ISTSS Guidelines Position Paper on Complex PTSD in Adults

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In view of definitional issues and, with very few exceptions, the absence of studies specifically designed to answer possible scoping questions, separate draft scoping questions on treatments for complex presentations of PTSD were not included for this revision of the ISTSS Treatment Guidelines. The ISTSS Board agreed that, rather than the Guidelines Committee undertaking systematic reviews to address specific scoping questions, it would be likely to be more beneficial to undertake a narrative review of the current situation with respect to "complex PTSD". This position paper is a component of the ISTSS guidelines; it considers what complex PTSD is, how it should be defined to enable the development of an evidence base of how best to treat it and makes recommendations to facilitate further research. A separate position paper considers the nature, evidence for and treatment of complex PTSD in children and adolescents.

Overview

For the past two decades, there has been substantial debate about whether there are qualitatively different symptom profiles that can develop from different experiences of traumatic events. It has been proposed that more complex symptom profiles, called "complex PTSD," can emerge from events that involve multiple, chronic or repeated types of traumas that are of an interpersonal nature and from which escape is difficult or impossible such as childhood abuse, domestic violence, genocide campaigns and being a prisoner of war (Herman, 1992). Symptoms that emerge from these types of traumas have typically included difficulties in emotion regulation, self-concept and relational capacities in addition to those of PTSD such as re-experiencing of the trauma, avoidance of trauma related stimuli and hyperarousal (Ford, 2015). Critiques about the utility of the complex PTSD construct have pointed to lack of clarity in its formulation and consequently lack of persuasive evidence regarding the phenomenon (de Jongh et al., 2016; Landy et al., 2015; Resick et al., 2012). A second debate has been whether individuals presenting with complex PTSD, in any of its formulations, would benefit from modified forms of established PTSD interventions or alternative forms of intervention (Cloitre, 2015; de Jongh et al., 2016).

Definition of Complex PTSD

Since the last ISTSS treatment guidelines were published and the ISTSS Consensus Guidelines for complex PTSD developed, there has been substantial progress in the formulation of a definition of complex PTSD. Specifically, in June of 2018, the World Health Organization (WHO) diagnostic system, the International Classification of Diseases and Related Health Problems (ICD) formally introduced a diagnosis of complex PTSD (CPTSD).

In ICD-11, PTSD and CPTSD fall under a general parent category of Disorders Specifically Related to Stress. PTSD consists of 3 core elements or clusters: re-experiencing of the traumatic event in the present, avoidance of traumatic reminders,

and a sense of current threat. This formulation conceptualizes PTSD as a conditioned fear response and emphasizes symptoms that tie the disorder directly to traumatic events (Brewin et al., 2009). CPTSD includes the 3 core elements of PTSD as well as 3 additional elements that reflect the impact that trauma can have on systems of self-organization, specifically problems in emotion regulation, self-concept, and relational domains under conditions of sustained, multiple or repeated traumatic exposure. The conceptual frame of CPTSD includes a fear as well as a resource loss model (e.g., Hobfoll et al., 2011) to explain traumatic stress reactions. A diagnosis of either PTSD or CPTSD can be made but not both. A summary of the evidence supporting the ICD-11 decision to make a diagnostic distinction between PTSD and CPTSD is reported by Brewin and colleagues (2017).

The ICD-11 diagnoses of PTSD and CPTSD are made in reference to symptoms and impairment, not trauma history. In contrast to what may be generally assumed, the experience of chronic or repeated traumas is a risk factor not requirement for CPTSD. This more refined relationship between type of event and symptom profile gives room for consideration of genetic and environmental influences. For example, people who have some degree of psychological vulnerability and experience a particularly horrendous event, such as a gang rape or witnessing the murder of their child, might develop complex PTSD. Conversely, individuals who have experienced chronic trauma, such as repeated sexual abuse in childhood, but who have a good amount of personal resilience and/or have had the support of caring individuals might not develop CPTSD but rather PTSD or potentially neither disorder.

While there is substantial evidence supporting the ICD-11 distinction between PTSD and CPTSD (Brewin et al., 2017), it should be noted that an alternative formulation has been brought forward by the DSM-5 which has not developed a diagnosis of complex PTSD. Rather, it has acknowledged the heterogeneity of symptoms resulting from exposures to a variety of traumatic events by broadening the definition of PTSD to include a new symptom cluster (alterations of cognitions and mood) and the addition of a dissociative subtype.

The ICD-11 and DSM-5 formulations of post-traumatic stress reactions are quite distinct. Nevertheless, these differences may but need not necessarily lead to differences in treatment recommendations.

Treatment Implications

"Personalizing medicine" is a strategy that has been successful in optimizing outcome for physical health disorders (Institute of Medicine, 2011). This approach involves the identification of symptoms that are clinically significant (e.g., are severe or associated with functional impairment) to a particular patient and tailoring interventions or series of interventions to address these problems. Part of the ICD rationale for organizing trauma symptoms into two disorders is the expectation that doing so will facilitate the use of personalized treatment. Given that CPTSD is comprised of greater number

and diversity of types of symptoms relative to PTSD, its treatment may involve greater diversity of treatment interventions and/or longer duration. The potential to personalize treatments by complexity and severity of presentation is consistent with WHO guidelines for treatment planning which includes the twin goals of optimizing outcome for the individual patient and deploying limited resources to those who need it most.

Given that the ICD-11 PTSD and CPTSD diagnoses are new, there are no clinical studies to date addressing the need for or potential benefits of applying different treatments to each disorder. However, indirect evidence from a recent meta-analysis suggests that currently available evidence-based therapies for PTSD that do and do not include a trauma focus are likely to be helpful (Karatzias et al., in preparation). The meta-analysis reviewed studies that included measures that were representative of symptom clusters of PTSD, as well as those specific to CPTSD (i.e., affect dysregulation, negative-self-concept, disturbances in relationships). There were only two studies that included all symptoms clusters representative of CPTSD per ICD-11. However, analyses assessing outcomes for each of the specific symptom clusters as they were available across studies revealed that cognitive-behavioral therapies and EMDR yielded outcomes superior to waitlist or treatment as usual. Notably, moderator analyses found that treatment outcome across all symptom domains was moderated by onset of trauma, with childhood trauma being associated with less beneficial outcomes. These results suggest that treatment improvements can be directed towards individuals with childhood trauma. Moreover, to the extent that individuals with childhood trauma are representative of those with CPTSD (e.g., Brewin et al., 2017) the results provide consideration that there may be similar reduced treatment benefit among those with CPTSD compared to PTSD when using established therapies. The data also suggest that to the extent that novel or adapted treatments may be of value, current evidence-based treatments can provide the conceptual and empirical foundations for these developments.

Future Directions

There are several research strategies that can be applied to identify optimal treatments for CPTSD. One strategy is to assess whether compared to established treatments, greater benefits result from protocols that add interventions, either in a sequenced or integrative fashion, which directly address problems that are particularly problematic among those with CPTSD (e.g., emotion regulation, negative self-concept and disturbances in relationships). Relevant additional interventions may derive from cognitive, behavioral, mindfulness, psychodynamic, interpersonal, pharmacological or technology-based formulations. The use of established treatments as a comparator is important as it remains unknown whether adapted or novel treatments will be superior to already established treatments. Sequenced and integrated treatments that have been developed thus far order interventions where those that focus on the symptoms

uniquely associated with CPTSD precede direct exposure to or cognitive re-appraisal of the trauma. The importance and impact of this ordering would be useful to examine. A second research strategy which has yet to be implemented is to test the effect of the order of the treatment components in sequenced or integrated treatment protocols (e.g., trauma processing followed by emotion regulation interventions as compared to the reverse). Outcomes may differ depending on patient preferences and which symptom clusters are associated with more impairment.

A third research strategy is to evaluate the benefits of multi-component treatments where the components are selected and ordered in a flexible manner according to the salient symptoms and problems of a particular patient. Flexible implementation of problem specific treatment modules is a treatment strategy that has been tested and found successful in pediatric samples (e.g., Weisz et al., 2012). This type of flexible treatment strategy may be both an efficient and effective treatment approach for CPTSD as well as one that feels relevant to the patient and is consistent with the "patient-centered care" paradigm.

Research in trauma interventions has, in a relatively short time, identified effective treatments. Innovations in research design and treatment formulation provide the opportunity to continue improving therapies in terms of symptom resolution, quality of life, functional status and enhanced resilience for adults with CPTSD.

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