Guideline for the treatment and planning of services for complex post-traumatic stress disorder (CPTSD)

#### 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 is generally accepted that, in addition to the symptoms of post-traumatic stress disorder (PTSD) (American Psychiatric Association, 2013), people suffering CPTSD experience persistent and pervasive impairments in regulating their emotional experience and sustaining their relationships, and difficulties with their sense of self. This may include beliefs about themselves as diminished, defeated or worthless (Maercker *et al*., 2013).
* At present, CPTSD is not a formal diagnosis within the DSM-5 (American Psychiatric Association, 2013) or ICD-10 (World Health Organisation, 1992) systems, but is likely to become incorporated into the forthcoming ICD-11. There is overlap with the existing diagnoses of borderline personality disorder (BPD), emotionally unstable personality disorder and the dissociative disorders. However, 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 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 (van der Kolk, 2014). Repeated childhood trauma is correlated with increased physical and mental health difficulties, as well as a greater likelihood of social and forensic problems (Felitti *et al.*, 1998). Effective psychological therapies can, however, ameliorate these biological and psychological consequences.
* Unlike PTSD, there is no current NICE guideline or Cochrane review of the effectiveness of psychological and pharmacological interventions for CPTSD within the UK. The Board of the UK Psychological Trauma Society (UKPTS), therefore, proposed a review of both published evidence and accepted good clinical practice to develop a guideline for those working clinically or planning services for people with CPTSD.
* Evidence and clinical consensus suggests a phased approach is likely to be of benefit particularly with individuals showing more severe symptoms. It is recommended that this approach entails three sequential but overlapping phases:
	+ Phase one: Stabilisation (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).
* Whilst untreated CPTSD is often a chronic problem, a meta-analysis of randomised, controlled trials of psychological therapies for adult survivors of childhood sexual abuse found psychological therapies to be effective (Ehring *et al.,* 2014).
* There is currently insufficient evidence to recommend any particular therapy over another, but it is generally agreed that treatment needs to address three domains: cognitive, affective and sensorimotor.
* 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. 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.
* The UKPTS considers that failure to address CPTSD in the UK population will continue to cause intergenerational health consequences, and further compound social and economic costs.

#### 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 mental health services. Service planning for CPTSD should take place within the wider context of trauma-informed care (Bassuk *et al.,* 2016).

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 complex post-traumatic stress disorder (CPTSD). Guidelines and systematic reviews regarding post-traumatic stress disorder (PTSD) have been available for some time (National Institute for Health and Clinical Excellence (NICE), 2005; National Institute for Health and Clinical Excellence, 2013; Bisson & Andrew, 2009). In Scotland, the Matrix, a guide to delivering evidence based psychological therapies included sections on both PTSD and CPTSD (NES, 2015), but no guidance specifically regarding CPTSD has been available in the UK.

#### What is CPTSD?

Before we consider CPTSD, it is important first to understand PTSD. PTSD was first 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 cognitions and mood, and arousal:

* **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 cognitions and mood** may 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.
* **Arousal symptoms** may 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. In addition, there are two possible subtypes:

* 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.

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, which defines CPTSD 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*)*

Thus whilst the symptoms of PTSD emphasise the cognitive and behavioural consequences of an individual’s acute response to an overwhelming event, CPTSD could be considered to encapsulate the systemic effects and chronic adaptations to repeated and/or sustained inescapable events. Several authors have proposed that the constellation of difficulties managing emotions and interpersonal relationships, together with an impaired sense of self, can be understood as the long-term sequelae of childhood trauma. Other clinicians working with combat veterans and adult victims of domestic abuse or political torture have reported a similar pattern of difficulties.

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).

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 after the adult is in a safe environment.

There is significant overlap between the symptoms of CPTSD and borderline personality disorder (BPD). People meeting criteria for BPD commonly report having experienced sexual, emotional and physical abuse as a child. Seventy-five percent 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: an unstable sense of self, unstable and intense interpersonal relationships, impulsiveness, and 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 effect of repeated overwhelming experience in CPSTD appears to be mediated by personal sensitivities and differences. An example of this is the interpersonal and social processing difficulties of those people on the autistic spectrum. For these individuals, the nature of their neurodevelopmental processing difficulties may produce a CPTSD response to lower level interpersonal stressors than in others who are better able to understand and moderate social communication (Dell'Osso & Dalle Luche, 2015; King, 2010).

Any therapeutic intervention for CPSTD 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 context, and with this level of support and personal resource.

***The conceptual basis of effective therapy for CPSTD***

CPTSD has been shown to be most likely following chronic, repeated interpersonal violence. 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 is 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 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 & Lewis-Fernandez, 2011; Morina & Ford, 2009). This has been recognised in the ICD-10 diagnostic category ‘Enduring changes of personality following catastrophic events’.

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 1 to 2 is dependent on the acquisition of skills rather than being determined by time in therapy.

Cloitre *et al.* (2014) tested the phasing of the three stages and found that treatment drop-out increased and treatment gains reduced when exposure work was carried out before a skills-based stabilisation phase. 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.

Some authors have suggested, however, that it is possible to achieve clinical change in the treatment of CPSTD without adopting a systematic phased approach and that this may vary with symptom severity and client population. More specifically, some propose that stabilisation and psychoeducation can occur in parallel with, rather than precede, trauma-focused therapy. Corrigan & Hull (2015) raised a number of concerns about the psychotherapeutic treatment of CPTSD, including the prevailing assumptions relating to evidence and research methodology. They also questioned whether the multifaceted presentation of CPTSD might be more effectively treated with a more complex, multimodal intervention that is not necessarily phased.

While such an approach may be possible, particularly where there are additional containing factors present (e.g. via group or residential therapy), it may be conceptually appropriate and safer to adopt a sequential phased-based approach, particularly with individuals who are more severely affected and less contained. The ISTSS consensus guidelines surveyed 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).

*Assessment*

Given that individuals with CPTSD often have difficulties with trust, the building of the therapeutic relationship is an essential aspect of the assessment process. Where this proves difficult, work on interpersonal relationships is likely to be key to the stabilisation phase of treatment. Establishing clear boundaries is particularly important to create a sense of predictability and greater safety. 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 indicates a phased approach to treatment, a range of interventions may be offered to help the client manage 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 is 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. Psychoeducation
	1. models of simple PTSD and how multiple trauma complicates presentation (memory models)
	2. explaining the impact of developmental trauma
	3. explaining windows of tolerance (level of arousal which the client can tolerate; see below)
	4. explaining dissociation
2. Establishing safety and readiness for therapy
	1. addressing issues relating to housing, benefits, asylum, debts, bills
	2. family tracing instigated through the Red Cross tracing service for those separated from family in situations of armed conflict
	3. provision of childcare
	4. dealing with substance misuse
3. Grounding for dissociation/flashbacks

a) grounding in the present using the senses

b) discrimination training

1. Symptom management
	1. managing nightmares
	2. panic and anxiety
	3. mood: increasing activity and reducing isolation
	4. pain and physical health
	5. titrating medication
2. Skills training
	1. mindfulness
	2. interpersonal skills
	3. emotion-regulation skills
	4. distress tolerance
	5. self-compassion

Each of these elements is now discussed in detail.

**1. 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. 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 (2000) cognitive model**, 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 PTSD.

**Brewin’s dual representation theory of PTSD** (Brewin *et al.,* 1996; Brewin & 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. Under extreme stress the hippocampus becomes significantly less active and the amygdala significantly more active. Under these conditions the C-rep is weakened and, albeit 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. 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.

Models of PTSD are often 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]](#footnote-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 of 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, as a result of reliable and consistent carer response to infant distress, the individual in adulthood will be able to regulate their emotional experiences. 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 discharge emotion), or dissociation. Alternatively, an individual may experience ongoing 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 experience of somatic distress or disorganisation.

Phased-based approaches to the treatment of CPTSD build emotional resilience and integrative capacity, which can only happen with an increased window of tolerance.

*d) Explaining dissociation*

Some people dissociate during trauma (Holmes *et al.,* 2005; Murray *et al.,* 2002; Ozer *et al.,* 2003). They may spontaneously ‘go blank’, ‘switch off’ or ‘leave’ their bodies (derealisation or depersonalisation) in an attempt to distance themselves from the distress they are feeling. Consequently, the trauma 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 & Holmes, 2008). Recalling traumatic events then triggers 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 below (see fig. 1). In areas 5 and 6, dissociation is likely.

*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. This can result in multiple diagnoses to explain these symptoms. For this reason, it is essential that an individualised formulation is developed that unifies the range of experiences and symptoms presented by the individual in response to the trauma.

Figure 1. Defence cascade



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

**2. Establishing safety and readiness for therapy**

Beforeproceeding 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 issues related to:

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

**3. 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 including mindfulness and yoga (van der Kolk *et al.*, 2014).

**4. 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 straightforward 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 where depression is severe to improve the client’s mood. Given the extent to which trauma disrupts the sense of self, and causes the individual to stop activities and roles they previously valued, increasing activity levels can form part of the process of reclaiming their life. Ehlers and Clark (2000) argue that this should be introduced early in treatment, rather than waiting until phase 3, 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*

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.

*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 the possible effects of different medications on memory processing should ideally 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 25).

**5. Skills training**

A number of packages have been used to address the skills deficits associated with a disorganised attachment pattern. For those who self-harm, 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 within the context of a disorganised attachment (Fonagy, 2000; Fonagy & 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.

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 randomised controlled trials (RCT) (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. The table below summarises the areas prioritised in skills training (table 1.).

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 reexperiencing 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 taught by someone able to facilitate the containment of these traumatic intrusions and related emotion.

**Table 1: Goals of skills training in CPTSD**

|  |  |
| --- | --- |
| **Increase** | **Decrease** |
| Mindfulness | Identify confusionEmptinessCognitive dysregulation |
| Interpersonal skills | Interpersonal difficultiesFears of abandonment |
| Emotional regulation skills | Affect labilityExcessive anger |
| Distress tolerance | Impulsive behaviourSuicide riskSelf-harm |

**6. Compassionate mind training**

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 are no RCTs on compassion-focused therapy, but it has been found to be effective in a range of mental and physical health-related populations (Leaviss & Uttley, 2015). Compassion-focused therapy is widely incorporated into the phase 1 treatment of those who have experienced early trauma and poor attachments. In increasing the capacity for self-soothing and self-directed compassion clients are, in practice, more able to process their traumatic shame-based memories within their window of tolerance.

***Phase 2: Trauma processing***

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

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 & James, 2012). While exposure to shame can be therapeutic, care needs to be taken.

As shame carries an implicit social context, extremes of this emotion may be treated effectively by including 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.

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 have been 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. Trauma-focused cognitive behavioural therapy**

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 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.

*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 available.

**2. Prolonged exposure: application and adaptions for CPTSD[[2]](#footnote-2)**

PE has gained awards[[3]](#footnote-3) in the USA for its effectiveness with 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 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 are 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 in discussions, 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.

*Training*

It is important that clinicians have prior training in the standard 10-session prolonged exposure (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

**3. Eye movement desensitisation and reprocessing**

Eye movement desensitisation and reprocessing (EMDR) (Shapiro, 2002) integrates imaginal exposure and cognitive restructuring with alternating rhythmic stimuli. Conventionally this would involve eye movement, but can include other forms of dual-attention stimuli (e.g. alternating hand-tapping or audio tones). EMDR appears to facilitate access to the traumatic memory network and help reprocess information with new associations between disturbing memories and more adaptive memories or information. This is thought to lead to better information processing, an alleviation of emotional and physiological distress, and the development of cognitive insights. EMDR seeks to work on three levels: the target trauma, past events that underpin current dysfunction, and future templates addressing potentially distressing situations in a more adaptive manner.

*Training*

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

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

*EMDR applications and adaptations for CPTSD[[4]](#footnote-4)*

Key points:

* Use a phased-based therapy approach with more time on stabilisation work, especially resource development and installation (RDI).
* Manage dissociation by ensuring the client is ‘in the present’ while processing past memories, with a focus on practising ‘coming back to the present’.

*Starting EMDR*

Developing a strong therapeutic alliance is key. This can be enhanced with techniques such as eliciting compassion for the child-self, or recognising that the child is still loathed, and considering compassion towards them. With people who have experienced multiple disrupted attachments, particularly in early childhood, having at least one healthy attachment present is a good indicator for starting memory processing fairly early in the therapy process.

Areas of risk for the client need to be fully assessed. Within EMDR, self-harm may be tolerated within reason because such behaviour is accepted as a current coping strategy; however, an assurance of the client being committed to minimising risks as far as possible and the therapist being able to elicit some form of safety is essential. Other risks such as substance use (including prescribed benzodiazepines or other medication) are also tolerated as long as they do not impede the client’s capacity to utilise the processing, i.e. to not attend appointments intoxicated or use substances immediately after EMDR sessions. Risks associated with dissociation require careful consideration and planning. Where clients are vulnerable to engaging in risky behaviours, such as unwanted sexual interactions, or getting seriously lost due to not remembering their current whereabouts, or neglecting their self-care/ that of others including children, will require additional support from other people and/or services.

A rough guide for when to start processing within EMDR (Korn, 2009):

* dissociative identity disorder – start after one year of stabilisation
* if severe dissociation – start after two months of stabilisation
* BPD – start after two months of stabilisation.

Resource development and installation should focus on developing core resources and self-capacities: the client needs to feel stronger, safer, more grounded, and more tolerant of strong affect, so that they can stay in the present and also be connected to the therapist while accessing memories. The process should focus on sensorimotor, mastery experiences, relational resources, skill-based or behavioural experiments or experiences, along with any associated affective and somatic components, and these should be installed using brief sets (10-12) of bilateral stimulation. Negotiation with different ego states may also be indicated, as well as using the adult ego state as an imagery resource to support the client when processing child abuse memories (e.g. to comfort the child or challenge the abusing adult). With dissociative states, using the technique of Constant Installation of Present Orientation and Safety (Knipe, 2008) can be helpful to facilitate staying in the present. Clients are asked to gauge how dissociated they are using a ‘back of the head’ scale to demonstrate how physically present they feel with the therapist (e.g. if beyond the back of the head the client is dissociating). Non-EMDR strategies and skill-development focusing on ego strengthening and stabilisation can also be integrated.

*EMDR processing*

During processing the therapist should stay alert to signs of dysregulation (hypoarousal, hyperarousal, blanking, shutting down, avoiding and dissociating) and blocking beliefs. They should actively use cognitive interweaves:

* shame, self-blame, self-loathing and negative cognitions related to defectiveness/unworthiness = responsibility (e.g. ‘I’m bad’ to ‘I did the best I could’)
* fear and avoidance and an ever-present sense of danger = safety
* extreme mistrust, helplessness and hopelessness = choice (e.g. ‘I’m powerless’, ‘I have no control’ to ‘I have choices’, ‘I’m in control now’)
* bring the self in (‘You’re not alone’) and ask protective parts to step back.

With regards to targeting memories, the process should begin with more current memories rather than early developmental trauma, especially if the client is highly dissociative, and focus on those with highest distress, according to measuring subjective units of distress (SUDs) on the 0-10 point scale with 10 being the most distressing. If channels of traumatic memories are associated, it is important to separate these memories. Titrate eye movements with shorter sets, more time in between, or use alternate hand taps. As attachments are disrupted it is important to understand this; using CBT between processing sessions can be helpful.

For phase three, future templates should be used to increase relational capacity. The clinician should rehearse and problem-solve anxiety-provoking situations imaginally with the client, e.g. attending a family wedding with the perpetrator, social gatherings entailing fear of being judged. Overall, the client needs to feel safe.

**4. Narrative exposure therapy**

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

*Training*

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

*NET: application and adaptions for CPSTD[[5]](#footnote-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 & 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 & Fazel, 2010; Halvorsen & 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 done 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 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:

1. **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 where there have been 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.
2. **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.
3. **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.
4. **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.), 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 peaks 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.
5. **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 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 personal relationships, and in occupational activities that promote health and wellbeing, rather than re-enacting powerlessness.

Herman (1992) described this stage as one of reconnection with one’s 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 themself formed by the traumatic environment. Learning to actively 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 cognitive behaviour therapy of BPD: attaining basic capacities (stage one), i.e. developing DBT skills; reducing post-traumatic stress (stage two) and increasing self-respect and achieving individual goals (stage three). 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 & Pickard, 2013; McFetridge & 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 & Tedeschi, 2014). Great care must be taken 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 & 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 change 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 & 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 & Brodbeck, 2000; Pearlman & MacIan, 1995); therapists with a history of trauma (Jenkins & Baird, 2002; Van Deusen & Way, 2006; Cunningham, 2003); and those with most exposure to trauma cases (Schauben & 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.

***Conclusions***

Whilst Complex post-traumatic stress disorder is not a formal diagnosis as yet, it has been recognised by clinicians working within the field for many years (Herman, 1992). Those suffering CPTSD often experience persistent and pervasive impairments in regulating their emotional experience, sustaining their relationships, and difficulties with their sense of self. This is 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.

A phased approach, in accord with other therapy models, is likely to be of benefit, particularly with individuals having more severe symptoms. It is recommended that this entails three sequential but overlapping phases:

* 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 adult survivors of childhood sexual abuse. There is currently insufficient evidence to recommend any particular therapy over another however, 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), 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 CPSTD. 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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# ***Appendices***

**Appendix 1: Initial client assessment proforma**

**INITIAL ASSESSMENT PROFORMA**

**Patient Name: D.o.B:
Date(s) completed:**

**Clinician:**

Check Psychometrics and Assessment checklist completed ⁯ ⁯

|  |
| --- |
| 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 & 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, ongoing 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, ongoing criminal case in relation to trauma previous, extended contact with mental health services/treatment with negligible change.* |

1. See for example: <http://media.psychology.tools/Worksheets/English/PTSD_And_Memory.pdf> [↑](#footnote-ref-1)
2. Based on discussion between Gill Moreton, Clare Fyvie and Mark McFetridge. [↑](#footnote-ref-2)
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). [↑](#footnote-ref-3)
4. Based on an interview with Alexandra Richman and on Korn (2009). [↑](#footnote-ref-4)
5. Based on discussion with Katy Robjant. [↑](#footnote-ref-5)