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Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide

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Over the last 40 years there have been considerable efforts to better describe, understand and treat psychological difficulties following the experience of traumatic events. Most

of this has focused on the diagnosis of Posttraumatic Stress Disorder (PTSD). However, epidemiological surveys have shown that a wide range of problems may emerge post-trauma. Clinicians and others have long complained that PTSD does not fully capture the nature of the difficulties presented by those people who have experienced prolonged and multiple traumatic experiences, often in childhood. Judith Herman wrote a seminal text describing the nature of "Complex PTSD", focusing on women who had experienced childhood sexual abuse (Herman, 1992). For her, Complex PTSD included: alterations in regulation of affective impulses (including anger and self-destructiveness); alterations in attention and consciousness (dissociative responses); alterations in self-perception (e.g. chronic shame and guilt); alterations in perceptions of the perpetrator (e.g. sympathetic bond); alterations in relationship to others (e.g. pervasive distrust); somatization and/or medical problems; and alterations in systems of meaning (including hopelessness). Similarities between Complex PTSD and Borderline Personality Disorder (BPD) can be seen in these criteria.

Although a diagnosis of Complex PTSD was considered for DSM-IV, it was finally included in the associated features section as the diagnosis Disorders of Extreme Stress Not Otherwise Specified (DESNOS, or sometimes shortened to DES). This was at least partly because it did not fit in the category of anxiety disorders, and could be within dissociative disorders, or somatization disorders, or even personality disorders. As Herman says in the foreword to this book, this is "exactly the point" (p. xiii).

This book is welcome as it pulls together theoretical and clinical approaches to understanding and helping people with difficulties following multiple and prolonged traumatic experiences. Such people may or may not in fact have PTSD, and as such the term "Complex PTSD" is not helpful in my opinion (use "complex traumatic stress disorders" if you insist). The editors co-author a good overview chapter to set the scene, and a helpful concluding chapter. These are sensible, measured and recommended – even if you do not agree with all the contents. Further "theory" chapters include neurobiological and developmental research, therapeutic alliance, cultural competence, vicarious trauma, and specific chapters on children and adolescents.

Complex Traumatic Stress Disorders, Complex Trauma, and Complex PTSD

The editors define complex psychological trauma as involving traumatic stressors that: (1) are repetitive or prolonged; (2) involve direct harm or neglect and abandonment by caregivers; (3) occur at developmentally vulnerable times such as early childhood; and (4) have the potential to severely compromise a child's development. Restricting the definition of complex traumatic stress disorders in this way may help in identifying a slightly more homogenous group than otherwise, and also help rein in clinicians who are more cavalier talking about "complex trauma" or "Complex PTSD". I have heard it used colloquially to cover a multitude of circumstances: for people who have multiple problems and experienced traumatic events at some time in their life (but then which complicated clients have not?); for people with flashbacks and nightmares, who may meet criteria for PTSD, who also have a lot of social and interpersonal problems; for people who meet criteria for PTSD who haven't improved with one treatment or another; and so on.

However, such a definition may lead to further ignoring the study of others who fall outside it. This definition rules out those people who have been tortured in adulthood, or who have experienced warfare or state-organized violence, as described by many people in our clinics who are refugees or seeking asylum. While perhaps not surprising, given that the authors are

almost all from the US and ICD-10 is a non-US classification system, it was still disappointing that the diagnosis Enduring Personality Change as a Result of Traumatic Experiences (EPC) was not in the index and only mentioned briefly in one chapter. In my experience, there is overlap between the clinical presentations associated with EPC and complex traumatic stress disorders as defined in this book. This is acknowledged elsewhere in the literature such as Terr's (1991) distinction between Type I (single traumatic event) and Type II trauma (multiple and prolonged traumatic experiences). For Terr, Type II trauma also includes war, community violence and domestic violence, as well as childhood abusive experiences. Elsewhere, the further diagnostic category of "Developmental Trauma Disorder" for children and adolescents has been proposed (van der Kolk, 2005). The utility of such a term awaits further investigation.

One concern in discussing these issues with clients, clinicians and referrers is the potential to dichotomize PTSD into "complex" and "simple". The editors themselves are suitably circumspect: "Although there is substantial controversy concerning whether these complex traumatic stress reactions constitute a singular disorder warranting a distinct diagnosis, we refer to them as *complex traumatic stress disorders* for the purpose of parsimony." (p. 442), and "*we are in no way diminishing the complexity that is inherent in the criteria for 'Traditional' PTSD.*" (p. 25, original emphasis). However, sadly other authors in this book (no names. . .) slip too easily into unhelpfully characterizing the situation as one of "Complex PTSD" vs. "Simple PTSD".

Assessment and treatment of complex traumatic stress disorders

I'm not sure if the book fully lives up to its subtitle as "an evidence-based practise guide" as some of the chapters cheerfully admit that there is currently no clinical evidence for the approach described. Most chapters are at least empirically grounded clinical interventions (Salkovskis, 2002) forming part of an "*evolving evidence base for preliminary treatment recommendations and provisional best practices* for complex traumatic stress disorders" (p. 84, original emphasis).

"When diagnosing other disorders" the clinician is encouraged to "consider the potential role of adaptation to complex trauma" (p. 21). Asking for the history of past traumatic experiences should be a part of a full clinical assessment. However, in my opinion, clinicians should be wary of jumping to the conclusion that a person's presentation is "complex trauma" or that that is what needs treatment, rather than addressing some pressing social problem, or providing initial treatment for an axis-I disorder. Broadly, the suggestions made about assessment in this book are sensible. A variety of self-report measures and structured interviews to assess various forms of posttraumatic disturbance are discussed and "the clinician is advised to avoid, whenever possible, non-standardized measures in the assessment of trauma effects, complex or otherwise" (p. 108). I was amused though (rightly or wrongly, and from an admitted position of ignorance) by the suggestion from one set of authors that the Rorschach should also be used in assessment.

Herman (1992) described a now well-known phased intervention approach for people with "Complex PTSD": Stage 1 – establish safety; Stage 2 – come to terms with the trauma story (including traditional trauma-focused PTSD treatments); Stage 3 – reconnect with people and society. This has been widely adopted as a clinical heuristic for much work with people following traumatic experiences. It is embedded within the NICE guidelines

for PTSD when discussing working with refugees and asylum seekers in particular. Modern cognitive-behavioural treatments for PTSD, such as Ehlers et al.'s (in preparation) *Cognitive Therapy for PTSD*, are also consistent with this, with the need to reduce "ongoing threat" (Herman Stage 1) prior to trauma-focused work.

The individual chapters on treatment approaches introduce you to a bewildering array of acronyms as each therapy has its own brand name. These chapters are variable in quality, especially with regard to available evidence (see Table 1). All chapters have helpful therapy transcripts to illustrate treatment but the timescales and typical number of sessions are not always provided.

The key points to be drawn from these chapters are that: (1) interpersonal schema/beliefs/emotions/behaviours are important and will be activated in the therapy relationship; (2) teaching self-soothing/emotion dysregulation strategies is likely to be necessary; and (3) some emotional processing, exposure, reliving, or at least reducing avoidance of the specific traumatic material, is required.

The chapters also broadly assume therapists already know how to teach emotion regulation skills and do prolonged exposure or reliving effectively. Hence, to be able to treat complex traumatic stress disorders it would seem sensible to be able to treat competently people who experience a range of problems including low mood (depression), intrusive memories and nightmares (PTSD), or panic attacks.

There are other limitations in these treatment chapters, most noticeably in the omission of developments in therapy from elsewhere. Paul Gilbert's work on taking a compassion focused perspective is very relevant to such clients but mention of compassion occurs only twice in the book, once in relation to therapists' compassion fatigue. Debee Lee's work applying compassionate mind to traumatic stress reactions is similarly missing. In addition, there is barely a mention of EMDR (a recommended treatment for PTSD), recent applications of imagery in therapy (e.g. Holmes et al., 2007), or schema focused approaches (Young et al., 2003).

Summary/conclusion

This book addresses important issues and was stimulating both academically and clinically (as this rather lengthy review testifies to). However, it does not (and can not) provide definitive answers to the questions posed about providing treatment for people with multiple problems who have experienced traumatic events. The book will be useful to most therapists, but especially those who regularly work with people whose main problems are associated with abusive or neglectful experiences in early childhood. Such people may meet criteria for Borderline Personality Disorder, or have extensive psychiatric histories, characterized by changing main diagnoses, and dissociative behaviours and self-harm. The book will be best used with other texts (some of which are listed in the bibliography) and CBT for such problems requires further development. This is likely to come from an integration of treatment approaches for BPD, PTSD, depression, and of techniques such as imagery, and compassion-focused approaches.

I leave the final word to the editors: "Does identifying a history of complex psychological trauma and complex reactions (labelled here as complex traumatic stress disorders) make a meaningful difference in clinical conceptualization and assessment, psychological and psychopharmacological treatment, and professional practice management and self-care?"

Table 1. Summary of chapters describing treatment approaches for complex traumatic stress reactions

Treatment	Evidence for treating complex traumatic stress disorders	Clinical approach and comments
Contextual Therapy	No current efficacy studies.	Based on theory that family environment is related to long-term psychological problems over and above the contribution made by the abuse. "Herman phases" 1 and 3 prominent. Focus is less on "reclaiming life" than acquiring skills for the first time. Involves interpersonal issues, self-soothing, and extensive cognitive work.
Cognitive Behavioural Therapy	Six trials demonstrating efficacy and 20 other outcome studies.	Co-authored by Marylene Cloitre who led a key treatment trial in this field. Addresses emotion regulation, cognitive behavioural understanding of interpersonal schema, and exposure to trauma memories.
Contextual Behavior Trauma Therapy	Little established efficacy for this population.	A 3 rd wave therapy: integration of Acceptance and Commitment Therapy (ACT), Dialectical Behavior Therapy (DBT) and Functional Analytic Psychotherapy (FAP). Main strategies are "radical acceptance and behavioural activation" via process of emotion regulation skills training, use of therapeutic alliance and acceptance based exposure to traumatic memories.
Accelerated Experiential-Dynamic Psychotherapy (AEDP) Emotion Focused Therapy for Trauma (EFTT)	Single study evidence for EFTT is "submitted for publication".	AEDP and EFTT covered in same chapter – as are similar approaches. Key factor is "adaptive processing of intense emotions in the context of a safe relationship" (p. 287). Explicitly draws comparison to mentalization-based treatment for Borderline Personality Disorder (Bateman & Fonagy, 2004).
Sensorimotor Psychotherapy	No current efficacy studies	Key focus is mindfulness of body experience. Focus on movements, smells, "feelings without words" so memory is experienced as being in the past rather than still happening. Move in ways that couldn't at the time e.g. actually put hands up to defend self when get the feeling/motivation/memory. Similar approach adopted in "stimulus discrimination" in CT for PTSD (Ehlers et al., in preparation)

Table 1. Continued.

Treatment	Evidence for treating complex traumatic stress disorders	Clinical approach and comments
Pharmacotherapy	"Limited scientific and clinical evidence for a rational pharmacotherapy" (p. 335).	"...role of medication is primarily to decrease intensity of symptoms so that psychotherapy may proceed" (p. 338). Not necessarily SSRIs; also may use anti-psychotic and anxiolytic medication.
Internal Family Systems Therapy	No current efficacy studies	"Within clients exists an undamaged essence that, once accessed, can become an effective leader of their internal and external worlds" (p. 357). Some similarities with Transactional Analysis, role of schema modes, and Paul Gilbert's self-self relating and use of compassion. Interpersonal processes also important.
Emotion Focused Therapy for couples	Some preliminary studies.	Based on attachment theory. Relationship activates overwhelming emotions associated with old trauma and which are "ordered and reshaped" into new responses. "Newly integrated emotions can then evoke new responses in interactions with a partner" (p. 387). Some similarities to using relationship and partner as vehicle for behavioural experiments and/or stimulus discrimination in individual CBT treatment.
Family Systems Therapy	No studies yet for complex traumatic stress presentations.	Strongest evidence comes from studies of families with traumatized toddlers and early school age children (Child-Parent Psychotherapy, CPP).
Group Therapy	Variety of studies from various therapeutic orientations.	Approaches vary by orientation, specific client group, and whether focus is first PTSD itself, rather than other problems associated with experiencing prolonged and multiple traumatic events.

(p. 441). Well, the editors suggest the answer is yes. This book poses this and related questions well, but as the editors say in the next paragraph, "Whether a complex trauma framework will enhance the outcomes for persons whose posttraumatic reactions transcend those found in the currently available criteria for PTSD remains an empirical question" (p. 441).

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