic events and will often dictate the course of therapy. For example, for very young children, cognitive components of a cognitive–behavioral intervention strategy may exceed the child's developmental capacity to comprehend abstract conceptual material. Age may also affect the severity of the trauma response; for example, some studies have shown that a child is at greater risk for adverse effects of sexual abuse in the first 10 years of life than later in life (Hall, 1999; Faust & Kelly, 1999). One can argue that this is the case because children are attempting to master crucial and fundamental cognitive and emotional developmental attainments within these years. Erik Erikson, Jean Piaget, and Lawrence Kohlberg have delineated personality, cognitive, and moral models of developmental progression in children. In each stage of development, traumatic events may be reorganized and experienced differently. Therefore, child sexual abuse and other traumas must be examined through the context of a developmental lens.

Family variables may also influence both the traumatic reaction and the progression of therapy. Families with greater conflict and disorganization may be less likely to provide a safe environment

once the child discloses abuse or other trauma. The parent may blame the child for abuse and thus alienate the child from an essential source of support. In fact, consistent maternal support of sexually abused children has been shown to be a major predictor in favorable child-abuse outcomes (Harter & Neimeyer, 1988). Parental psychopathology, even that of vicarious PTSD symptoms in response to the child's victimization, can be a key factor preventing adults from attending effectively to the traumatized child's needs. It has been well established that depressed mothers parent ineffectively and that this factor can contribute substantially to maladjustment in children (e.g., Forehand, Lautenschlager, Faust, & Graziano, 1986).

The invalidating impact of lack of family support can engender feelings of rejection and shame, which places the child at further risk for abuse and victimization. It is also important to note that families who do not adequately protect their children are less likely to report adverse and abusive incidents to authorities. The failure to report such adverse events signals to the perpetrator that there will be no repercussions for abusive behavior, literally placing the child in harm's way. The consequent increase in feelings of being unsafe can exacerbate PTSD symptoms, particularly general arousal, hypervigilance, and nightmares.

Children, especially adolescents, can draw upon social support within their peer groups to buffer the effects of sexual abuse and other traumas. From such support, they may experience validation from their peers, thereby lessening their feelings of shame and guilt. Peers may also offer safe physical environments to reduce the chances of repeated sexual abuse. A number of abused children will spend time at their friends' homes after school to avoid placing themselves at risk of abuse in their own home environments. The medical psychology literature also substantiates that children with traumatic medical situations fare much better with good peer support than those children without such a social support network (Reiter-Purtill & Noll, 2003).

Finally, academic success could be considered another potential buffer to ameliorate the negative effects of traumatic experiences and stressful life events. Success in this arena has been postulated to enhance the child's sense of self-efficacy and control (Masten & Coatsworth, 1998). In addition, the enhancement of reasoning skills and knowledge through academic achievement can contribute to increasing youth's adaptive coping capacities.

By shoring up these protective and buffering factors and intervening to diminish or eliminate risk factors, the intensity of children's responses to trauma can be correspondingly reduced. Involving the school system to capitalize on the child's academic, athletic, artistic, or musical talents can enhance self-efficacy and coping ability. Aiding a child and his or her caretakers to mobilize peers and friendships in the face of adversity can reduce the intensity and duration of the traumatic response.

Treatment

Although the literature examining treatment effectiveness for PTSD is scant in general, research on childhood PTSD treatment has lagged significantly behind that of adult work. In reviewing the literature, it is evident that two treatments are used more frequently than others for the treatment of PTSD. Both family systems and CBT appear promising in the treatment of adults with PTSD; more recently, preliminary evidence has suggested both to be useful in treating children with PTSD. Faust, Norman-Scott, and Hutchings (2001), in a National Institute of Mental Health study, found that both family systems and CBT are effective in reducing psychological sequelae in sexually abused children with PTSD. However, there are few data to indicate whether one treatment is more effective than another in treating complex trauma responses. Clinically, Faust (2000) noted that both forms of therapy can be combined. In Faust's Child and Adolescent Traumatic Stress Program, both treatments are often utilized in complex cases of child-abuse trauma manifestations. Both theoretically and conceptually, the use of individual therapy in combination with family intervention is warranted for complicated trauma cases in that the contextual variables that mediate or moderate the trauma responses are often family related. For example, as delineated above, family conflict, lack of cohesion and support, poor supervision, perpetrator relationship to the family, and parent psychological adjustment have all been identified in the literature as impacting children's responses to trauma. The common factor among these variables is their familial context. It follows, then, that in addition to addressing the trauma skills

directly, intervention must target the structural context that impacts the trauma response, namely, the family.

The individual component of the therapy can shore up coping skills and target the trauma symptoms directly. However, one must be careful that the form of individual treatment selected does not violate theoretical assumptions inherent in the family treatment approach employed. For example, CBT and family therapy can be easily combined without violating the theoretical premises of either. However, one could not conduct both individual psychodynamic psychotherapy and family therapy, since the unconditional stance of the individual therapist must be altered to allow the family practitioner to move freely in and out of family system process. In these cases, different therapists would be needed to conduct and share each of the respective treatment modalities to prevent this type of contamination of the treatment process

Complex Trauma Reaction and FST

A majority of the FST PTSD research has focused upon adult subjects, primarily war veterans. Sexual abuse is a frequently identified trauma in children, and the child-abuse literature has identified FST as a viable treatment modality in the treatment of sexually abused children, although research does not discriminate among diagnostic groups. There is a small recent body of research supporting the effectiveness of FST in the treatment of sexually abused children with PTSD (Faust, Ransom, Weiss, & Phelps-Doray, 1999; Faust et al., 2001). Results have indicated that FST significantly reduced anxiety symptoms and depressive symptoms from pre- to posttreatment in these children. Family therapy appears to be a particularly viable treatment choice in complex trauma cases since family variables have been identified that complicate the trauma reaction (see above).

One of the most important premises of FST is that behavior problems and psychological symptoms are not caused in a linear fashion but rather are initiated and/or maintained in a circular manner within an intimate community (i.e., the family). This means that the therapist does not implicate the direction of causality from one source directly to another but rather that the problems develop in an interpersonal context in a multidirectional fashion. The therapist who views symptom presentation as circular would focus on the parents' behaviors in determining problem manifestation while simultaneously gleaning the manner in which the child elicits responses from his or her parents, which determines the behavior in which he or she ultimately engages. Further, the systemic therapist would attempt to determine how other family subsystems (and other nonfamily systems, such as schools) impact the child and his or her parents' exchanges as well as how these exchanges in turn impact the family subsystems (and external systems). This is particularly important in addressing complicated trauma reactions in children. As noted above, peer and academic competence can markedly ameliorate the impact of stressful life events.

FST therapists alter the family structure in various ways to promote the ultimate goal of symptom reduction and elimination. Two forms of systemic therapies include structural family therapy and strategic family therapies. Structural family therapists conceptualize the family as a system that functions in a specific social context. The system operates in a series of transactional patterns (Minuchin, 1974). Transactional patterns are automatic (by means of repetition) methods by which family members interact with one another (Faust, in press). One outcome of these familial transactional patterns is the determination of roles family members assign to one another as well as the power ascribed to each role.

Family transactional patterns help outline the boundaries between family members, other dyads or triads, and other subsystems. From the FST perspective, family-member exchanges also help dictate the boundaries among and between individual family members as well as defining subsystems within the families. The boundaries help to regulate and modulate the amount and kind of contact that family members have with one another as well as with others outside the family system (Minuchin, 1974). Hence, the boundaries also serve to determine the responsibilities and power that are attached to family roles; they protect the individuality of each family member and shape their contributions to family homeostasis. The parent role, as an example, is one of executive power with a clear delineation between children and parents since the head of household, or executive subsystem, has great responsibility to protect the children within the family system. It is a deterioration of the boundaries and thus the

roles and concomitant power that contribute to the formulation of family system derailment.

Children who are at risk for, and have been subjected to, trauma are often given more power by their families than they can assimilate. Giving children too much power in a family system fosters the self-perception that they are in charge of their own well-being. Knowing that they are unable to protect themselves on many levels as adults, they feel vulnerable and unsafe. When children who are ascribed excessive responsibility for their own welfare are traumatized, this reinforces the sense that they are in danger, and trauma symptoms persist (Faust, in press; Faust, 2000). Redistribution of power after a child has been traumatized can inappropriately change the roles that the child previously assumed in the family. Furthermore, by assigning the child a role with an inappropriate degree of power, boundaries change between family members. The goal of structural FST for traumatized children is to alter the family structure and interactions such that power is appropriately ascribed and roles are adequately delineated, thereby enhancing feelings of safety and reducing trauma symptoms in children.

The other form of systemic family therapy—strategic family therapy—postulates trauma symptoms to be the result of maladaptive communication in the family system. Therefore, strategic family therapists identify dysfunctional repetitive patterns of family communication that are contributing to the maintenance of these traumatic symptoms. Strategic family therapists address problems that evolve from all levels of family communication. Intervention mirrors the content, level, and process of communication. From this theoretical perspective, families become immobilized by repetitive ways of maladaptive communicating and problem solving. Hence, these therapists enable families to problem solve in ways in which families have not previously considered.

FST conceptualizes trauma symptoms as developing because of the family communication patterns and interactions around the traumatic event. Research has delineated that families of traumatized children and adults have greater familial conflict, are less supportive and more isolated, and have problems with communication as well as with the assignment of age-appropriate tasks and responsibilities (Faust & Kelly, 1999). As a consequence, the traumatized patient in such a family system experiences a sense of vulnerability, increasing susceptibility to fearful feelings and hence to PTSD symptoms. In the case of domestic violence as the traumatic event, some of these violent families demonstrate poor boundaries, a subservient mother figure, lack of interpersonal support, family disorganization, and high conflict, ultimately leading to problems in the roles each family member assumes and the manner in which they implement associated responsibilities. The oppressed mother may lend her power to her child who will often identify with the aggressor (father-figure) parent. The violent father will encourage such identification, thereby inadvertently strengthening the child's pseudoparental role. Hence, the child is assigned a role that is nearly equivalent to an executive head of household (i.e., parent), and the mother has inadvertently relinquished her parental role to her child. She once again has become subservient to her partner as well as to her child. Hence, the child who has now been reassigned a role as his or her own parent may then feel responsible for his or her own parenting, including safety and protection. This causes the child to feel susceptible to imminent harm, and thus PTSD symptoms persist, even after the termination of the domestic violence or other traumatic circumstances. These familial messages are not only delivered overtly. They are also conveyed covertly through the vehicle of meta-communication.

Frequently, prior to addressing the issue of abuse, the professional must address broader systemic issues. For example, in her strategic family therapy protocol, Cloe Madanes focuses on the lack of protection within the family as key in the treatment of sexually abused children. She frames the abusive episode as being limited to an exceedingly brief period of minutes out of the child's entire lifetime, in contrast to the constantly present impact of general family functioning (e.g., Madanes, 1990). While she does not explicitly distinguish between circumscribed and ongoing trauma, it is implicitly evident in her discussion that children who have been traumatized and who have posttraumatic symptoms and concomitant psychological sequelae struggle with lack of protection. Once there is a realization that they are safe and can mobilize both internal and external resources to ensure their protection, trauma symptoms as well as mood-related symptoms remit. In families where children have complicated trauma reactions, it is evident that family

disorganization and chaos prevail. It is particularly advantageous for children with complex trauma reactions to heighten their sense of safety and protection by addressing family functioning through systemic family intervention.

Individual Therapies for Complex Trauma Reactions

Once family therapy has been implemented to address some of the complicating variables in complicated trauma reactions, individual therapy can enhance the child's sense of mastery and self-efficacy, thereby shoring up adaptive coping mechanisms.

Cognitive–behavioral. As is the case for many childhood disorders, CBT efficacy research for traumatized children has evolved from adult research. For example, the work of Foa, Rothbaum, Riggs, and Murdock (1991) indicated that both classical conditioning and operant conditioning and the cognitive component of information processing are responsible for the PTSD reaction in adult rape victims. Hence, they have published studies demonstrating the efficacy of graduated exposure and cognitive restructuring in the treatment of adult rape victims (Foa et al., 1991). This model appears to be extremely appropriate in the treatment of children who have complicated trauma reactions, given the theoretical suppositions of fear acquisition.

From a classical conditioning perspective, it is likely that there is a generalization of the fear response, especially in complex trauma cases. It is believed that individuals who have severe PTSD or complex trauma reactions have associated the trauma with a myriad of previously neutral or nonneutral stimuli, thereby generalizing their fear response across many different situations. This may explain the extensive avoidance observed in these children, as well as a frequently identified complex and/or extensive symptom presentation. Operant conditioning also appears to play a role in shaping trauma reactions. Individuals successfully avoid the generalized traumatic stimuli, reinforcing such escape. Consequently, they have learned to "turn off" the unpleasantness associated with the conditioned stimuli.

In addition to learning or conditioning, other unique trauma symptoms such as flashbacks are explained through cognitive interpretation of the event. Cognitive processes may explain why children have a more deleterious and complex response to incest than extrafamilial abuse. "If the abuse occurs in the home by a caretaker then the child is likely to associate many environmental stimuli (including a variety of components of parenting) to the trauma and the perceived threat of abuse" (Faust, 2000). Additionally, children abused by an involved caretaker often feel more hopeless and distrustful than children traumatized by someone external to their family of origin. Hence, it is the cognitive interpretation of the traumatic event that may be of primary importance in the development of symptoms. There are data to indicate that children abused within the family have a more negative view of the world than those children abused by nonfamily members. A comprehensive CBT model is therefore employed that considers the many features of PTSD and complex trauma reactions in children and the theoretical underpinnings that drive such a reaction.

In applying this CBT model, stimuli that engage the fear response are first addressed through systematic exposure/desensitization to extinguish the fear responses across situations. Systematic desensitization, a form of reciprocal inhibition, is incorporated to pair stimuli that elicit the fear response with a relaxation technique. Through such exposure, the connection between trauma-associated stimuli and the fear response is severed. In addition, since the child is prevented from terminating the unpleasantness associated with the traumatic stimuli in a safe environment and has utilized adaptive coping strategies, nonadaptive avoidance is not reinforced. Finally, children are instructed in positive self-talk to change their cognitive attributions of the traumatic stimuli. Cognitive reappraisal is particularly important for complex trauma cases since there are a myriad of variables and life events apart from the traumatic situation that can lead to protracted trauma responses. Hence, the therapist can help the child alter his or her understanding of the family situation, both related to the traumatic event as well as independent of the event. It is through this cognitive rehabilitation that children strengthen their mastery of fears and heighten general self-efficacy, which allows them to reinterpret both the traumatic events and their life situation in a more adaptive manner.

CBT intervention for PTSD. CBT for the treatment of PTSD includes four procedures: (a) coping-skills instruction; (b) relaxation training;

(c) systematic desensitization, both imaginal and quasi in vivo; and (d) behavioral parent education (with a possible emphasis on contracting to enhance compliance and extinguish the fear response).

The first segment of the module is to disseminate to children active coping skills by which to directly reduce anxiety and disconnect the association of anxiety and the reinforcing qualities of avoidance. These skills also increase the patient's sense of mastery and self-efficacy and locus of control, since it is a skill children can actively and directly do themselves, in order to conquer their fear and anxiety. Adaptive self-statements are taught to facilitate coping both as the child engages in the desensitization (see below) as well as when he or she is confronted with feared stimuli in other areas of their lives. Many traumatized children make distorted self-statements because of the traumatic event and as a response to their maladaptive family and environmental situations. In addition to desensitization procedures, session time includes teaching the child to identify and challenge maladaptive self-statements, especially those related to the trauma and concomitant fear. The child is also instructed to generate adaptive cognitions and attributions as well as to replace the maladaptive self-statements with adaptive ones.

The second CBT component includes the instruction of relaxation skills. Once the individual has mastered these skills, a fear hierarchy is developed. Relaxation techniques developed especially for children, including diaphragmatic breathing and progressive body-muscle relaxation, are utilized. Such relaxation modification for children includes imagery incorporated and attached to the tense–relax phase of each muscle group. Once the therapist instructs the child in progressive muscle relaxation, an imaginal scene of a relaxing safe place is affixed to the procedure.

After the therapist completes the relaxation training, he or she will need to initially develop a fear hierarchy with the child and parent independently. Often, the child, because of the avoidance component of the PTSD, will be unable to provide details of the traumatic event or feared stimuli for the fear hierarchy. The caretakers may be helpful in filling in the gaps as well as other sources of information such as police reports, newspaper accounts, and court documents. The hierarchy includes both those items that the child cognitively fears (he or she can verbalize) as well as those stimuli that are actively avoided. The child and parent independently rate the child's level of fearfulness for each item on the hierarchy. Next, the child and therapist work alone together so that the child is exposed to the feared stimuli imaginally, through the therapist's description of the feared stimuli.

In addition to aiding in the development of a fear hierarchy, the primary caretakers are also included in the treatment as they are instructed in parenting skills to enhance their child's coping. They are instructed to reward appropriate use of coping skills, including the child's use of adaptive self-statements. The caretakers are also taught to help eliminate maladaptive fear responses. For example, the parent may be asked to not attend to a specific component of a fear response while simultaneously reinforcing more adaptive responses (differential reinforcement of alternate behaviors; Faust & Kelly, 1999). Parents are instructed in the use of effective reinforcers, including tangible, verbal, and nonverbal rewards; they are also taught when to administer these rewards and under what conditions. To integrate all of these parenting skills, caretakers are taught the methods by which to develop a written behavioral contract. The instruction of the parent skills is delivered through the imparting of direct information (including written handouts), therapist modeling and demonstration, and shaping in session when caretaker and child are present.

Integrating Family Systems and Cognitive Behavioral Therapy

The integration of FST and CBT is particularly important for those individuals with complex PTSD since it is the individual's context that likely complicates stress reactions. As stated previously, it is possible to integrate both FST and CBT for PTSD without violating theoretical assumptions of either, since FST focuses on family context and environment and the latter addresses the development of individual coping responses of the child. In fact, it is likely that by focusing both on the context in which the trauma occurred and/or in which the child lived during the event as well as on individual coping resources, recovery may be enhanced, particularly in cases of complicated trauma reactions since the therapist can facilitate the child's environment to maximize therapeutic gains.

There are several alternatives in the method by which treatment can be integrated. Sometimes, the therapist will start treatment with individual CBT so as to reduce the resistance of the family. By working individually with the child first (and including the caretakers as aids in their child's behavioral contracting, etc.), therapists allow parents to have the chance to become acquainted with the therapist as well as to observe the results of treatment. This enables the parents to trust the therapist. This trust heightens their receptivity to FST. An alternative combined treatment method is to divide the sessions so that half of the session is devoted to individual CBT and the remaining half to FST.

Finally, on occasion the integration of CBT with FST occurs at specific points in family therapy. For example, cognitive restructuring and desensitization can be incorporated around the time when the FST therapist places the trauma in context, reducing the traumatic event to hours or minutes of the child's lifetime. Similarly, direct integration can also include incorporation of the parent-training package of CBT while restructuring the family system. These components dovetail easily together such that on many occasions caretakers must reclaim their executive head of household (top of the family hierarchy), and the parent component of the CBT package helps to empower them to do so. By empowering the parents, parents are able to set appropriate limits and boundaries with all family members.

The one serious threat to successful integration of both FST and CBT is the therapist's alliance with the patient. In CBT, the therapist has a working alliance with the patient in order to meet the goals of the therapy contract, whereas with FST, alliances with family members shift during and across sessions. The therapist must pay particular attention to this balance and should warn child patients that while he or she will always be their advocate, during family therapy this may not appear to be true, as the therapist needs to alter familial interactions. With respect to the FST protocol for PTSD emanating from abuse, there is more direct therapist alliance with the child surrounding the abuse than with other issues since pressure is removed from the child to disclose, and the focus is to remove the child from the responsibility for the abuse. The alliance issue may be more problematic, however, when the therapist attempts to restructure the family and improve communication about nonabuse issues. It is our recommendation that prior to attempting the integration of both FST and CBT that the therapist has adequate experience in implementing each without incorporating the other.

Summary and Conclusions

Trauma does not occur in a vacuum. There are many variables of the traumatic event itself, unique characteristics of the survivors themselves, and a myriad of dynamic contextual variables, including the family, school, and community contexts that all potentially impact the course of the traumatic event and its concomitant impact upon the youth. It is evident that no one individual responds to trauma in a predictable or consistent manner. Over the years, researchers and clinicians have determined that trauma reactions are determined by characteristics of the traumatic event, the individual's premorbid functioning and history, and the current context in which he or she lives. While data are less available to support this conclusion with youth, there are data to indicate that children's psychological adjustment and coping resources are significantly influenced by a number of mediating and moderating variables, including family environment, peer relationships, academic performance, and other talents, as well as constitutional variables, such as age and maturity. These variables can complicate the child's traumatic response and influence the course of treatment. Prior to addressing the trauma symptoms, the clinician may have to address critically pressing issues first, including the child's safety, grief reactions for loss of caretakers, and adjustment to new residences. Treatment needs to be geared toward altering the family environment to help promulgate the recovery of the traumatized child as well as to provide support and nurturance of the child's psychological and physical needs. In addition, restructuring of the family environment may be necessary to prevent retraumatization and to enhance the child's sense of safety. Family issues that complicate the trauma reaction may also be addressed in family therapy. Individual work, through CBT, can also directly reduce trauma symptoms as well as increase individual coping resources. The two forms of treatment can be skillfully integrated such that the family system can be strengthened with improved family communication and by teaching parents, the executive heads of household, behavioral parenting skills that not only decrease the child's

anxiety but that also strengthen the hierarchical and power structure of the family system.

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