Complex PTSD: Fact or fiction in evidence based practice

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Fact or Fiction

- Fiction – does this exist?
- Clinicians’ consensus it does
- But DSM-V has not included diagnosis as perception not enough evidence
- Difficult to research treatments for disorders that aren’t tightly defined
- ICD-11 may include it? UKPTS has a chance to influence things?
Definitions and Concepts
Defining the Terminology

Type I trauma

Type II trauma
Defining the Terminology

Type I trauma
- ASD
- PTSD
- Complicated PTSD

Type II trauma
- Complex PTSD

PTSD

DESNOS/
Complex Trauma
Nice guidelines

• PTSD
  – 2005 TFCBT and EMDR

• Complex PTSD
  – Clinical innovation informed by evidence based practice
  – Emerging evidence base for phased based approach
ISTSS Expert reference definitions

PTSD symptoms
• Intrusion
• Avoidance
• Hyperarousal

Self regulating capacities --- threat system
• Emotion regulation difficulties
• Disturbances in relational capacities
• Alterations in attention and consciousness
• Adversely affected belief systems
• Somatic distress or disorganisation
Case scenarios

Complex PTSD
Complex Trauma
Key areas of deficits

• Affect regulation
• Integrated sense of self
• Sense of self not defined and shaped by trauma
• Interpersonal functioning
• Trust and safety
• Memory disorganization
• Cluster of PTSD symptoms that reflect memory disorganization
Functioning within healthy attachments

Inner abilities that allow us to maintain a cohesive and coherent sense of self (Pearlman & McCann, 1994)

1. To maintain an inner sense of positive connection with others - **AFFILIATION**

2. To maintain a sense of self as viable, benign and positive – **LOVABLE**

3. To experience, integrate and tolerate feelings **Self soothing to regulate affect**

4. Have experiences of internalised loving others **Inner working reciprocal roles**
Underdeveloped functionality as a consequence of poor attachments

- Difficulty with the connection with internalised others
  - Difficulty with self soothing, expression of profound isolation, experience of self as oddly different, hiding self from others, relationship problems

- Development of internal safe soothing images?

- Underdevelopment of self worth?
  - Self denigrating statements, lack of self care, substance abuse, isolation
  - Development of compassionate self talk, supportive problem solving, motivation to care to care for self

- Underdevelopment of affect tolerance?
  - Dissociation, self harm, aggressive behaviours, substance abuse, affective lability, numbing
  - Developing of safe feelings, compassionate problem solving
Phased based approach

Phase I
- Psychoeducation

Phase II
- TFCBT/EMDR/PE
- TFCBT/EMDR/NET/PE
- CFT/DBT/MBT

Phase III
- TFCBT/NET/EMDR/PE

Phase IV
- Reclaiming life

Recovery

Window of tolerance
Philosophy of phasing therapy

• Window of Tolerance (Ogden, Minton & Pain, 2006)
  – ‘sculpted’ by early attachment relationships
  – Auto-regulation is ability to calm when arousal rises to upper limits (sympathetic activation) of WoT or increase activity when arousal drops (parasympathetic activation)
  – Affect intolerance is response to under- or over-activity of stress response system – inability to tolerate intense emotion (e.g. addictive behaviour, self-harm to discharge emotion, dissociation) vs. low activation as way of life (e.g. numb, inert, disengaged)
‘Window of tolerance’ – pacing change

Arousal

Hyperarousal – hypermetabolic CNS-ANS limbic-autonomic circuits: panic (freeze, fight, flight, dissociative anger, ‘danger zone’)

Both extremes – limbic system dominant

Ideal therapeutic location for maximal change

Hypoarousal – hypometabolic CNS-ANS circuits: stressful, parasympathetic dominant responses (hr decrease, flop, sleep, depression, shame, disgust, abandonment, hopeless despair ‘death zone’)

Optimal zone of functioning

Reduced capacity with trauma

Time
Window of Tolerance and adult trauma

• WoT narrows as a consequence of repeated trauma and influences:
  – Emotion regulation abilities
  – Relational capacities
  – Capacity for attention and consciousness
  – These experiences negatively influence belief systems
  – Increase experiences of somatic distress or disorganisation

• Phased-based approaches build emotional resilience and integrative capacity and thus increases WoT
What is the evidence: Phase I DBT

- DBT alone empirical evidence in BPD — reduces self harm:
  - Priebe et al. (2012) RCT (n=80):
    - 22% greater reduction in SH for every 2 months in therapy for DBT completers compared to TAU
    - Poor therapeutic alliance, low motivation to change, high impulsivity and neuropsychological factors (lower executive control, visual memory performance) predicted therapy attrition
What is the evidence: Phase I CMT


- Reduces self-criticism and increases self-soothing capacities
- General well-being increased
What is the evidence: Phase I MBT

- MBT alone empirical evidence in BPD – reduces suicide attempts:
  - Bateman & Fonagy (1999) initial RCT (n=44):
    - Improvement in depressive symptoms, decrease in suicidal and self-mutilatory acts, reduced inpatient days, and better social and interpersonal function began after 6 months and continued to the end of treatment at 18 months
  - At 8 years follow up, Bateman & Fonagy (2008):
    - 14% compared to 87% met BPD criteria, but primary reduction on suicidal behaviour
  - Bateman & Fonagy (2009) out-patient RCT (n=134) reduced suicide attempts and hospitalization
What is the evidence: Phase I SFT

• SFT alone empirical evidence in BPD – ‘fully recovered’:
  – Giesen-Bloo et al. (2006) RCT Schema Therapy (SFT) vs Transference Focused Psychotherapy (TFP) (n=86):
    • Two sessions per week of SFT or TFP for 3 years
    • Full recovery in 45% SFT and 24% TFP
    • One year later % fully recovered increased to 52% SFT and 29% TFP, with 70% of the patients in the SFT group achieving “clinically significant and relevant improvement”
    • Dropout rate only 27% for SFT, compared to 50% TFP, indicating SFT ‘greater sense of allegiance among patients’
What is the evidence: Phase II

- Bisson & Andrew (2007, 2009) Cochrane database of systematic reviews:
  - Individual TFCBT, EMDR, stress management and group TFCBT are effective in the treatment of PTSD
  - TFCBT & EMDR superior at 2-5 months f/up
What is the evidence: Phase II

• Ehlers et al. (2010) *Do all psychological treatments really work the same in posttraumatic stress disorder?:*
  – Good evidence that trauma-focused psychological treatments (TFCBT and EMDR) are effective in PTSD; but that treatments that do not focus on the patients' trauma memories or their meanings are either less effective or not yet sufficiently studied
  – 20 years evidence increased effect sizes in TFCBT – content of treatment does matter
  – Need to research active mechanisms for change
Emerging evidence: Phase II NET

- Robjant et al. (2010) review of NET
  - NET superior to other treatments in reducing PTSD symptoms in asylum seekers and refugees

- Pabst et al. (2011) feasibility study co-morbid BPD and PTSD (n=12):
  - Mean 14 sessions NET, 1-2 developing prospects for future
  - At 6 months: Significant reduction in depression, dissociation (p<0.05)
  - Impact on PTSD and BPD (p<0.1)
    - Increased suicidal/self-harm thoughts before discussing related traumatic events faded
Emerging evidence: EMDR

- Korn (2009) systematic review:
  - No RCTs on complex PTSD
- van der Kolk, et al. (2007) RCT (n=88) compared childhood vs adult trauma
  - 8 sessions EMDR less effective for childhood trauma (33% vs 79% asymptomatic at 6-months)
- Clinical anecdotal evidence routinely used as phase II intervention with increased focus on affect management and resource installation
- Single case studies show effective outcomes
What is the evidence: Phase III

- Recommendations include, but no empirical evidence for:
  - ‘Reclaiming life;
    - functional reintegration/pursuit of new goals
  - Fuller development of self-identity
  - Transition out of therapy
  - Consolidating gains in emotional social and relational competencies
  - Relapse prevention
Phased based approaches

The evidence
## What is the evidence: Phased based approaches

<table>
<thead>
<tr>
<th>Reference</th>
<th>Sample Description</th>
<th>Total n</th>
<th>Treatment Groups</th>
<th>Outcome Measures</th>
<th>Effect Sizes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bradley &amp; Follingstad, 2003</td>
<td>Incarcerated females, CA Group</td>
<td>59</td>
<td>DBT (24) WL (25)</td>
<td>TSI-A Arousal TSI-Intrusive TSI-Dissociation IIP</td>
<td>.68; .05* 1.00; -.16 .94; .15</td>
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<td>Chard, 2005</td>
<td>Females, CSA Group + Ind</td>
<td>71</td>
<td>CPT (36) WL (35)</td>
<td>CAPS DES</td>
<td>2.79; .20 .74; .16</td>
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<tr>
<td>Classen et al., 2010</td>
<td>Females, CSA Group + case mgt</td>
<td>166</td>
<td>TFGT (55) PFGT (56) WL (55)</td>
<td>PCL TSI-Self-reference TSI-Anger</td>
<td>.58; .90; .56 .35; .36; .20 .40; .14; .09</td>
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<tr>
<td>Cloitre et al., 2002</td>
<td>Females, CPA/CSA Individual</td>
<td>58</td>
<td>STAIR+MPE (31) WL (27)</td>
<td>CAPS TSI-Dissociation NMR IIP</td>
<td>1.79; .35 1.65; .19 1.42; .22 1.58; .18</td>
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<tr>
<td>Cloitre et al., 2011</td>
<td>Females CPA/CSA Individual</td>
<td>104</td>
<td>STAIR+MPE (33) STAIR+SC (38) SC+MPE (33)</td>
<td>CAPS TSI-Dissociation NMR IIP</td>
<td>1.51; 1.74; 1.47 .91; .99; .81 1.27; .78; .77 .75; .66; .47</td>
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<tr>
<td>Dorrepaal et al., 2010</td>
<td>Females, CPA/CSA Group</td>
<td>55</td>
<td>Stabilization (55)</td>
<td>DTS 1.06, DES 1.04</td>
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<tr>
<td>Ford et al., 2011</td>
<td>Females, IVP Group</td>
<td>?</td>
<td>TARGET, PCT, WL</td>
<td>CAPS 1.06; 1.04; .30, NMR .89; .31; .00, PCT .51; .37; .26</td>
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<tr>
<td>Steil et al., 2011</td>
<td>Females, CSA Group</td>
<td>29</td>
<td>DBT-PTSD Residential Tx</td>
<td>PDS .83</td>
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<tr>
<td>Zlotnick et al., 2002</td>
<td>Females, CSA Group</td>
<td>48</td>
<td>AM (17), WL (16)</td>
<td>DTS DES .74; .04, .63; -.03 *within group effect size</td>
</tr>
</tbody>
</table>
Headlines and highlights

• Phase based approaches are demonstrating effective outcomes

• No consensus on phases
  – ISTSS suggests:
    • 6 months - phase I
    • 3-6 months - phase II
    • Undetermined as follow-up only - phase III

• No research on mechanism of change
Impact of personality disorder on PTSD treatment?

- Hembree, Cahill & Foa (2004):
  - Impact of co-morbid PDs on the outcome of TF-CBT
  - 75 adult women with chronic PTSD resulting from rape or nonsexual assault in adulthood or sexual abuse in childhood - PE with or without cognitive restructuring
  - 39% of participants met DSM-IV criteria for PD
  - No difference between women with and without PDs on the prevalence of PTSD at the end of treatment
  - Participants with PD less likely to attain good end-state functioning, but this may be attributable to the fact that they started off slightly worse than those without personality disorders
Treatment has to reflect areas of deficit

- Affect dysregulation
- Dissociation – coping strategies
- Traumatic memories
- Interpersonal functioning
- Sense of self and re-integration
ISTSS Expert reference definitions

PTSD symptoms
• Intrusion **TFCBT, EMDR, NET**
• Avoidance
• Hyperarousal

Self regulating capacities --- threat system
• Emotion regulation difficulties **** CMT DBT MBT
• Disturbances in relational capacities CMT
• Alterations in attention and consciousness
• Adversely affected belief systems CBT? SFT CPT
• Somatic distress or disorganisation EMDR? Sensory motor?
Case work in action

• Still looking at evidence for treatment for a clinical presentation with discrepant presentations
• Need to agree consensus on definition before the evidence base can grow
• Need to research phase based treatment for Complex PTSD after CA and adult repeated trauma and new interventions (e.g. NET)
• Role of pharmacology?
Feeling of current and constant threat (flashbacks etc.)

Coping behaviour - Physical or mental avoidance of trauma

Nature of trauma memory

Bad or negative thoughts/beliefs about yourself, others or about the world

Early Experiences

BASED ON COGNITIVE MODEL OF PTSD Ehlers & Clarke, 2000

Dr Deborah Lee 2012 BTSS
Feeling of current and constant threat (flashbacks etc.)

Key fears
- Nature
  - High affect (fear and shame).
  - Bodily/somatic memory

Shame (self-blame), anger, guilt, disgust

(flashbacks etc.)

Coping behaviour - safety behaviours
- Avoidance, dissociation, sexual avoidance, self-harm

Unintended consequences
- Relationships, depression, isolation safety and stability, social support

Early Experiences
- Chronicity, developmental stage, attachment, lack of emotional nurturance, trauma
  - Lack of safeness

Bad or critical thoughts/key fears
- Extreme self-attacking, self-blame, guilt, others’ view of self, disclosure

Resilience
- Dr Deborah Lee 2012 BTSS
Phased based Approach
Lee 2012

Phase I

Phase II

Phase III

Phase IV

Recovery

Psychoeducation

Compassionate resilience

TFCBT/NET/EMDR

Reclaiming life
Concluding points

• Complex PTSD is not fiction

• UKPTS in position to develop clinical practice guidance on definitions, diagnosis and treatment
• Clinicians’ consensus it does
• But DSM-V has not included diagnosis as perception not enough evidence
• Difficult to research treatments for disorders that aren’t tightly defined
• ICD-11 may include it? UKPTS has a chance to influence things?
What do you think?.............