



The ISTSS Expert Consensus Treatment Guidelines For Complex PTSD In Adults

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ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults

1. Introduction:

Overview. ISTSS has developed guidelines for the treatment of PTSD, the first of which were produced in 2000 followed by a revision published in 2008 (Foa, Keane, Friedman & Cohen, 2008). The 2008 guidelines acknowledge that the PTSD framework does not include salient symptoms and problems of individuals who are exposed to prolonged and repeated trauma such as childhood sexual abuse, domestic violence, and political violence, commonly referred to as Complex PTSD, and that these disturbances contribute to distressed lives and disability. Accordingly, ISTSS has now developed best practices guidelines to aid clinicians in making decisions about the treatment of individuals with Complex PTSD.

The guidelines are the result of the efforts of the Complex Trauma Task Force (CTTF), a work group appointed by President Bonnie Green in November of 2000, with the mission of promoting a better understanding of the difficulties of individuals who have suffered sustained and repeated interpersonal trauma. The specific goals of the task force were to compile clinical and empirical knowledge about these survivors and to make recommendations regarding the study of the effects of complex trauma and its treatment (Green, 2000). The task force first published a series of papers on Complex PTSD in 2005 in a special section of the *Journal of Traumatic Stress* (Volume 18). In addition, a proposal to conduct an expert consensus survey, similar to that completed for the 2000 ISTSS guidelines on PTSD, was proposed and supported

by the ISTSS Board in 2008. The intention of the survey was to obtain expert opinion about the salient symptoms of Complex PTSD and more importantly, recommendations for its treatment.

This report was recently published in the *Journal of Traumatic Stress* (Cloitre, Courtois, Charuvastra, Carapezza, Stolbach, & Green, 2011). The results of the survey indicated that 84% of 50 expert clinicians endorsed a phase-based or sequenced approach as a first line treatment for Complex PTSD. There was also strong consensus that the treatment be patient-centered and that interventions be tailored to prominent symptoms. The guidelines presented here are based on the results of that survey as well as on a review of the empirical and clinical literature included in the survey report.

Definition of Complex PTSD. In order to conduct an expert consensus survey, report on the treatment recommendations of those surveyed and, ultimately, produce clinically useful guidelines, a single definition of Complex PTSD was required. The diagnostic conceptualization of Complex PTSD described in the clinical and empirical literature has varied, with symptom sets substantially overlapping but not identical. The syndrome has been alternately named Disorders of Extreme Stress Not Otherwise Specified (DESNOS) (Herman, 1992; Pelcovitz, Van der Kolk, Roth, Mandel, Kaplan, & Resick, 1997), PTSD and its Associated Features in the DSM-IV (APA, 2000), and Enduring Personality Change after Catastrophic Events (EPCACE) in the ICD (WHO, 1992). The selected definition included a range of symptoms organized into conceptually coherent and frequently used categories derived from the diagnostic descriptions cited above.

The ISTSS task force definition of Complex PTSD included the core symptoms of PTSD (re-experiencing, avoidance/numbing, and hyper-arousal) in conjunction with a range of

disturbances in self-regulatory capacities. The latter were grouped into five broad domains: (a) emotion regulation difficulties, (b) disturbances in relational capacities, (c) alterations in attention and consciousness (e.g., dissociation), (d) adversely affected belief systems, and (e) somatic distress or disorganization. Complex PTSD is typically the result of exposure to repeated or prolonged instances or multiple forms of interpersonal trauma, often occurring under circumstances where escape is not possible due to physical, psychological, maturational, family/environmental, or social constraints (Herman, 1992). Such traumatic stressors include childhood physical and sexual abuse, recruitment into armed conflict as a child, being a victim of domestic violence, sex trafficking or slave trade; experiencing torture, and exposure to genocide campaigns or other forms of organized violence.

Relationship to Diagnostic Systems. The guidelines are intended to be a resource for clinicians when considering treatment options for patients who experience the symptoms of PTSD (re-experiencing, avoidance and hyperarousal) as well as disturbances in some or all of the five domains described above.

In addition, it is expected that the guidelines will be relevant to treatment decisions based on diagnostic assessments derived from either the International Classification of Disorders (ICD: World Health Organization) or the Diagnostic Statistical Manual (DSM; American Psychiatric Association). The ICD-11 proposal includes a new diagnostic category, Complex PTSD, which would replace EPACE and which has a symptom profile that substantially overlaps with the ISTSS profile (see World Health Organization. (n.d.) *ICD-11* Alpha). In regards to the *DSM-5* process, the proposal for trauma disorders currently includes a dissociative subtype of PTSD with preferred treatments likely to be similar to those recommended for Complex PTSD (see Lanius, Brand, Vermetten, Frewen, & Spiegel, 2012).

2. Description of Complex PTSD Treatment

The symptom profile of Complex PTSD recognizes the loss of emotional, social, cognitive and psychological competencies that either failed to develop properly or that deteriorated due to prolonged exposure to complex trauma. The treatment for Complex PTSD, then, emphasizes not only the reduction of psychiatric symptoms, but equally, improvement in key functional capacities for self-regulation and strengthening of psychosocial and environmental resources. Recent prospective studies of complex trauma samples have demonstrated that psychosocial resource loss (e.g, reduced self-efficacy, prosocial behaviors, social support) is common and that these losses contribute to the severity and chronicity of PTSD symptoms over time (Betancourt, Brennan, Rubin-Smith, Fitzmaurice, & Gilman, 2010 ; Hobfoll, Mancini, Hall, Canetti, & Bonanno, 2011). Strength-based interventions are integral to each phase of Complex PTSD treatment and are intended to improve functioning, contribute to symptom management and facilitate the integration of the survivor into family and community life.

The recommended treatment model involves three stages or phases of treatment, each with a distinct function. Phase 1 focuses on ensuring the individual's safety, reducing symptoms, and increasing important emotional, social and psychological competencies. Phase 2 focuses on processing the unresolved aspects of the individual's memories of traumatic experiences. This phase emphasizes the review and re-appraisal of traumatic memories so that they are integrated into an adaptive representation of self, relationships and the world. Phase 3, the final phase of treatment, involves consolidation of treatment gains to facilitate the transition

from the end of the treatment to greater engagement in relationships, work or education, and community life.

3. General Strength of the Evidence

To date, there are nine¹ published studies in which Complex PTSD symptoms among adults were the targets of treatment and in which a history of complex trauma was a requirement for enrollment (See Table 1 for summary and effect sizes). These studies all identified childhood physical and/or sexual abuse as requirement for enrollment. Almost all (7 of 9) of the studies were randomized controlled trials (RCTs) that investigated enhanced or phase-based trauma treatment models. Four evaluated the benefits of stabilizing and rehabilitative programs with no or very limited trauma memory processing components (Bradley, & Follingstad, 2003; Dorrepaal et al., 2010; Ford, Steinberg, & Zhang, 2011; Zlotnick et al., 1997). Four included a trauma-focused component integrated with a sequenced (Cloitre, Koenen, Cohen, & Han, 2002; Cloitre et al., 2010; Steil, Dyer, Priebe, Kleindiest, & Bohus, 2011) or parallel (Chard, 2005) component addressing stabilization, skills training, and issues specific to repeated and early life trauma. One included a trauma-focused group treatment supported by case management (Classen et al., 2011). To date, there is one study (Cloitre et al, 2010) that has completed a head-to-head comparison of a phase-based treatment (skills training followed by memory processing) as compared to an exposure-focused treatment and to a skills focused treatment. Results of this study indicated the superiority of the phase-based approach as compared to the exposure-focused condition while the results for the skills only condition fell in the middle.

¹ One newly published study (Ford, Steinberg, & Zhang, 2011) has been added to the 8 reviewed in the survey report.

There are currently no published randomized controlled trials of phase-based or sequenced treatments for populations with Complex PTSD related to adult-onset complex traumas such as that experienced by refugees and individuals exposed to torture or genocide. Such populations often have experienced loss of home and material resources, loss of or distance from family, cultural dislocation, and significant ongoing emotional turmoil and distress. Observations of these material, social, psychological and emotional circumstances have led to recommendations for sequential or phase-based treatments in which emotional stabilization and resource development occur before trauma memory processing (Hinton, Rivera, Hofmann, Barlow, & Otto, 2012; Nickerson, Bryant, Silove, & Steel, 2011). Preliminary investigations using phase-based approaches among refugees with PTSD and various comorbid symptoms (but not assessed for Complex PTSD) have suggested that the introduction of emotion regulation strategies, particularly those focused on somatic experience, facilitates PTSD reduction (see Hinton et al, 2012; Morina, Maier, Bryant, Knavelsrud, Wittmann et al, 2012).

A review of Table 1 reveals that stabilization therapies are associated with moderate to large effect sizes for PTSD, emotion regulation and social/interpersonal outcomes. Therapies which include both stabilization/skills building and memory processing generally appear superior to those which include only the stabilization component. Individual therapies yielded larger effect sizes than group therapies.

4. Recommendations

The recommended treatment model is a phase-oriented or sequential treatment guided by a hierarchy of treatment needs assessed prior to treatment. Phase 1 focuses on *stabilization and skills strengthening* and has several main functions. The first goal is to ensure that the priority of

any mental health treatment, patient safety, has been achieved. A second goal is to strengthen the individual's capacities for emotional awareness and expression, increase positive self-concept and address feelings of guilt and shame, and increase interpersonal and social competencies.

Strengthening these domains improves functioning in day-to-day life, builds confidence and provides motivation for engagement and continuation in treatment. Lastly, the presence of an initial skills building phase enhances the effectiveness of trauma processing work and contributes to PTSD symptom reduction (see Cloitre et al, 2010)

The Phase 1 goal of achieving patient safety entails reducing patient or environmental characteristics that make the patient a danger to him/herself or others. This often requires reduction of symptom acuity (e.g., through the use of medication) and improvement in basic self-management skills. When an individual continues to be exposed to conditions of risk, such as when he or she continues to live in a dangerous or violent circumstance or community that cannot be escaped, a safety plan should be developed and resources identified and engaged (e.g., family members, community safety patrols). Phase 1 introduces psychoeducation about the effects of trauma, particularly of a sustained, early life or cumulative nature, as it relates to the individual's development, life course, worldview, relationships, and symptoms. Interventions in this phase should be evidence-based and matched to individual patient needs with an emphasis on emotion regulation skills, stress management, social and relational skills building, and cognitive restructuring. Meditation and mindfulness interventions are strong secondary interventions, meaning that they are important and useful interventions but not by themselves sufficient. In Phase 1, the therapeutic relationship is important in the development of emotional and social skills through the expression of support, validation, encouragement and in the role

modeling of a healthy relationship. The preferred format for phase 1 treatment is individual therapy but (therapist-led) group therapy is an appropriate alternative.

Phase 2 focuses directly on *the review and reappraisal of trauma memories*. The process involves some form of review or re-experiencing of the events of the trauma (e.g., through narration) in the context of an actual and subjectively experienced safe environment. The therapeutic benefit of the process arises from the patient's capacity to maintain emotional engagement with the distressing memories while simultaneously remaining physically, emotionally and psychologically intact. The therapist's presence, encouragement, guidance and feedback support the patient in maintaining a sense of safety and in the continued exploration of the memory. The experience of safety, along with the attendant availability of attentional, cognitive and emotional resources, provides the therapeutic circumstances in which reappraisal of the meaning of the traumatic experiences can be conducted. Its purpose is to facilitate the reorganization and integration of the traumas into autobiographical memory in a way that yields a more positive, compassionate, coherent and continuous sense of self and relatedness to others. Individual therapy (including in conjunction with group therapy) is recommended for this treatment phase.

Successful trauma memory processing approaches vary, but have in common an organized recounting of the events, primarily through language but sometimes supported through other media such as artwork or other symbols of remembrance and reappraisal of the traumas (e.g., Narrative Exposure Therapy; Schauer, M., Neuner, F., & Elbert, T. (in press)). During the sessions devoted to trauma memory processing, it is recommended that treatment include continued review and application of interventions related to strengthening emotion management, self-efficacy, and relationship skills.

Phase 3 marks the transition out of therapy to greater engagement in community life. Towards the end of the treatment, therapist and patient *consolidate the gains* in emotional, social and relational competencies. The therapist supports and guides the individual in applying skills to strengthen safe and supportive social networks and to build and enhance intimate and family relationships. Plans for education, employment, recreation and social activities or meaningful hobbies should be considered and organized. Phase 3 planning also includes proposed use of “booster” sessions to refresh skills or address a life challenge, an articulation of relapse prevention interventions, and identification of alternative mental health resources. Phase 3 is essentially a plan for follow-up care, a part of treatment that is routine for other psychiatric disorders associated with significant personal and social resource loss but may be overlooked in the treatment of Complex PTSD.

5. Course of Treatment

At present, there are insufficient data and a lack of consensus regarding the ideal duration of treatment or its specific course. The length of treatment for patients with Complex PTSD symptom profiles in the research literature has varied from 4 to 5 months and these timelines have been associated with substantial benefits. However, ISTSS experts in this survey recommended the need for longer courses of treatment than have been applied in clinical trials. While there was no consensus on an ideal treatment duration, the majority of experts considered 6 months a reasonable length of time for Phase 1, and 3 to 6 months for Phase 2, producing a combined treatment duration of 9 to 12 months for the first two phases.

Phase 3 was pre-defined in the survey as a 6-12 month interval during which symptoms were in remission, and expert were queried regarding the course of action during this interval.

Consensus recommendation was that this period be comprised of weekly visits tapering off over time based on the patient's status.

Decisions about the duration of each phase of treatment as well as the transitions across phases require the clinician's judgment and must take many factors into account. For Phase 1, the clinician should observe and consider reduction in symptoms along with the patient's demonstrated ability to reduce unhealthy coping or emotion-regulation strategies (such as drug abuse, self-injurious behaviors, and risk-taking or aggressive behaviors), as well as to demonstrate an increase in executive functioning and life skills. Phase 2 processing of trauma memories should be initiated when there is agreement between the clinician and patient that the patient has enough skills and life stability to safely engage in trauma-focused work. During this phase, relapses are expected and planned for, with the patient sometimes returning to Phase 1 tasks to re-learn or re-consolidate skills before continuing with trauma processing. The movement to Phase 3 occurs when symptoms have been generally and consistently remitting over time and is a decision that is made in a collaborative fashion between therapist and patient.

It should be noted that for some individuals with Complex PTSD, the duration of the intensive treatment phases (1 and 2) may be necessary for periods significantly longer than the estimated 12 months identified above. Given the continuing risk of exposure to traumatic and other forms of life stressors and the personal vulnerability of some patients, there may be need to return to Phase 1 during or after Phase 2 is completed. For severely impaired patients, treatment of several years may be necessary and/or may be required intermittently over the individual's lifetime.

6. CONCLUSION

At the present time, the use of a phase-based treatment approach for adults with Complex PTSD has excellent consensus as well as two Level A (randomized controlled) studies supporting its use. Evidence supports the benefit of this treatment approach in enhancing outcomes related to PTSD symptoms, and equally importantly, in resolving other key aspects of this disorder, including persistent and pervasive emotion regulation problems, disturbances in relational capacities, alterations in attention and consciousness (e.g., dissociation), adversely affected belief systems, and somatic distress or disorganization. In addition, the guidelines recognize and highlight the importance of flexible, patient-tailored treatments where interventions are matched to prominent symptoms.

The recommendation of a phase-based approach as the optimal treatment strategy for Complex PTSD is consistent with those offered by other expert bodies focusing on trauma spectrum disorders (e.g., the Australian Center for Posttraumatic Mental Health, 2007; the International Society for the Study of Trauma and Dissociation, 2011; and the National Institute for Clinical Excellence, 2005; American Psychological Association Division 56 (Trauma Psychology) and International Society for the Study of Trauma and Dissociation, in preparation), suggesting uniformity of opinion on best practices, broadly conceived, for the effects of complex trauma.

The investigation has also helped uncover important knowledge gaps in the study of this patient population. While assessment measures and strategies have been developed to capture the symptoms of Complex PTSD (see Briere, & Spinazzola, 2009), more work is needed to provide reliable, streamlined, and clinician-friendly instruments. Additional research is needed to

evaluate phase-based treatment approaches in relevant populations such as refugees and others who have experienced repeated, prolonged or multiple forms of violence in adulthood.

There is evidence that complex trauma populations such as those with histories of childhood sexual or physical abuse can utilize and receive benefit from brief trauma-focused therapies, although the degree of benefit has been variable depending on the study (see Cloitre et al, 2011). Identification of the optimal treatments for different trauma-related syndromes and disorders is a critical next step in the trauma research agenda. Systematic research is necessary to determine what kinds of therapeutic strategies and interventions maximize benefits for specific patient populations. This includes tests of the current paradigm such as direct comparison of sequential versus single mode trauma-focused therapies, testing the order of the components in phase-based therapies (.e.g., skills-to-exposure versus exposure-to-skills), and evaluating rate of change to identify the length of treatment that yields maximum benefit.

Optimization of outcomes also includes exploration of novel treatment approaches such as complementary medicine strategies that focus on somatosensory experience and the mind-body relationship, for which there is emerging evidence regarding efficacy (e.g., Telles, Singh, & Balkrishna, 2012). Lastly, the development of clinician-friendly algorithms that identify preferential treatments based on patient symptom presentation (see e.g., Baars, Van der Hart, Nijenhuis, Chu, Glas, & Draijer, 2011) would facilitate effective treatment matching in community clinics.

Complex PTSD Clinical Trials (n=9)										
Author, year	Sample characteristics	Treatment Modality	Tx Conditions (n)	Measures	Pre-Post WG ES*	Pre to 1-3Mo FU WG ES*	Pre to 6-12Mo FU WG ES*			
Bradley & Follingstad, 2003			Total (59)							
	Incarcerated Females, CA	Group	DBT Grp (24)	TSI-A Arousal	.68	—				
				TSI-Intrusive	1.00					
				TSI-Dissociation	.94					
				IIP	.75					
			WL (25)	TSI-A Arousal	.05	—				
				TSI-Intrusive	-.16					
				TSI-Dissociation	.27					
				IIP	.15					
Chard, 2005			Total (71)			3 Mo FU	12 mo FU			
	Female, CSA	Group plus Individual	CPT (36)	CAPS	2.79	2.50	2.41			
					DES	.74	.85	1.01		
			WL (35)	CAPS	.20	—	—			
				DES	.16					
Classen et al, 2010			Total (166)				6 mo FU			
	Female, CSA	Group plus case management	TFGT(55)	PCL	.58	—	.66			
					TSI-Self Reference			.35	.56	
					TSI-Anger			.40	.59	
				PFGT (56)	PCL	.90	—	.91		
						TSI-Self Reference			.36	.57
						TSI-Anger			.14	.43
				WL(55)	PCL	.56	—	.43		
						TSI-Self Reference			.20	.20
						TSI-Anger			.09	.01

Cloitre et al, 2002			Total (58)			3 Mo FU	9 Mo FU
	Female, CAP/CSA	Individual	STAIR+MPE (31)	CAPS	1.79	2.55	3.05
				TSI-Dissociation	1.65	1.61	1.85
				NMR	1.42	1.59	2.05
				IIP	1.58	1.41	1.83
			WL (27)	CAPS	.35	—	—
				TSI-Dissociation	.19		
				NMR	.22		
				IIP	.18		
Cloitre et al, 2011			Total(104)			3 Mo FU	6 Mo FU
	Female, CPA/CSA	Individual	STAIR+MPE (33)	CAPS	1.51	2.03	2.23
				TSI-Dissociation	.91	.99	.81
				NMR	1.27	1.22	1.44
				IIP	.75	1.24	1.46
			STAIR+SC (38)	CAPS	1.74	1.65	1.91
				TSI-Dissociation	.99	1.14	1.24
				NMR	.78	.41	.86
				IIP	.66	.20	.64
			SC+MPE (33)	CAPS	1.47	1.44	1.37
				TSI-Dissociation	.81	.75	.92
				NMR	.77	.56	.95
				IIP	.47	.42	.68
Dorrepaal et al, 2010			Total (55)				6MO FU
	Female, CPA/CSA	Group	Stabilization Group Tx (55)	DTS	1.06	—	1.00
				DES	1.04	—	.40

Ford et al, 2011						3 Mo FU	6 Mo FU
	Female, IVP	Group	TARGET	CAPS	1.06	1.11	1.17
				NMR	.89	.53	.86
				IIP-Involvement	.51	.27	.76
			PCT	CAPS	1.04	1.11	1.16
				NMR	.31	.52	.72
				IIP-Involvement	.37	.42	.17
			WL	CAPS	.30		
				NMR	.00		
				IIP- Involvement	.26		
Steil et al, 2011			Total (29)			6 weeks FU	
	Female, CSA	Group	DBT-PTSD Residential Tx	PDS	.83	1.38	—
Zlotnick et al, 1997			Total (48)				
	Female, CSA	Group	AM Group (17)	DTS	.74	—	
				DES	.63		
			WL (16)	DTS	.04	—	
				DES	-.03		

*Within-group effect size by Cohen’s d ; CA=Childhood Abuse; CSA=Childhood Sexual Abuse; CPS=Childhood Physical Abuse; IVP=Interpersonal Violence; DBT GRP=Dialectical Behavior Therapy Group; WL= Waitlist; CPT=Cognitive Processing Therapy; TFGT= Trauma Focused Group Therapy; PFGT=Present Focused Group Therapy; STAIR=Skills Training in Affective and Interpersonal Regulation; MPE= Modified Prolonged Exposure; SC=Supportive Counseling; Tx=Treatment; TARGET=Trauma Affect Regulation: Guide for Education and Therapy; PCT=Present Centered Therapy; AM=Affect Management; TSI=Trauma Symptom Inventory; IIP=Inventory for Interpersonal Problems; CAPS=Clinician Administered PTSD Scale; DES=Dissociative Experiences Scale; PCL= The Posttraumatic Stress Disorder Checklist; IIP-32=Inventory for Interpersonal Problems-32 item version; NMR=Negative Mood Regulation; IIP-Involvement= IIP subscale identifying tendency for over-involvement; PDS=Posttraumatic Diagnostic Scale; DTS=Davidson Trauma Scale.

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