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Guideline for the treatment and planning of services for complex post-traumatic stress disorder in adults

UK Psychological Trauma Society

Authors

Mark McFetridge, the Retreat York, UK

Alison Hauenstein Swan, Institute of Psychotrauma, London

Sarah Heke, Institute of Psychotrauma, London

Thanos Karatzias, Edinburgh Napier University & NHS Lothian Rivers Centre for Traumatic Stress

Neil Greenberg, King's College, London

Neil Kitchiner, Veterans' NHS Wales, Cardiff

Rachel Morley, NHS Greater Glasgow & Clyde

Board Members of the UK Psychological Trauma Society (UKPTS) 2014-2016

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Executive summary

- Complex post-traumatic stress disorder (CPTSD) has been recognised by clinicians working within the field for many years, notably since 1992 (Herman, 1992). It has recently been proposed that CPTSD be included as a new diagnosis in ICD-11 (Maercker *et al.,* 2013). Prevalence estimates for CPTSD range from 0.6 per cent in a USA community sample to 13 per cent in a veteran sample (Wolf *et al.* 2015). In a treatment-seeking trauma clinic outpatient sample, 75.6 per cent met the proposed ICD-11 criteria for CPTSD (Karatzias *et al.,* 2016).

- The proposed ICD-11 diagnosis of post-traumatic stress disorder (PTSD) includes three clusters of symptoms:

    - re-experiencing of the trauma in the present
    - avoidance of traumatic reminders
    - a persistent sense of threat manifesting in increased arousal and hypervigilance.

  These symptoms define PTSD as a response characterised by some degree of fear or horror related to a specific traumatic event. The symptom profile of CPTSD includes these core PTSD symptoms, but in addition persistent and pervasive 'disturbances in self-organisation' that describe impairments in regulating emotional experience, in sustaining relationships, and in the sense of self. The latter may include beliefs about oneself as diminished, defeated or worthless (Maercker *et al.,* 2013).

- Unlike PTSD, there are no current NICE (National Institute for Health and Care Excellence) guidelines on, or Cochrane review of, the effectiveness of psychological and pharmacological interventions for CPTSD in the UK. The Board of the UK Psychological Trauma Society (UKPTS), therefore, proposed a review of published evidence and accepted good clinical practice to develop a guideline for those working clinically or planning services for people with CPTSD. This guideline was developed in response to the forthcoming edition of ICD-11; CPTSD is not described in DSM-5 (American Psychiatric Association, 2013) and, furthermore, not all

traumatic responses are accounted for by the DSM-5 PTSD criteria. The guideline reflects the current state of evidence regarding the treatment of CPTSD following exposure to traumatic stressors. Following the publication of ICD-11 we anticipate significantly more published research on the treatment of CPTSD. The UKPTS intends to update this guideline as further evidence becomes available.

- There is debate in the literature about whether CPTSD shares common characteristics with other conditions including borderline personality disorder (BPD), emotionally unstable personality disorder, dissociative disorders, and medically unexplained symptoms. There is, however, emerging evidence to suggest that CPTSD presents with many distinctive features, including a lower risk of both self-harm and fear of abandonment, and a more stable negative sense of self than BPD. Whilst studies suggest comorbidity is high, not all individuals with BPD or severe dissociative disorders report a history of formal traumatic experience(s), which is clearly required for CPTSD (Cloitre *et al.,* 2014). A psychological formulation is a more flexible approach for conceptualising people experiencing any of these difficulties, and more able to incorporate additional systemic and attachment factors.

- Research has found CPTSD to be associated with structural and functional changes in the emotional centres of the brain (limbic system), and with significantly impaired emotional, interpersonal and occupational functioning (van der Kolk, 2014). Repeated childhood trauma is closely correlated with increased physical and mental health difficulties, as well as a significantly greater likelihood of social and forensic problems (Felitti *et al.,* 1998). CPTSD has been found to be associated with more frequent and a greater accumulation of different types of childhood traumatic experiences, and with poorer functional impairment (Karatzias *et al.,* 2016). Evidence suggests that therapeutic input (psychological, social and pharmacological) may be able to ameliorate some, or all, of the consequences of complex traumatisation.

- Whilst there is an on-going debate about whether a stabilisation phase is necessary or may represent an unhelpful delay, most published studies in

complex trauma have used a phase-based approach to treatment. There is significant variation between studies in the duration and content of the phases. In clinical practice the phases can be tailored to individual need, taking account of the individual risk behaviours and capacity to tolerate emotional distress within psychological therapy. Indeed, most treatment of non-complex PTSD is also likely to include an element of stabilisation even if carried out briefly during the initial therapeutic contact.

- The phase-based model, originally proposed by Herman (1992), involves three overlapping phases of treatment, which may be cyclical. The individual may need to return to earlier phases as therapy progresses:
    - Phase one: stabilisation (establishing safety, symptom management, improving emotion regulation and addressing current stressors)
    - Phase two: trauma processing (focused processing of traumatic memories)
    - Phase three: reintegration (re-establishing social and cultural connection and addressing personal quality of life).
- The most effective trauma-focused therapy for the treatment of CPTSD is unknown. There is currently insufficient evidence to recommend any particular therapy over another, but in accordance with the general literature on the impact of post-traumatic stress, it is generally agreed that treatment needs to address three domains: cognitive, affective and sensorimotor.
- Trauma-focused therapy should not be unnecessarily delayed or avoided, but it is equally important that it be considered in light of recent risk behaviours and the individual's presentation. Most trauma-focused therapies incorporate exposure elements with varying levels of intensity. Clinicians should proceed with caution when applying therapies with exposure elements to patients with CPTSD and apply them in an individualised and incremental way. Where there has been recent self-harming or parasuicidal behaviour the clinician should act with due

consideration of safety (and potential effectiveness) and include a stabilisation and psychoeducation phase.

- A number of existing effective therapies for PTSD have been adapted for phase 2 (trauma processing) of CPTSD, including prolonged exposure and eye movement desensitisation and reprocessing (EMDR). Other therapeutic approaches such as narrative exposure therapy (NET), compassion-focused therapy, dialectical behaviour therapy, and the therapeutic community, may be helpful with some or all phases.
- Untreated CPTSD is often a chronic problem, but a meta-analysis of randomised controlled trials (RCTs) of psychological therapies for adult survivors of childhood sexual abuse found psychological therapies to be effective (Ehring *et al.,* 2014).
- The UKPTS considers that failure to address CPTSD in the UK population will continue to cause intergenerational health consequences and incur considerable social and economic costs for the UK. Successfully addressing CPTSD also accords with the UK priorities of working with survivors of interpersonal trauma including childhood sexual abuse, reducing the negative health inequalities associated with adverse childhood experiences and reducing suicide.

The purpose of this guideline

This document has been produced by the UK Psychological Trauma Society (UKPTS) as a guide for healthcare professionals, commissioners and those tasked with the strategic planning of adult mental health services. People with lived experience of complex post-traumatic stress disorder (CPTSD) reviewed earlier drafts of the guideline and helped shape its final content.

Service planning for CPTSD should take place within the wider context of trauma-informed care (Bassuk *et al.,* 2016). The UKPTS recognises that complex traumatic experiences of repeated violence and abuse often occur in the context of situations of inequality, including gender and ethnic inequality, and can lead to further health and social disadvantages. There is a need for responses at many levels including trauma prevention, psychosocial interventions and

sociopolitical responses. However, these guidelines focus only on clinical treatment.

This guideline is not intended to represent a training resource or to equip clinicians to undertake any of the clinical interventions outlined. Instead it aims to assist appropriately trained and experienced health professionals to structure their clinical interventions and to help plan effective services for people with CPTSD. Guidelines and systematic reviews regarding post-traumatic stress disorder (PTSD) have been available for some time (NICE, 2005; National Institute for Health and Care Excellence, 2013; Bisson and Andrew, 2009). In Scotland, the Matrix, a guide to delivering evidence based psychological therapies (NES, 2015) included sections on both PTSD and CPTSD, however no specific guidance about CPTSD has been available in the UK.

What is CPTSD?

Before we consider CPTSD, it is important first to understand PTSD. PTSD was introduced as a psychiatric diagnosis in 1980 in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) (American Psychiatric Association, 1980), and revised most recently in DSM-5 in 2013 and ICD-10 (World Health Organisation, 1992). DSM-5 describes PTSD as encompassing four distinct clusters of symptoms, which must have been present for more than one month following exposure to threatened or actual death, serious injury, or sexual violence. The clusters delineate symptoms of re-experiencing, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity:

- **Re-experiencing symptoms** include spontaneous memories of the traumatic event, recurrent dreams related to it, flashbacks, or other intense or prolonged psychological distress.
- **Avoidant symptoms** include active avoidance of distressing memories, thoughts, feelings or external reminders of the event.
- **Negative alterations in cognitions and mood** include a broad range of feelings, from a persistent and distorted sense of blame of self or others,

to estrangement from others or markedly diminished interest in activities, to an inability to remember key aspects of the event.

- **Alterations in arousal and reactivity** include aggressive, reckless or self-destructive behaviour, sleep disturbance, hypervigilance or related problems.

The number of symptoms required to satisfy the criteria varies with the cluster. Of note, the four symptom clusters outlined above have been contested within the literature. Armour *et al.* (2016) recently published a systematic review of DSM factor analytic studies assessing the underlying dimensionality of DSM PTSD

In addition, there are two possible subtypes described in DSM-5 (2013):

- PTSD dissociative subtype, where the individual presents with prominent dissociative symptoms (experiences of feeling detached from one's own mind or body, or experiences in which the world seems unreal, dreamlike or distorted)
- PTSD preschool subtype, in children younger than six years.

The PTSD dissociative subtype has been confirmed in several empirical studies (Armour *et al.,* 2014; Steuwe *et al.*, 2012; Wolf *et al.*, 2012).

Judith Herman (1992) was among the first to use the term 'complex PTSD' and to assert that repeated, inescapable and overwhelming experiences can underpin a range of adult psychiatric presentations and diagnoses. Her fellow researcher Bessel van der Kolk added that chronically traumatised children are likely to suffer a form of 'developmental trauma disorder' as a consequence of these repeated experiences (van der Kolk *et al.,* 2009).

Unlike PTSD, CPTSD has yet to be formally recognised within the psychiatric classification systems. It is likely that this will be remedied in the forthcoming ICD-11, with CPTSD defined as:

> *'A disorder which arises after exposure to a stressor typically of an extreme or prolonged nature and from which escape is difficult or impossible. The disorder is characterised by the core symptoms of PTSD*

*as well as the development of persistent and pervasive impairments in affective, self and relational functioning, including difficulties in emotion regulation, beliefs about oneself as diminished, defeated or worthless, and difficulties in sustaining relationships.' (*Maercker *et al.,* 2013*)*

The ICD-11 model of PTSD includes symptoms reflecting three clusters:

- re-experiencing of the trauma in the present
- avoidance of traumatic reminders
- a persistent sense of threat that is manifested by increased arousal and hypervigilance.

These symptoms define PTSD as a response characterised by some degree of fear or horror related to a specific traumatic event. The symptom profile of CPTSD includes the core PTSD symptoms plus three additional symptoms that identify 'disturbances in self-organisation' (Maercker et al., 2013):

- affect dysregulation
- negative self-concept
- disturbances in relationships.

Whilst the symptom clusters of PTSD identify the cognitive and behavioural consequences of an individual's acute response to an overwhelming event, CPTSD encapsulates the systemic effects and chronic adaptations to repeated and/or sustained inescapable events. Several authors have proposed that the constellation of difficulties in managing emotions and interpersonal relationships, together with an impaired sense of self, be understood as the long-term sequelae of childhood trauma. Emerging evidence suggests that unlike PTSD, CPTSD is most likely associated with exposure to childhood stressors and repeated traumatisation (Cloitre *et al*., 2009; Karatzias *et al*., 2016). Other clinicians working with combat veterans (Ford, 1999) and adult victims of domestic abuse or political torture have reported a similar, albeit less prevalent, pattern of difficulties (Herman, 1992; June ter Heide *et al*., 2016).

A large-scale systematic community study of the long-term consequences of adverse childhood experiences in the USA (Felitti *et al.,* 1998) supported the

urgent need to intervene in cases of potential CPTSD. The Adverse Childhood Experiences (ACE) study concluded that an individual's personal childhood solutions to negative care experiences later become significant adult and public health issues (Felitti *et al.,* 1998). The results of the ACE study indicate that many adult psychological symptoms can be interpreted as contemporaneous attempts to manage adverse childhood experiences (e.g. dissociation), which then persist, even after the adult is in a safe environment.

More recently, significant evidence supports a relationship between a history of childhood trauma and the experience of hearing voices and other hallucinatory phenomena as an adult. This relationship has been found to be mediated by an individual's propensity to dissociate (Varese *et al.*, 2012).

There is a significant overlap between the symptoms of CPTSD and the diagnostic criteria of borderline personality disorder (BPD). This and related diagnoses have received criticism in recent years, and BPD in particular has been challenged as lacking validity (Herman, 1992). It is possible that many of these diagnoses overlap significantly or are comorbid due to shared psychological underpinnings. Brand and Laniuus (2014) suggested BPD, CPTSD and dissociative disorders all share an underlying deficit in emotion regulation.

People meeting criteria for BPD commonly report having experienced sexual, emotional and physical abuse as a child. Seventy-five per cent of 214 consecutive in-patients with severe BPD had a documented history of reported childhood sexual abuse (McFetridge *et al.,* 2015). This high comorbidity has been reported across cultures (Zhang *et al.,* 2012).

A closer examination of the nature of symptoms can, however, distinguish BPD from CPTSD. BPD presents a greater risk of self-harm, frequent suicidal behaviours and a shifting sense of self (as opposed to one that it is pervasively negative as in CPTSD). There is also often an intense fear of abandonment that is not evident with CPTSD (Maercker *et al*., 2013).

Cloitre *et al.* (2014) systematically examined symptom clusters and found four symptoms that greatly increased the likelihood of a diagnosis of BPD as opposed to CPTSD: (a) an unstable sense of self; (b) unstable and intense interpersonal relationships; (c) impulsiveness, and (d) frantic efforts to avoid abandonment.

The latter symptom may also help differentiate BPD from bipolar disorder. In BPD, the cycling of an individual's moods is more dependent on what is going on in their life, particularly anything that may rekindle a fear of abandonment. In addition, the cycling is more rapid in both BPD and CPTSD than in bipolar disorder, and involves specific emotions such as fear or shame, rather than generic mood.

The effects of overwhelming experience(s) in CPTSD may also be mediated by personal sensitivities and differences; the existence of CPTSD is not defined by the occurrence of repeated overwhelming experiences, but by the currently experienced constellation of difficulties. Whilst repeated childhood trauma is strongly associated with adult CPTSD, it is feasible that CPTSD could, for some individuals, follow a single traumatic incident as an adult (Cloitre *et al.,* 2013). The interpersonal and social processing difficulties of people on the autism spectrum may represent one form of individual variation in sensitivity. For these individuals, the nature of their neurodevelopmental processing difficulties may produce a CPTSD response to lower level interpersonal stressors than in others with increased capacity to understand and moderate social communication (Dell'Osso and Dalle Luche, 2015; King, 2010).

Any therapeutic intervention for CPTSD should be informed by careful formulation of the effect of the specific traumatic experiences endured by the particular individual at their age and stage of life, in these circumstances and contexts, and with a specific level of support and personal resources.

The conceptual basis of effective therapy for CPTSD

CPTSD has been shown to be most likely following chronic, repeated interpersonal trauma in either adulthood or childhood (e.g. Forbes *et al.,* 2012; Karatzias *et al.,* 2016). Results of the DSM-IV Field Trial suggested that traumatic events have the most pervasive impact on an individual during their first decade of life, while those who experience trauma in adulthood are more likely to develop PTSD than CPTSD (van der Kolk *et al.,* 2005). Repeated abuse in childhood interferes with neurobiological development (Ford, 2005), impairing the capacity for sensory, emotional and cognitive integration. The ACE study

provided evidence that repeated childhood trauma correlated with increased physical and mental health difficulties, as well as a greater likelihood of social and forensic problems (Felitti *et al.,* 1998).

There is, however, growing awareness that CPTSD may also develop in adults exposed to extreme circumstances such as combat, torture, domestic violence or highly aversive political unrest. Dissociation, somatisation and disturbances of affect regulation and interpersonal functioning, and changes in beliefs about the self and the world have been identified in such groups in addition to high rates of PTSD (de Jong *et al.,* 2005; Hinton and Lewis-Fernandez, 2011; Morina and Ford, 2009). This has been recognised in the ICD-10 diagnostic category 'Enduring changes of personality following catastrophic events'.

Recent work on early maladaptive schemas suggests that interpersonal trauma is also associated with a generalised elevation of maladaptive schemas, rather than a unique schema profile comprised of specific schemas (Karatzias *et al.*, 2016b). This can explain the idiosyncrasy, severity and multiplicity of impact of interpersonal trauma, and can assist the formulation of present difficulties from a cognitive perspective.

Since Pierre Janet (1925) first suggested that the sequelae of prolonged trauma should be treated within a sequential approach, this has been broadly accepted among the majority of clinicians. The psychological treatment of multiple and prolonged trauma was later distinguished into three stages (Herman, 1992):

- Phase one: improving symptom management, self-soothing and addressing current life stressors to achieve safety and stability in the present
- Phase two: trauma-focused work to process traumatic memories
- Phase three: re-establishing social and cultural bonds, and building on treatment gains to enable the client to develop greater personal and interpersonal functioning.

Courtois and Ford (2009) delineated the work of each of these phases and stressed that transition from phase one to two is dependent on the acquisition of skills rather than being determined by time in therapy.

Studies have further developed our understanding of how childhood attachment experiences and style, and adult reflective functioning and affect regulation capacities, are related (Fonagy *et al.*, 2004). The attachment history of the client (and clinician) will be present in the therapy relationship and should be considered as part of the early therapeutic work to develop a safe and trusting relationship. This will be key to the clients willingness to later approach the vulnerability entailed within their traumatic experiences, and to the clinicians ability to be able to assist the containment of the associated distress.

It is intuitive to many clinicians that an increased capacity to self-regulate and tolerate distress is beneficial prior to addressing traumatic memories directly; indeed, the initial sessions of many psychotherapeutic approaches address phase one issues albeit in less detail than a formal phased-based approach.

The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults includes surveys with experts in the field of CPTSD: 82 per cent of the expert panel agreed that a phased approach should be used when treating CPTSD (Cloitre *et al.,* 2012). Cloitre *et al.* (2014) tested a phased model and found that treatment drop-out increased, and treatment gains reduced, when exposure work was carried out before a skills-based stabilisation phase. No study to date has compared phased approaches for CPTSD with non-phased approaches.

Some studies have suggested that it is possible to achieve clinical change in the treatment of CPTSD without adopting a systematic phased approach. DeJongh *et al.* (2016) reviewed available evidence and concluded that a stabilisation phase to develop affect regulation is unwarranted and that those with CPTSD undertaking trauma-focused therapy do not show an increase in dissociation or parasuicidal behaviour. The authors conclude that there is a danger of demoralising the client through unnecessarily delaying evidence-based trauma-focused therapy. Corrigan and Hull (2015) also raised a number of concerns about the treatment of CPTSD, including the prevailing assumptions relating to evidence and research methodology. They also suggested the multifaceted presentation of CPTSD may be more effectively treated with a multimodal intervention that is not necessarily phased.

DeJongh *et al.* (2016) do not address whether people with CPTSD with recent histories of self-harm and suicidal behaviours require stabilisation. Furthermore,

these individuals are less likely to be included in RCTs and particularly those studies testing the absence of a stabilisation (safety) phase. There may be, therefore, a lack of evidence to support the withdrawal of the stabilisation phase in those at greater risk of self-harm and suicidal behaviour. It would appear proportionate, given current evidence, to conclude that trauma-focused therapy should not be unnecessarily delayed or avoided by a stabilisation phase; however, it is equally important that this is considered in light of the individual's presentation and recent risk behaviours. Where there has been recent self-harming or parasuicidal behaviour, the clinician should err on the side of safety (and potential effectiveness) and include a stabilisation and psychoeducation phase.

For safety reasons and in the absence of concluding evidence regarding models of care for CPTSD, we recommend a phased approach to treatment as a first line of support. The type and intensity of a phase-based intervention should be informed by formulation and appropriate to the individual's needs for support. This is an area that requires further research.

Engagement and assessment

Trauma, especially when it is interpersonal, can have a highly negative impact on people's capacity to develop and maintain relationships, and such relationship problems appear to be even more complicated in individuals who have experienced severe cumulative interpersonal violence, neglect, or abuse (Pearlman and Courtois, 2005). Mistrust, emotional lability, and relational instability in response to a history of pervasive abuse can pose challenges to the formation of therapeutic relationships.

Gender can be an important factor in the therapeutic relationship, depending on the trauma and attachment history. Clients' preferences for the gender of their therapist should be respectfully considered, but not presumed. Particular attention needs to be given to clarifying the boundaries within therapy to create a sense of predictability and safety. Therapist and client should also discuss the importance of attending to the likely breaches of these from a position of

therapeutic curiosity. This potentially reduces the risk of the therapist becoming overly accommodating, resentful or exhausted.

Dissociation may also complicate the development of the therapeutic relationship. Shifts between ego states may be subtle, triggered by feelings of threat, and may result in feelings of confusion in the therapist. Early psychoeducation on dissociation may be useful in developing a shared understanding and language for these relational shifts within sessions. Developing a trusting therapeutic relationship can be a key component of the stabilisation phase.

It may be necessary to provide some psychoeducation or develop grounding strategies before a client is able to discuss their trauma history for the purpose of assessment. It may also be necessary to agree a plan for how to manage dissociation, which can interfere with the assessment process. Where exposure-based interventions will form part of the subsequent treatment package, an important outcome of assessment is the client's informed consent to work therapeutically on traumatic memories. This agreement could be deferred until after a period of psychoeducation and stabilisation.

A detailed summary of assessment topics is outlined in the appendices (Appendix 1).

Phase 1: Stabilisation and psychoeducation

Where assessment and subsequent formulation indicate that a phased approach to treatment is appropriate (e.g. due to severe difficulty in regulating emotions and the use of self-harm or parasuicide or significant dissociation), a range of interventions may be offered to help the client cope with their emotions, relationships and symptoms. This phase of treatment will usually begin with a number of sessions of psychoeducation. Stabilisation and psychoeducation are important in counterbalancing some of the disorientation and sense of being overwhelmed that can result from traumatic experiences. Understanding symptoms and emotional responses can help those who have experienced trauma to feel less powerless and out of control. Psychoeducation can be the

first step towards gaining, or regaining, a sense of control and a more compassionate sense of self.

Below is an overview of phase one of treatment; the content and order of interventions will vary according to each client's specific needs:

1. Establishing a therapeutic relationship
2. Psychoeducation
    a) models of simple PTSD and how multiple trauma complicates presentation (memory models)
    b) explaining the impact of developmental trauma
    c) explaining windows of tolerance (level of arousal tolerable to client)
    d) explaining dissociation
    e) explaining symptoms and emotional responses
3. Establishing safety and readiness for therapy
    a) addressing issues relating to housing, benefits, asylum, debts, bills
    b) increasing social support and interpersonal safety
    c) family tracing, instigated through the Red Cross tracing service, for those separated from family in situations of armed conflict
    d) provision of childcare
    e) dealing with therapy-interfering substance misuse
4. Grounding for dissociation/flashbacks
    a) grounding in the present using the senses
    b) discrimination training
5. Symptom management
    a) managing nightmares
    b) panic and anxiety

c) mood: increasing activity and reducing isolation

d) pain and physical health, including medically unexplained symptoms

e) titrating medication

6. Skills training

a) mindfulness

b) interpersonal skills

c) emotion-regulation skills

d) distress tolerance

e) self-compassion

f) grounding techniques

7. Compassion-focused therapy.

Each of these elements will now be discussed in more detail.

1. Establishing a therapeutic relationship

The development of a therapeutic relationship can be a significant therapeutic task when people with CPTSD have had their relationships repeatedly violated in the past. Harris and Fallot (2008) outline five guiding principles of trauma-informed practice, which might be used to guide the development of a therapeutic relationship of safety, trustworthiness, choice, collaboration and empowerment.

In establishing a therapeutic relationship attention may need to be given to:

- the client's lack of trust following abuse or violence at the hands of authority figures or other adults
- responding to hopelessness through establishing a basis for working together and instilling reasonable hope

- developing safe and supportive boundaries
- acknowledging and honouring loss, betrayal and injustice
- understanding and building on what matters to the individual and their sources of strength and resilience.

2. Psychoeducation

Psychoeducation for CPTSD usually features an explanation of PTSD, including the reason for intrusive symptoms and justification for exposure work, as well as an explanation of symptoms and skills-deficits. This aims to increase the individual's understanding of the difficulties, commitment to therapy and self-compassion, and reduce shame. Frequently covered topics are summarised below.

a) Models of PTSD

The three main models used to explain PTSD are:

- Ehlers and Clark cognitive model
- Brewin's dual representation theory of PTSD
- Foa's fear network.

According to the **Ehlers and Clark cognitive model** (Ehlers and Clark, 2000), PTSD becomes persistent when, in processing the traumatic event and/or its sequelae, the individual perceives a continuous sense of serious current threat.

Two key processes are implicated:

- negative appraisals of the trauma and its sequelae
- disturbance of autobiographical memory, characterised by strong perceptual memories (such as intrusive images and emotions) that are disconnected from their context and an intellectual understanding of the trauma.

This leads to behavioural and cognitive responses and strategies (e.g. avoidance) designed to reduce the perceived level of threat and associated distress. Although effective in the short term, these strategies prevent cognitive change in the longer term and hence maintain post-traumatic stress.

Brewin's dual representation theory of PTSD (Brewin *et al.,* 1996; Brewin and Saunders, 2001; updated in Brewin, 2011) describes two components of memory representations: sensation-based (S-rep) and contextual (C-rep).

In healthy memory, the two components are paired and form the 'hot' and 'cold' parts of the memory respectively. Under extreme stress the hippocampus becomes significantly less active and the amygdala significantly more active. Under these conditions the C-rep is weakened and, rarely, can be absent at the most traumatic moment of a memory. This means that the S-rep loses its context (so is not integrated with time, place and surrounding knowledge) and can only be retrieved involuntarily, and is associated with a much more powerful autonomic response. These are experienced in PTSD as flashbacks.

Foa's fear network (Foa *et al.,* 1992) proposes that trauma forms a fear network in long-term memory, which is activated by trauma-related cues. Information from the network enters the consciousness and leads to intrusions and attempts to avoid and suppress memories. Successful resolution of the trauma requires integration of the fear network and existing memory structures. However, this is challenged by the unpredictable and uncontrollable nature of trauma; disruption of cognitive processes of attention and memory at the time of trauma; and the creation of a disjointed and fragmented fear network.

The Ehlers and Clark (2000) model is easily explained to clients and offers a helpful way to illustrate the need for an exposure-based intervention and tackling behavioural avoidance. It is commonly used to guide formulation in people with PTSD. Brewin's model has neuropsychological support and is useful as a rationale for the usefulness of imagery and nightmare rescripting, while Foa's model is a useful way of explaining the impact of multiple trauma and as a rationale for treatment. It is an important part of psychoeducation for narrative exposure therapy (NET) and can also be useful in introducing eye movement desensitisation and reprocessing (EMDR) therapy. Nevertheless, it is important

to note that all these theoretical conceptualisations have been developed primarily to explain PTSD rather than CPTSD.

Models of PTSD can often be introduced to clients using metaphors or simple diagrams. Common metaphors include the image of a linen cupboard, a filing cabinet or a photo album. Some clients find these metaphors helpful, while others prefer a simple explanation[1] of how memories are stored in the brain.

b) Explaining CPTSD including developmental trauma

Attachment theory forms a useful basis for explanations of developmental trauma and some clients may benefit from reading about this. The foundations for difficulties in recognising and regulating affect can be explained through attachment and reciprocity. A parent/carer's ability to resonate with an infant's internal states, and translate them into actions and words appropriate to the child's stage of development, will eventually lead to the child's ability to connect internal states with words. Mother-infant synchrony contributes to the organisation and integration of neural networks and the development of self-regulation. At times of threat or distress our attachment system is activated and we revert to our underlying internal working models. If these are organised and stable, thanks to reliable and consistent carer response to infant distress, the individual will be able to regulate their emotional experiences in adulthood. Where this is not the case, the individual will have difficulty identifying and safely regulating their emotions, and will be more likely to find them overwhelming.

c) Explaining windows of tolerance

A person's window of tolerance (Ogden *et al.,* 2006) is sculpted by their early attachment relationships. Auto-regulation is the ability to calm oneself when arousal rises (sympathetic activation) to the upper limits of the window of tolerance or to increase activity when arousal drops (parasympathetic activation). Many people with CPTSD show affect intolerance in response to under- or over-activity of the stress response system. Such inability to tolerate intense emotion may result in, for example, addictive behaviour, self-harm (to

[1] See for example:
http://media.psychology.tools/Worksheets/English/PTSD_And_Memory.pdf

discharge emotion), or dissociation. Alternatively, an individual may experience on-going low activation, such that they spend considerable periods in a numb, inert, or disengaged state.

A person's window of tolerance narrows as a consequence of repeated trauma and influences, resulting in:

- reduced emotion regulation abilities
- reduced relational capacities
- reduced capacity for attention and consciousness
- negative influence on belief systems
- increased somatic distress or disorganisation.

Treatment of CPTSD builds emotional resilience and integrative capacity, which can only happen with an increased window of tolerance.

d) Explaining dissociation

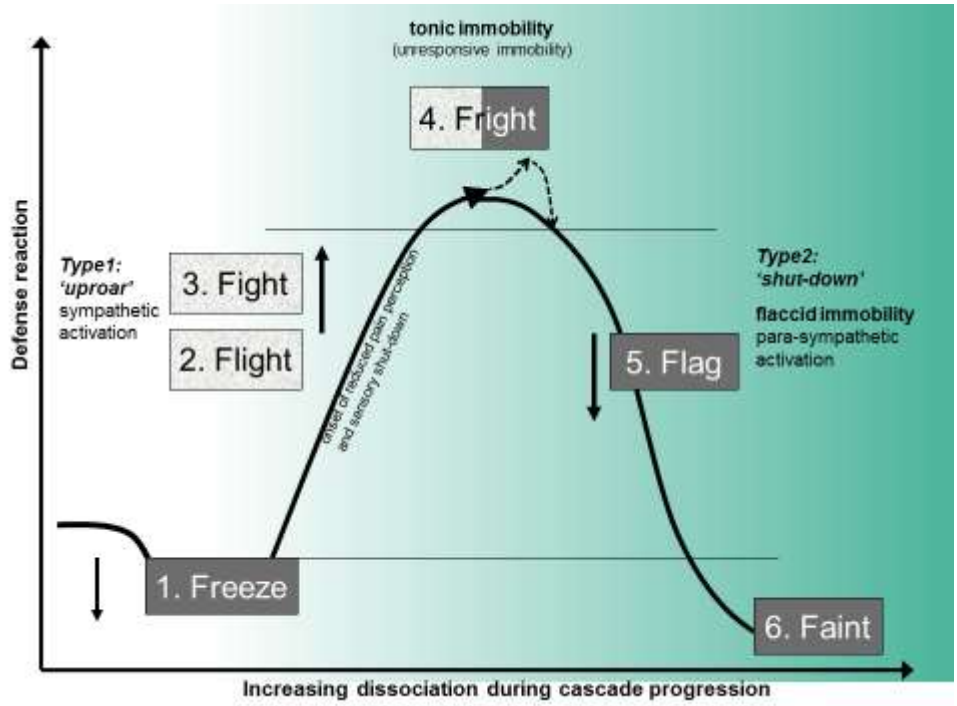
Dissociation is defined in DSM-5 (2013) as 'disruption in the usually integrated functions of consciousness, memory, identity or perception of the environment'.

Some people dissociate during trauma (Holmes *et al.,* 2005; Murray *et al.,* 2002; Ozer *et al.,* 2003). Such peritraumatic dissociation may be experienced as spontaneously 'going blank', 'switching off' or 'leaving' their body (derealisation or depersonalisation), and may be an attempt by the individual to distance themselves from the distress they are feeling. Consequently, the traumatic memory, or parts of the memory, can become inaccessible to conscious awareness (Wright *et al.,* 2006). The encoding of the memory can become altered by traumatic experiences resulting in fragmented yet vivid sensory-perceptual memories or 'flashbacks' (Grey and Holmes, 2008). Recalling traumatic events might then trigger dissociation.

Even when there is no peritraumatic dissociation, recall of traumatic memories can result in a parasympathetic response that makes dissociation likely (Schauer *et al*., 2011). This is illustrated in Figure 1: in areas 5 and 6 in the diagram, dissociation is likely.

The theory of structural dissociation of the personality postulates that the personality of traumatised individuals is unduly divided into two basic types of dissociative subsystems or parts (Nijenhuis *et al.,* 2010). One type (referred to as the Apparently Normal Part/s) primarily functions in line with the individual's daily life goals; the other type (Emotional Parts) are dissociative parts, fixated in the trauma and primarily serving a defensive function. The more severe and chronic the traumatisation, the more dissociative parts are likely to exist. Helping clients to understand why they may have developed different parts as a means of coping with repeated trauma may serve to increase understanding of the disintegration often experienced in CPTSD. This model may also offer an integrated formulation of the multiple diagnoses that many people with CPTSD have acquired. For further explanation of the diagram, see page 37.

Figure 1. Defence cascade



Source: Schauer and Elbert (2010).
Key: Lighter area= sympathetic activation. Darker areas = parasympathetic activation

e) Explaining symptoms and emotional responses

People with CPTSD often present with a wide range of symptoms associated with their attempts to manage the emotional distress linked to trauma, resulting in multiple diagnoses to account for these symptoms. For this reason, it is essential

that an individualised formulation is developed that brings together the range of symptoms and difficulties experienced by the individual.

3. Establishing safety and readiness for therapy

Before proceeding to the exposure phase of therapy, clients may need support to improve the social stability of their lives. Social worker or support worker interventions should be instigated to tackle social issues related to:

- housing, benefits, asylum, debts, bills
- family tracing
- childcare
- substance misuse.

Given the correlation between insecure attachment and CPTSD (Muller *et al.,* 2000; Pearlman and Courtois, 2005), the development of a trusting therapeutic relationship may require significant attention, particularly in the early phase of therapy. Help in accessing supportive relationships and establishing safety and boundaries in other relationships may also be a necessary early therapeutic goal.

4. Grounding for dissociation and flashbacks

Clients should be taught a range of grounding strategies to counteract dissociation. These strategies can make use of a range of sensory and imagery-based techniques and may include mindfulness and yoga (van der Kolk *et al*., 2014).

5. Symptom management

a) Managing nightmares

A three-fold approach to nightmares is recommended:

- sleep hygiene

- adapting grounding techniques to be used on waking
- nightmare rescripting.

In practice, often only the first two approaches are used if treatment is to include trauma-focused work because it is assumed that nightmares will resolve when traumatic memories are processed. Brewin's Dual Representation theory (Brewin, 2011) is useful in explaining the rationale for rescripting.

b) Panic and anxiety

Anxiety problems are often secondary to PTSD and are therefore unlikely to resolve with common anxiety management techniques; however, breathing techniques and other coping strategies will help clients to feel some control over their symptoms. An understanding of the role of avoidance in maintaining anxiety and the need for graded exposure to fears will be useful later in therapy in addressing safety behaviours and will also help with increasing activity to improve mood.

c) Mood: increasing activity and reducing isolation

Activity scheduling may be necessary as a first-line intervention to improve the client's mood where depression is severe. Given the extent to which trauma disrupts the sense of self, and causes the individual to stop activities and previously valued roles, increasing activity levels can form part of the process of reclaiming one's life back. Ehlers and Clark (2000) argue that this should be introduced early in treatment, rather than waiting until phase three, because it helps:

- bring hope
- lift mood
- retrieve memories of the self before trauma
- access pre-trauma problem-solving resources
- challenge the sense that they are not the same person as before, i.e. that they have changed permanently for the worse.

d) Pain and physical health including medically unexplained symptoms

Given the frequency of chronic pain and health conditions (Felitti *et al.,* 1998) in people with CPTSD, pain management may be necessary before commencing work on trauma. Many people with CPTSD also experience medically unexplained symptoms. Providing appropriate conceptualisations of medically unexplained symptoms following childhood trauma will facilitate the normalisation and acceptance of such symptoms.

e) Titrating medicine

Ideally, medication should be titrated before trauma-processing commences so the client is as stable as possible. This also ensures that symptom change during processing can be accurately attributed to this. There is little research in this area but ideally the possible effects of different medications on memory processing should be considered (Jeffreys, 2015; Thomaes *et al.,* 2014; Hetrick *et al.,* 2010).

This guideline does not intend to provide a comprehensive review of the use of medication for treating PTSD or CPTSD; however, further information is provided in the Biology and pharmacology section (see page 39).

6. Skills training

A number of packages have been developed to enhance coping skills associated with a disorganised attachment pattern. Dialectical behaviour therapy has been demonstrated to be particularly useful in reducing self-harm (Harned *et al.,* 2008). Mentalisation-based therapy is a manualised psychodynamic therapy developed for individuals with borderline personality disorder, who fail to develop a capacity to mentalise (Fonagy, 2000; Fonagy and Bateman, 2005). Mentalisation is the process by which we implicitly and explicitly interpret the actions of ourselves and others as meaningful on the basis of intentional mental states. The object of treatment is to increase mentalisation capacity and thereby improve affect regulation and interpersonal relationships.

In Scotland, a new 10 session group intervention called 'Survive and Thrive' has been developed with the aim of increasing stabilisation, understanding of the

links between past trauma and current symptoms, and preparing for trauma-focused therapy. Preliminary studies, including a controlled investigation, have demonstrated that Survive and Thrive might be a useful intervention to promote stabilisation (Karatzias *et al.*, 2014, Ball *et al*., 2013). A further development is Trauma Recovery and Empowerment (TREM), which is a manualised group programme with three main aims: learning strategies for self-comforting and self-monitoring; connecting past abuse with current difficulties; and skills acquisition. A multi-site controlled investigation of TREM (Fallot and Harris, 2008) found significant symptom reduction, although findings should be replicated in fully powered RCTs (Karatzias *et al.*, 2016c).

Marylene Cloitre has developed a brief skills training programme for those with CPTSD called STAIR (Skills Training in Affect and Interpersonal Regulation). The eight-session programme covers affect regulation, distress tolerance and interpersonal skills. Cloitre has demonstrated in several RCTs (Cloitre *et al.,* 2002; Cloitre *et al.,* 2010) that trauma-focused narrative therapy is more effective when it follows STAIR than without or before STAIR. Table 1 summarises the areas prioritised in skills training.

Mindfulness is a key component in a number of skills-training packages for CPTSD. Mindfulness may be particularly useful with CPTSD because its focus on present sensations is the very antithesis of dissociation, and mindfulness exercises tailored to the needs of the client can help the client to stay present. Furthermore, its emphasis on the acceptance of bodily sensations can offer a useful approach for those with somatic re-experiencing of traumatic memories. However, although mindfulness is considered a core element of some effective psychological therapies (Linehan, 1993), there are no clinical trials on the effectiveness of mindfulness with PTSD or CPTSD. Farias and Wikholm (2015) warn that mindfulness may cause a person to access powerful, negative emotions or memories because keeping the mind constantly busy may be a coping strategy for some individuals to avoid intrusions, and so stilling the mind through mindfulness creates a risk of intrusions. Mindfulness should therefore only be offered to those who are able to facilitate the containment of these traumatic intrusions and related emotion.

Table 1: Goals of skills training in CPTSD

Increase	Decrease
Mindfulness	Identify confusion Emptiness Cognitive dysregulation
Interpersonal skills	Interpersonal difficulties Fears of abandonment
Emotional regulation skills	Affect lability Excessive anger
Distress tolerance	Impulsive behaviour Suicide risk Self-harm

7. Compassion-focused therapy

Compassion-focused therapy was developed by Paul Gilbert (2013) as an integrated and multimodal approach drawing from evolutionary, social, developmental and Buddhist psychology, and neuroscience. It is based on the hypothesis that the self-soothing affect regulation system is poorly accessed in people with high shame and self-criticism, in whom the 'threat' affect regulation system dominates orientation to their inner and outer worlds. A key therapeutic aim is to use compassionate mind training to help people develop and work with experiences of inner warmth, safeness and soothing.

To date, there have been no RCTs on compassion-focused therapy for traumatic stress, but it has been found to be effective in a range of mental and physical health-related populations (Leaviss and Uttley, 2015). Compassion-focused therapy is widely incorporated into the phase one treatment of those who have

experienced early trauma and poor attachments. In increasing the capacity for self-soothing and self-directed compassion, clients are believed to be more able to process their traumatic shame-based memories within their window of tolerance. Empirical evidence is required to support the use of compassion-focused therapy in CPTSD.

Phase 2: Trauma processing

Having established safety for the client in the present, and developed skills and strategies for them to maintain stability during emotional distress, attention can move to addressing the client's traumatic memories.

Herman (1992) referred to this second phase as one of 'remembrance and mourning'. While attention is first given to bearing witness to the client's experience, Herman highlighted the importance of reaching a point of grieving for the direct and indirect loss inherent in all complex trauma, especially those involving care givers. She noted the potential defensive function of fantasies of revenge or of premature forgiveness in avoiding the necessary grieving of the loss of what was and might have been.

There are additional issues to consider in treating CPTSD with psychological therapies. Some authors have suggested CPTSD is likely to be shame-based, rather than fear-based as with PTSD (Lee and James, 2012). While exposure to shame can be therapeutic, care needs to be taken. There is also evidence to suggest that other negative emotions such as disgust might be important in the experience of complex traumatic stress reactions (McKay *et al.*, 2014).

As shame carries an implicit social context, extremes of this emotion may be treated effectively by group-based interventions. These can help address shame elements because the client's experiences are shared and compassion is felt and expressed for others. This has been recognised over many years through the tradition of 'survivor groups' (Sturkie, 2013). There is evidence for the effectiveness of group therapy for adults with histories of childhood sexual abuse, regardless of whether these are trauma-focused or present-focused groups (Classen *et al.,* 2011). This suggests that the processes entailed within

group treatment may be more important contributors to outcome than the content.

It has also been proposed that effective trauma-processing therapy needs to address 'top down' and 'bottom up' processes; employing cognitive, emotional and sensorimotor (physical, sensory and movement) elements.

> *'The capacity of art, music and dance to circumvent the speechlessness that comes with terror may be one reason they are used as trauma treatments around the world.'* (van der Kolk, 2014)

This highlights the need for psychological therapies to address the range of difficulties and their modalities as experienced by those with CPTSD.

CPTSD, unlike PTSD, is predominantly relational. The traumatic origins, maintenance of difficulties and eventual recovery are all likely to be significantly mediated by the relationship with others. The question yet to be adequately addressed for CPTSD remains: 'what works for whom?'. A meta-analysis of individual and group psychological therapies for adult survivors of childhood sexual abuse concluded that psychological therapies are effective (Ehring *et al.,* 2014). Trauma-focused therapies were more efficacious than non-trauma-focused interventions, and therapies including individual sessions were more effective than pure group treatments.

A number of established therapies for PTSD can be adapted to address CPTSD in one or more of the recommended treatment phases; these approaches are described below. This list is not exhaustive, is not derived from a systematic review, and only includes approaches having established empirical support for use with PTSD. Although clinical research is clearly a useful guide, it is important to recognise that a lack of evidence is not evidence of a lack of effectiveness. The position may well change as the research base progresses for other emerging therapeutic approaches addressing the unique aspects of CPTSD.

1. Cognitive behavioural therapy approaches

Trauma-focused cognitive behavioural therapy (TF-CBT) builds on the cognitive models of PTSD developed by Ehlers and Clark (2000), Brewin *et al.* (1996) and

Brewin (2011). The core therapeutic intervention involves imaginal exposure to traumatic memories and cognitive restructuring of the most distressing trauma-related cognitions. It also includes behavioural and cognitive work on safety behaviours, and addresses more general avoidance of associative cues for traumatic memory, facilitating exposure to these cues. This can be to external elements such as the location of the traumatic events and/or to the internal physical sensations or emotional experiences associated with the trauma.

Exposure to trauma-related cues provides the opportunity to update the traumatic memory and traumatic associations, and learn that they can be encountered safely in the present. Exposure may also help develop the coherence of the memory of the traumatic events, adding missing elements and context that it was not possible to assimilate at the time during an overwhelming state of autonomic arousal. Imagery rescripting is another common component of TF-CBT. The efficacy of TF-CBT has been well researched, particularly in the treatment of single-incident trauma.

Cognitive processing therapy (CPT) is a 12-session therapy that has been found effective for PTSD and other corollary symptoms following traumatic events (Monson *et al.,* 2006; Resick *et al*., 2002; Resick and Schnicke, 1992). Although research on CPT originally focused on rape victims, CPT has been used successfully with a range of other traumatic events, including military-related traumas.

Cognitive behavioural conjoint therapy (CBCT) for PTSD is based on CPT principles. It is a 15-session manualised, disorder-specific conjoint therapy with the simultaneous goals of improving PTSD symptoms and enhancing intimate relationship functioning (Monson and Fredman, 2012). Evidence suggests that the health of intimate relationships is a factor in treatment engagement (Meis *et al.*, 2010). More specifically, the involvement of partners in trauma-focused out-patient therapy reduces drop-out and improves adherence to the interventions (Monson and Fredman, 2012).

Training

TF-CBT training varies widely, but is usually a component of general cognitive behavioural therapy (CBT) training which is integrated into some professional

training courses (e.g. in some clinical psychology and counselling psychology, and psychiatry training) or via a one-year part-time diploma programme or other courses aimed at a range of professionals. TF-CBT is often taught in workshops to experienced CBT practitioners. Manualised treatment is also available.

2. Prolonged exposure: application and adaptions for CPTSD[2]

Prolonged exposure (PE) has gained awards[3] in the USA for its effectiveness at treating people misusing substances and was selected as a model programme for national dissemination. It can be used with fear-based traumatic memories and shame-based memories. Key points to note include the importance of:

- conveying to the client that it is possible to change the intrusive symptoms of CPTSD
- titrating the client's arousal levels to keep them within a 'therapeutic window'
- maintaining high-quality supervision.

The clinician needs to be able to convey hope to the client and reassure them that they will be able to contain the distress the client is likely to experience during therapy.

A phase-based approach is recommended when using PE with complex clients. It may be necessary to alternate more frequently between the trauma-processing and stabilisation stages. The process tends to be less linear than with single-incident trauma processing.

Clinicians should check during a session that the client can listen safely and effectively to recordings of exposure sessions before asking them to do this between sessions. Some clients, who may also be diagnosed with a BPD, can be keen to move quickly through the processing in a manner that is not necessarily

[2] Based on discussion between Gill Moreton, Clare Fyvie and Mark McFetridge.
[3] 2001 Exemplary Substance Abuse Prevention Program Award from the USA Department of Health and Human Services and the Substance Abuse and Mental Health Services Administration (SAMHSA).

therapeutic. A period of three months without self-harm is recommended before commencing PE (Harned *et al.,* 2012). In many clinical settings, however, it may be unrealistic to expect clients to stop self-harm, so a contract should be agreed with the client stating that if self-harm worsens the exposure sessions will pause and a supportive focus will be adopted. Evidence supports the effectiveness of the expectation and contingency of stopping self-harm before PE; clients are motivated to resist their impulses more effectively to gain the opportunity to process their traumatic memories through PE (Harned *et al.,* 2012).

There is a range of methods of titrating the exposure, where necessary, including keeping the client's eyes open rather than closed, using the third person rather than first person, using the past tense rather than present tense, and viewing the scene from a distance.

There is debate about what the initial focus of PE should be. Some clinicians follow the recommendation (Foa *et al.,* 2007) that exposure focuses on the memory that haunts the client the most and that this is used from the beginning. Other clinicians feel that with complex clients the process should start with less traumatic memories.

Further research is needed in the effectiveness and acceptability of different levels of intensity of exposure procedures with people with CPTSD.

Training

It is important that clinicians have prior training in the standard 10-session PE protocol (Foa *et al*., 1994), so that they are able to adapt the standard PE protocol to complex trauma presentations and comorbidity.

Training workshops (two days duration) are available for clinicians seeking to use PE alongside dialectical behaviour therapy (DBT) for those with comorbid CPTSD and BPD.

2. Eye movement desensitisation and reprocessing[4]

EMDR is a psychotherapy first developed by Dr Francine Shapiro to reduce symptoms associated with PTSD. The therapist applies bilateral stimulation through alternative lateral eye movements, ear tones, or taps on the hands, while the client simultaneously accesses the stored traumatic memory through image, cognitions, affect and sensation (Shapiro 2001). The theoretical foundation for the application of EMDR is the Adaptive Information Processing (AIP) model, which emphasises the pivotal role of experiential contributors to present dysfunction (Shapiro 2001).

EMDR uses an eight-phase approach to address the past, present and future aspects of a traumatic or distressing memory that has been stored dysfunctionally. This eight-step protocol moves the client through case conceptualisation and preparation, desensitization and reprocessing of the traumatic memory, closure and follow up. Multiple outcome studies have shown EMDR to be an effective method for treating PTSD.

Training

EMDR training is a three-part course spread over seven days by a trainer accredited by EMDR Europe Association. There is also a further two-day training course on applying EMDR to children.

To become an accredited EMDR practitioner or consultant it is necessary to build up an appropriate portfolio of clinical work carried out under supervision with an accredited EMDR consultant.

*EMDR applications and adaptations for CP*TSD

Phase 1 stabilisation coincides with the second phase of Shapiro's eight-phase EMDR protocol. With CPTSD, the emphasis is on decreasing self-harming and addictive behaviours, suicidality, pathological dissociation and extreme emotional dysregulation. Clients need to increase their affect tolerance and capacity to observe their own experience mindfully without becoming overwhelmed and dysregulated. They need to learn how to maintain dual attention, focusing simultaneously on the past and present, as well as on

[4] Based on Korn (2009) and a discussion with Alexandra Richman.

internal and external realities. Learning to stay grounded in the present moment and connected to another person, while accessing emotions and traumatic memories is an essential prerequisite for moving on to EMDR trauma processing.

EMDR resource development and installation (RDI) involves deliberate and strategic interventions focused on helping the client access and develop core resources and self-capacities. The goal of EMDR RDI is to help clients access existing resources and develop new and effective coping skills. These resources may be mastery resources, relational resources, symbolic resources or modelling resources that are installed with short sets of bilateral stimulation.

In addition to the EMDR RDI protocol, EMDR clinicians have developed a number of valuable interventions designed to decrease pathological dissociation and post-traumatic dysregulation during the early and middle phases of treatment. Forgash and Knipe (2008) describe the installation of a 'home base' and a 'workplace' for the ego state system prior to any trauma-processing work. Knipe has introduced several EMDR-related strategies for tracking and targeting dissociative avoidance; enhancing present orientation and safety; reconciling conflicted ego states; and increasing clients' capacity for tolerating and regulating potentially overwhelming emotion.

For clients who are potentially dissociative, the degree of orientation to the present situation can be assessed through the use of the Back of the Head Scale (BHS). The constant installation of present orientation and safety (CIPOS) method is used in conjunction with BHS and consists of using eye movements to strengthen or install in the client's awareness a clear subjective sense of being present in the immediate real-life situation of the therapy office. Using CIPOS reduces the risk of unproductive, dissociated reliving of the traumatic event during processing. EMDR 'loving eyes' (Knipe 2008) is a technique where the 'loving eyes' of the adult self are encouraged to witness the painful affect held in a dissociated child ego state. Using eye movements, the adult self becomes aware of the child's painful life circumstances and experience and develops a compassionate 'loving' empathic stance to that child ego state.

The primary goal of the next phase is the processing of traumatic memories and the reduction and transformation of trauma-related beliefs, affective and essentially somatically held behavioural patterns, and symptomatology.

Within the eight-phase EMDR protocol, the clinician focuses on phases three to eight, working directly with traumatic memories and triggers. A symptom-focused approach attends to the most disruptive present-day symptoms, actively using the float-back technique to identify those traumatic experiences directly linked to present-day triggers and symptoms. This strategy is extremely useful in identifying those memories, embedded within the chaotic context of severe neglect, deprivation, loss and abuse, that are most activated and relevant to present-day dysfunction.

During trauma processing, the EMDR therapist is quite active in pacing and co-regulating the EMDR processing, helping the client to access and tolerate previously dissociated behavioural impulses, emotions, body sensations and thoughts. The clinician must remain alert to signs of dysregulation (e.g. hyper/hypo-arousal, freezing, numbing, inability to think, dissociative responses of blanking out, shutting down). They must actively use cognitive and other therapeutic interweaves (Shapiro, 2001) to keep the client engaged and moving towards the resolution of issues related to responsibility, safety and choices. For clients who present with extreme shame, self-blame, self-loathing and negative cognitions related to defectiveness/unworthiness (e.g. 'I'm inconsiderate/loathsome'), interweaves focus on responsibility. For clients who present with a high level of fear and avoidance and an ever-present sense of danger (e.g. 'I'm never safe, I'm going to die'), interweaves focus on safety, orienting the client to the present and highlighting differences between then and now. For clients who present with extreme mistrust, helplessness and hopelessness, and negative cognitions related to control or power (e.g. 'I'm helpless/powerless'), the focus is on choice. The more dissociated and fragmented a client is, the more interweaves will be necessary to maintain therapeutic processing.

During processing, the clinician must stay attuned to the client's tendency to avoid and defend against core emotions such as anger, sadness and longing. Frequent looping and blocks to processing are common with CPTSD. The clinician needs to anticipate the emergence of immobilising defensive and inhibitory emotions (shame, terror, loneliness, despair and hopelessness, explosive rage, blocking beliefs and ego state conflicts). Clinicians may also use interweaves designed to increase the supportive connection between the client and therapist;

to resolve ego state conflicts related to blocked processing; and to facilitate sensorimotor expression and completion of adaptive action tendencies.

In EMDR processing the clinician is giving attention to moment-to-moment dyadic regulation and modulation. For clients who struggle with affect tolerance, the clinician may use various titration, fractionation and modulation strategies. If the client is frozen in terror, overwhelmed by emotion and bodily sensations of torture, a mechanism of 'frame-by-frame', facilitated by bilateral stimulation, can move the client on to the moment when the trauma is over and they are safe, alive and in their body. In instances where clients have strong avoidance urges, the EMDR therapist targets the positive affect associated with the avoidance defence, which allows the client to maintain the avoidance defences while simultaneously processing the underlying traumatic material.

For phase three of EMDR, a future positive template protocol is used to help the client imaginally rehearse and problem-solve in preparation for upcoming situations and encounters. This uses dual attention bilateral stimulation to assist the client to process through difficulties and make adaptive changes.

A clinical strength of EMDR psychotherapy with CPTSD is that it allows chronically traumatised clients to process material without detailed recounting, even sometimes without words, facilitating the desensitisation and processing of material that was previously inaccessible, intolerable or shaming, unapproachable or difficult to transform.

4. Narrative exposure therapy

Narrative exposure therapy (NET) is a standardised, controlled, short-term intervention originally developed in conflict situations and extensively trialled in conflict settings in low- to medium-income countries (Robjant and Fazel, 2010).

Training

Experienced therapists require a two-day NET training course; lay therapists should participate in a two to three-week training course.

NET: application and adaptions for CPTSD[5]

NET (Schauer *et al.,* 2011) is a short-term intervention based on the core assumption that a trauma-related network of memory representations has resulted from multiple adverse and fearful experiences. Sensory-perceptual, emotional, cognitive and physiological components of the trauma memories are stored within the network, disconnected from contextual information including spatial-temporal information, and not incorporated within autobiographical memory.

NET has been used to treat a range of patient groups, including asylum seekers (Neuner *et al.,* 2010; Stenmark *et al.,* 2013), perpetrators of violence such as former child soldiers or veterans (Ertl *et al.,* 2011; Hermenau *et al.,* 2013; Crombach and Elbert, 2015), and comorbid BPD and PTSD (Pabst *et al.,* 2012). There have been a number of controlled trials of NET that support its efficacy (Robjant and Fazel, 2010; Halvorsen and Stenmark, 2010;). To date there is only one feasibility study supporting its use in development trauma (Pabst *et al.,* 2012).

The primary aim of NET is to reduce PTSD symptoms by changing associative memories related to traumatic experiences, contextualising these memories and restoring autobiographical memory. This is achieved by constructing a chronological narrative of the most arousing events in the client's life, incorporating imaginal exposure to traumatic events. NET can facilitate an individual to make meaning of the highly stressful events that have occurred during their life.

The process of NET begins with detailed psychoeducation, after which the client is encouraged to narrate the events of their life in chronological order, from birth to the present. This is done using a 'life line', symbolised by a line or a rope with flowers representing well-remembered positive events or relationships, and stones representing traumatic events. Each 'stone' is processed in turn using a form of exposure that focuses on sensory perceptions, thoughts, emotions, and body reactions and connects them to contextual information. Experiences at the time of the trauma are contrasted with the client's experience and context in the

[5] Based on discussion with Katy Robjant.

present. Information about the trauma is then integrated into a written narrative of the client's life. A number of features of NET are particularly pertinent to CPTSD:

a) **Connecting multiple trauma memories into a coherent narrative**: NET was developed in the context of populations affected by conflict in regions of crises and disaster. It is, therefore, by necessity, brief and designed to treat PTSD in the context of multiple traumatic events. NET works to connect the multiplicity of trauma and other memories into one coherent narrative, which fosters a more solid sense of identity. Since in NET the narrative begins at birth, the client is able to see how cognitions, beliefs about the self and symptoms develop over time. For example, seeing the development of dissociation in early trauma, and how it occurs in subsequent traumas, can help the client to understand the origins and function of their dissociation.

b) **Stabilisation incorporated into memory processing**: Strategies to reduce dissociation are integral to memory processing, rather than being taught in the abstract in an earlier phase of therapy. The process of contrasting between the past and present and the very interactive style of memory processing helps to mitigate against the tendency to dissociate. NET practitioners suggest that addressing symptoms successfully is the most effective method of stabilisation, so there is no need to delay treatment of PTSD with a stabilisation phase.

c) **Working with multiple traumas or limited sessions**: When an individual has experienced multiple traumas, it is possible to choose to work only on specific ones to make the therapy more manageable. Sometimes therapists suggest choosing a certain number of traumas or 'stones' from each period of the client's life; this would be those traumas with the highest salience, or the first, worst, typical and last event of a type.

d) **Evolutionary biological model of dissociation**: NET utilises an evolutionary biological model of dissociation that allows a framework for understanding and working with dissociation and deliberate self-harm within memory processing. Peritraumatic defensive responses tend to be

repeated when trauma memories are triggered. It outlines a six-F progression of responses (see Figure 1 on page 22), with dissociation becoming progressively more likely. The first F is the orienting response labelled 'freeze'. In the next two, 'fight' and 'flight', there are increasing levels of autonomic arousal, which peak with the 'fright' response of tonic immobility that is accompanied by tachycardia, vasoconstriction, hypertension, high emotional arousal, but with fear largely replacing anger. As parasympathetic activation takes over, there is a shut-down response, and finally, triggered by disgust or proximity of the danger, there can be a faint. It is hypothesised that this model can explain the role of deliberate self-harm because it can induce the 'flag' state, reducing tension and inducing a shut-down dissociative state.

e) **A shame-reducing approach**: Due to the close and interactive nature of the therapy, it is believed that attachment repair happens and shame reduces as clients discuss memories without experiencing rejection. This further helps them to develop a positive sense of identity.

Phase 3: Reintegration, reconnection and recovery

This phase has been the focus of less clinical and research attention than the other phases, yet it is key to the successful reclamation of a life and is thus central to any therapeutic endeavour. Phase three may be understood as the process of reengaging with others, and with oneself as an autonomous individual with rights and choices. It entails a willingness and capacity to relate compassionately to oneself and others, and (re)establish trust in self and others. This includes the freedom to choose to reengage in friendships and intimate relationships, and in occupational activities that promote health and wellbeing, rather than re-enacting powerlessness.

Herman (1992) described this stage as the client's reconnection with their life, or perhaps connection for the first time:

> *'In the third stage of recovery, the traumatised person recognises that she has been a victim and understands the effects of her victimisation. Now she is ready to incorporate the lessons of her traumatic experience into*

her life, she is ready to take concrete steps to increase her sense of power and control, to protect herself against future danger, and to deepen her alliances with those whom she has learned to trust.'

Herman (1992) stated that this process of assimilation includes a new awareness in the individual of the socialised attitudes that lead to their vulnerability, and reconciling with themselves in 'letting go' of the aspects of the self formed by the traumatic environment. Learning to defend oneself physically when frightened, if managed therapeutically, can address the somatosensory aspects of the traumatic memory and permit the learning of new behavioural responses to threat and cognitions. Reconnecting with others through increased (and judicious) trust may lead to a greater capacity for intimacy, and for some engaging in social action.

Linehan (1993) referred to similar stages in her DBT for BPD:

- stage one: attaining basic capacities, i.e. developing DBT skills
- stage two: reducing post-traumatic stress
- stage three: increasing self-respect and achieving individual goals.

The latter stage may include making more friends, resolving work problems, or making career choices according to the client's preferences.

The traumas that underpin CPTSD in an individual are usually interpersonal in nature and therefore highly likely to result in an impaired capacity to trust and develop reciprocally caring and supportive relationships. There is evidence for the effectiveness of group and therapeutic community approaches in addressing these interpersonal aspects and phase three aims (Pearce and Pickard, 2013; McFetridge and Coakes, 2010).

The stage of reconnection and reintegration requires time, which could mean months of intense re-exposure to whatever has been (perhaps subtly) avoided, or indeed maybe a lifetime of readjustment. More recently, clinicians have written about the possibility of 'post-traumatic growth' (Blore, 2012; Calhoun and Tedeschi, 2014). Great care must be exercised to balance hope with the validation of an individual's current reality and experience to ensure post-traumatic growth is not inappropriately interpreted, or expected of the client.

Biology and pharmacotherapy

The biological correlates of CPTSD have been reviewed by Marinova and Maercker (2015). These include marked structural and functional changes in the brain, particularly in the interrelating areas of the limbic system. Corresponding increases in the size and functional activity of brain centres have been found to follow psychological therapies. This would suggest that effective psychological therapies may not only improve emotional functioning, but also to some extent reverse the damaging neurobiological effect on the brain's emotional centres that can follow complex trauma.

There is little published research on the pharmacotherapy of CPTSD. There are, however, a number of reviews of the pharmacological treatment of PTSD (McCubbins and Morris, 2015; Hoskins *et al.,* 2015). The review by Hoskins *et al.* (2015) concluded that selective serotonin reuptake inhibitors (SSRIs) were found to be statistically superior to placebo in the reduction of PTSD symptoms, although the effect was small. Some specific medications have been shown to have a small positive impact on PTSD symptoms and with acceptable side effects. The strongest evidence exists for Fluoxetine and Paroxetine, as well as the serotonin–norepinephrine reuptake inhibitor Venlafaxine. More recent evidence suggests that Sertraline (another SSRI) is also an effective treatment for PTSD. Jerud *et al.* (2016) found Sertraline and prolonged exposure to be equally effective in improving emotion regulation in those with chronic PTSD, both at the conclusion of treatment (10 weeks) and follow up (six months).

There have been a number of studies, including a promising RCT, which have demonstrated the benefits of Prazosin in reducing intrusive PTSD symptoms (i.e. nightmares) in combat veterans (Raskind, 2015). A number of other medications have been trialled for the treatment of PTSD (e.g. antipsychotics, anticonvulsants), but consistent evidence of effectiveness is lacking.

To date, the research on the pharmacological treatment of CPTSD is minimal and more work is required to ascertain whether the reported benefits of pharmacotherapy for PTSD are applicable to the treatment of CPTSD.

Special considerations in treating CPTSD

The therapeutic relationship

As survivors of repeated childhood trauma tend to experience physiological responses to triggers, it has been suggested:

> *'They are prone to experience minor frustrations in the therapeutic relationship as violations. As a consequence, these patients are most at risk of being abused by their therapists, and by the medical profession in general, and, reciprocally, to be experienced by them as abusive, ungrateful and manipulative.'* (van der Kolk, 2001)

Given the lack of control clients have had over their index traumatic experiences, boundaries should be clearly negotiated, contracted and maintained to increase a sense of safety and predictability.

Parenting

Childhood abuse or neglect frequently results in insecure attachment. Consequently, when adults with CPTSD become parents, they may have particular difficulties with attunement and sensitive responses to everyday distress in their children. If the parent remains untreated, this could impact negatively on the social and emotional development of their children.

Therapist competency

Therapists need to be proficient in working with affect regulation as well as in carrying out trauma-focused therapy. Particular challenges for a therapist working with CPTSD include identifying and managing traumatic re-enactment, listening to graphic traumatic material and maintaining therapeutic boundaries (Douglas, 2013).

Supervision

Due to the likelihood of interpersonal difficulties and boundary issues in this client group, as well as the high level of affect and the disturbing nature of the traumatic material, regular supervision by a professional who is experienced in working with CPTSD is essential for the wellbeing of the client and therapist.

Vicarious traumatisation

Vicarious traumatisation (McCann and Pearlman, 1990) refers to the cumulative transformative effects upon the identity, world view, psychological needs, beliefs and memory system of the trauma therapist as a result of working with survivors of traumatic life events. Those most at risk are novice therapists (Ghahramanlou and Brodbeck, 2000; Pearlman and MacIan, 1995); therapists with a history of trauma (Jenkins and Baird, 2002; Van Deusen and Way, 2006; Cunningham, 2003); and those with most exposure to trauma cases (Schauben and Frazier, 1995). The work environment can mediate these potential vicarious responses to working with traumatised clients (Maslach *et al.,* 1997).

To reduce the risk of vicarious traumatisation, services should encourage:

- recognition of the early warning signs of traumatisation
- regular supervision
- peer support, team support, containing management support, including self-care groups within the workplace
- limits on exposure to traumatic material
- balancing of caseloads
- balancing days and scheduling of breaks
- good work-life balance.

Further research

Although evidence exists for the theoretical basis and psychological treatment of PTSD, this is not the case for CPTSD. There are a number of areas to address in future research (the following list is not exhaustive):

- theoretical models that distinguish PTSD from CPTSD
- theoretical models that explain the symptom clusters of CPTSD
- effectiveness and acceptability of psychological and pharmacological treatments for CPTSD
- effectiveness and acceptability of phase-based versus trauma-focused therapeutic approaches for CPTSD
- appropriate design of exposure-focused interventions for CPTSD (i.e. intensity, number of sessions).

Conclusions

Although CPTSD is not yet a formal diagnosis, it has been recognised by clinicians working within the field for many years (Herman, 1992). Individuals suffering CPTSD often experience persistent and pervasive impairments in regulating their emotional experience, sustaining their relationships, and difficulties with their sense of self, in addition to the symptoms of PTSD.

There is overlap with the existing diagnoses of borderline personality disorder (BPD), emotionally unstable personality disorder and the dissociative disorders. However, distinctive features to CPTSD include a lesser risk of self-harm and fear of abandonment, and a more stable negative sense of self than presented by individuals with BPD. While studies suggest the comorbidity is high, not all individuals with BPD report a history of trauma, which is clearly required for CPTSD.

Research has found CPTSD to be associated with structural and functional changes in the emotional centres of the brain (limbic system), and with significantly impaired emotional, interpersonal and occupational functioning.

Repeated childhood trauma is correlated with increased physical and mental health difficulties, as well as a greater likelihood of social and forensic problems. These biological and psychological consequences can, however, be ameliorated by effective psychological therapies.

Trauma-focused therapy should not be unnecessarily delayed or avoided, however it is equally important that this be considered in light of recent risk behaviours and the individual's presentation. Where there has been recent self-harming or parasuicidal behaviour, the clinician should err on the side of safety (and potential effectiveness) and include a stabilisation and psychoeducation phase.

Several studies and models suggest a phased approach to treatment is likely to be of benefit; however, the necessity of a stabilisation phase for all individuals is currently under debate. The duration and content of the phases are tailored to the individual, and take account of their risk behaviours and capacity to tolerate emotional distress in a therapeutic manner. Phases will overlap and may also be cyclical, with the individual needing to return to earlier phases as therapy progresses:

- Phase one: Stabilisation (symptom management, increasing emotion regulation skills and addressing current stressors)
- Phase two: Trauma processing (focused processing of traumatic memories)
- Phase three: Reintegration (re-establishing social and cultural connections and addressing personal quality of life).

Evidence indicates that psychological therapies can be highly effective for CPTSD. There is currently insufficient evidence to recommend any particular therapy over another, but it is generally accepted that treatment needs to address three domains: cognitive, affective and sensorimotor.

A number of existing effective therapies for PTSD have been adapted for phase two (trauma processing) in CPTSD, including prolonged exposure and eye movement desensitisation and reprocessing. Other therapeutic approaches such as narrative exposure therapy, compassion-focused therapy, dialectical

behaviour therapy, and the therapeutic community can be helpful with some or all phases.

Further research is urgently required to develop and evaluate therapeutic approaches for specifically addressing the core aspects of CPTSD. Failure to adequately address CPTSD in the UK population will lead to significant intergenerational health consequences, and further compound social and economic costs.

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Appendix 1: Initial client assessment proforma

INITIAL ASSESSMENT PROFORMA

Patient Name: **D.o.B:**

Date(s) completed:

Clinician:

Presentation *Describe according to mental state criteria (appearance, mood, cognition, thoughts, perception, behaviour). Check consistency of presentation with known history. Does the client understand the reason for referral? Why referred now?*
Presenting problems *List these in the order in which the client prioritises them, together with relevant quotes and any concerns observed by others.*
History of problems *Describe duration, severity and possible causes, according to client's worldview. Look also for interventions/processes/people that have influenced the problems, for better or for worse, including previous experiences of therapy, and how mental health system may have maintained difficulties.*
History of achievements *Education, positive relationships, children, jobs, aspects of life past and present that they are proud of, interests, values and priorities, spiritual or existential beliefs that are important. How have difficulties been managed in the past?*
Trauma history *Be as accurate as possible with geography, timeline, names, and identify if possible the most significant trauma of many – the 'index' trauma, personal meaning of traumas; experiences of head injury and/or traumatic brain injury; experience of human trafficking.*
Female genital mutilation *Is there a history of circumcision/cutting/FGM in patient's culture/family?*
'Index' trauma *Nature of traumatic stressor – what happened? Patient's role in event,*

state at time of event (unconscious, dissociation, under the influence of drugs or alcohol), thoughts and feelings about actions taken and not taken, personal meaning of index trauma.
Current symptoms of PTSD *Description of trauma-related and other symptoms in addition to CAPS/PDS etc.* **Post-trauma** *Perceptions of self, others, world since event, appraisal of event and of symptoms since, symptom management strategies.*
Current symptoms of CPTSD **Affective domain problems** *Emotion dysregulation (heightened emotional reactivity, violent outbursts, reckless or self-destructive behaviour, tendency towards experiencing prolonged dissociative states when under stress, emotional numbing, lack of ability to experience pleasure or positive emotions).* **Dissociative symptoms** *Disengagement, depersonalisation, derealisation, emotional constriction/numbing, memory disturbance, somatic symptoms including medically unexplained symptoms, identity dissociation.* **Self-disturbances** *Negative self-concept (persistent beliefs about oneself as diminished, defeated or worthless, may be deep and pervasive feelings of shame or guilt, e.g. not having overcome adverse circumstances, or not having been able to prevent the suffering of others).* **Interpersonal disturbances** *Persistent difficulties in sustaining relationships (difficulties in feeling close to others, avoid, deride or have little interest in relationships and social engagement, occasional experiences of close or intense relationships but difficulty maintaining emotional engagement).*

'Positive' psychotic symptoms *Ask about nature of hallucinations/delusions, congruent with trauma history? Directly or thematically? Or bizarre in quality? First/second person, kind of voice(s), recognisable, content, where coming from? Their understanding of their symptoms – origin, onset, etc.*
Background *Family and cultural history and context, personal/social relationships, children (if relevant), genogram, significant cultural and religious frameworks.*
Current sexual functioning *Problems with intimacy, not necessarily only following sexual abuse, as even in other cases of PTSD to non-sexual incidents, patients can problematically confound sexual arousal with physical arousal.*
Current social, housing, financial, employment situation and challenges *Asylum/refugee status and time in UK, current living situation including housing, financial problems and support networks, employment, education.*
Risk issues, drug and alcohol use *Consider dissociation, suicidal intent and self-injurious behaviour, threats by/to others, impact of TBI, domestic violence, child protection, vulnerable adult, neglect/self-care difficulties.*

Previous mental health problems and psychological help received – personal meaning of healthcare interventions *Professionals involved, ecomap.*
Initial formulation with the service user (predisposing, precipitating and perpetuating factors; protective factors and resilience) *This should be brief, transparent and free of jargon, the personal meaning to the service user of events and experiences should be included, awareness and inclusion of social/societal factors (politics, poverty, limited access to resources etc.).*
Summary and intervention plan ☐ *Normalisation* ☐ *PTSD psychoeducation and instilling hope (rationale for therapy)* ☐ *Self-help strategies (grounding, safe place, mindfulness, nightmare rescripting)* ☐ *Risk plan* *Interventions indicated by formulation, e.g. stabilisation, symptom management and stabilisation group, TF-CBT, EMDR, NET, further assessment or information required, plan and initial objectives agreed with client, plans with other agencies.*
Hopes for change now and in future, specific goals for trauma-focused intervention *What do they want to gain from therapy? Does he/she think change is possible? What does the client think will help? What issues are most important to start working on?*

Potential issues for treatment

Childcare, work, travel, potential inability to process: subjective safety, on-going threat, psychological distance, unstable physical environment, concurrent life events, lack of social support, use of alcohol or high levels of prescription medication, cognitive damage, risks from processing, self-harm/violence, child protection/neglect, reluctance in assessment to discuss trauma, on-going criminal case in relation to trauma previous, extended contact with mental health services/treatment with negligible change.

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