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Psychiatry and Addictions Case Conference

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WHAT IS COMPLEX PTSD? UNDERSTANDING CURRENT EVIDENCE AND TREATMENT IMPLICATIONS

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SPEAKER DISCLOSURES

✓ Any conflicts of interest?

PLANNER DISCLOSURES

The following series planners have no relevant conflicts of interest to disclose; other disclosures have been mitigated.

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OBJECTIVES

1. Understand the diagnostic criteria for DSM-5 PTSD and ICD-11 posttraumatic stress disorder (PTSD) and complex posttraumatic stress disorder (CPTSD)
2. Learn the primary debate points around CPTSD and evaluate the evidence for each point.
3. Learn about clinical considerations and treatment options for clients.

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AGENDA

- DSM 5 and ICD-11 diagnostic criteria
- Prevalence and characteristics of CPTSD
- Main points in CPTSD debate and review of evidence
- Clinical implications
- Key takeaways

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"A response to a clinical need to describe common difficulties associated with exposure to traumatic stressors that are predominantly of an interpersonal nature…(and the) need to capture nonfear or anxiety responses to traumatic events."

Karatzias & Levendosky, 2019

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DSM-5 PTSD (APA, 2013)

Criterion A Traumatic Stressor

Intrusions (1+)

1. Unwanted memories
2. Disturbing dreams
3. Re-experiencing
4. Emotional upset by reminders
5. Physical reactions to reminders

Avoidance (1+)

1. Internal avoidance (memories, thoughts, feelings)
2. External avoidance (people, places, situations)

Mood + Cognition (2+)

1. Difficulty remembering important parts
2. Negative beliefs
3. Inappropriate blame
4. Strong negative feelings
5. Loss of interest in activities
6. Feeling disconnected from others

Arousal (2+)

1. Irritability or aggressive behavior
2. Risky behavior
3. Hypervigilance
4. Exaggerated startle response
5. Difficulty concentrating
6. Sleep difficulties

Dissociative Subtype

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ICD-11 PTSD (WORLD HEALTH ORGANIZATION, 2019)

Traumatic Stressor

Re-experiencing (1+)

1. Intrusive memories or images
2. Flashbacks
3. Nightmares
4. Re-experiencing

Avoidance (1+)

1. Internal avoidance (memories, thoughts, feelings)
2. External avoidance (people, places, situations)

Sense of Threat (1+)

1. Hypervigilance
2. Exaggerated startle response

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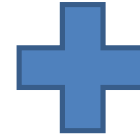
ICD-11 CPTSD (WORLD HEALTH ORGANIZATION, 2019)

PTSD



Affective Dysregulation (1+)

1. Heighted emotional reactivity to minor stressors
2. Violent outbursts
3. Reckless of self-destructive behavior
4. Dissociative symptoms when under stress
5. Emotional numbing

Negative Self-Concept (1+)

1. Persistent negative beliefs about oneself
2. Pervasive feelings of shame, guilt, or failure related to the stressor

Disturbances in Relationships (1+)

1. Persistent difficulties sustaining relationships
2. Persistent difficulties feeling close to others
3. Consistent avoidance of relationships and social engagement
4. Difficulty sustaining relationships

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PREVALENCE

- ICD-11 PTSD: 3.4%
- ICD-11 CPTSD: 3.8%
- DSM-5 PTSD: 8.3%

Risk Factors

PTSD/ CPTSD

1. Female-identifying
2. Higher adverse childhood experiences (ACE) score
3. Cumulative adult trauma

PTSD

1. Trauma type: captivity or SA perpetrated by non-caregiver

CPTSD

1. Trauma type: physical or sexual abuse by caregiver
2. Cumulative childhood trauma

Cloitre et al., 2019; Kilpatrick et al., 2013

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DEMOGRAPHIC CHARACTERISTICS OF CPTSD

- Greater likelihood of
  - Minority status
  - Lower education level
  - Lower socio-economic status
  - Unemployed
  - Not married
  - Live alone

(Karatzias et al., 2016; Perkonigg et al., 2016)

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CLINICAL CHARACTERISTICS

- Compared to ICD-11 PTSD, CPTSD associated with higher levels of (Cloitre et al., 2019)
  - MDD
  - GAD
  - Lower well-being
- Worse functional impairment among those who meet criteria for CPTSD (Cloitre et al., 2013; Cloitre et al., 2014; Perkonigg et al., 2016)
- No significant differences between DSM-5 PTSD and CPTSD in (Hyland et al., 2018)
  - Depression
  - Anxiety
  - Suicidal ideation and self-harm

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MAIN POINTS IN CPTSD DEBATE

- Is CPTSD the same as DSM-5 PTSD?
- Is CPTSD really just PTSD and co-occurring Borderline Personality Disorder (BPD)?
- Are DSO symptoms inherent to experiences of repeated traumatic events in childhood?
- Are existing gold standard PTSD treatments safe, acceptable, and effective for individuals with CPTSD?

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IS CPTSD DISTINCT FROM DSM-5 PTSD?

- 9 studies have identified distinct CPTSD and PTSD symptom profiles (Brewin et al., 2017)
- Several studies have not found distinct PTSD and CPTSD groups (e.g., Eidhof et al., 2019)
- Support for classes that differ by severity rather than symptom clusters (Wolf et al., 2015)

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IS CPTSD DISTINCT FROM BPD?

- Several studies found distinct symptom profiles consistent with BPD, CPTSD and no BPD, and ICD-11 PTSD (Cloitre et al., 2014; Knefel et al., 2016)
- Symptoms that distinguish risk for BPD:
  - Fear of abandonment
  - Unstable sense of self
  - Unstable relationships
  - Impulsiveness

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IS CPTSD DISTINCT FROM BPD?

- Strong overlap between CPTSD and BPD (Jowett et al., 2019)
- Distinct CPTSD and BPD classes not found among a non-treatment seeking racially and ethnically diverse sample (Saraiya et al., 2021)
- Suggested that classes differ by level of trauma exposure and symptom severity rather than unique symptom profiles (e.g., Hyland et al., 2019)

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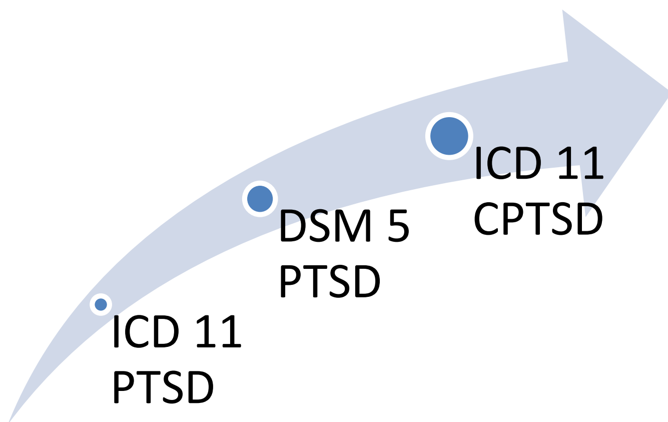
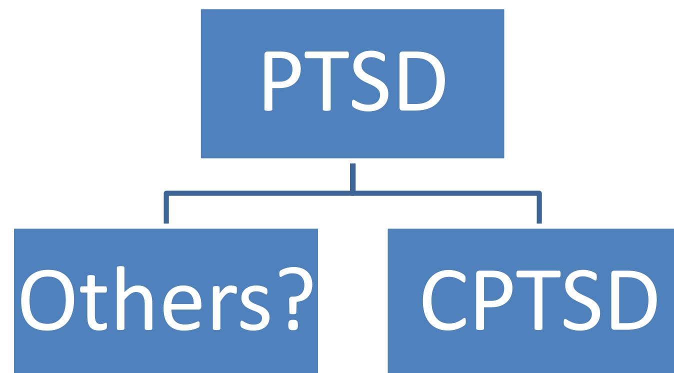
LACK OF CONSENSUS (RESICK ET AL., 2012 REPLY)

- **Conflicting definitions:** Some say prolonged interpersonal childhood traumas are the basis for CPTSD whereas others say adults who survived war, torture, or mass violence may also be a basis for CPTSD.

- **Structure:** Is CPTSD a unique diagnosis from PTSD? Or is it a variant of PTSD, either a subgroup or on the more severe end of a PTSD dimension?





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ARE DSO SYMPTOMS INHERENT TO CHILDHOOD TRAUMA?

- Individuals with and without a history of childhood abuse have similar levels of ER abilities (Jerud et al., 2016)
- Many survivors of repeated traumatic events do not develop DSO symptoms (Ter Heide et al., 2016)

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ARE EXISTING TREATMENTS SAFE/TOLERABLE/EFFECTIVE?

- Skills training as a prerequisite for memory processing based on theory and clinical anecdotes (e.g., Cloitre et al., 2010)
- High dropout rates in RCTs delivering exposure-based therapy cited
- Phase-based treatment dropout rates are similar to exposure-based treatment (Cloitre et al., 2002)
- Reductions in distress with exposure treatment are similar between those with single-exposure vs repeated trauma exposure (Jerud et al., 2017)

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CLINICAL IMPLICATIONS

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CLINICAL IMPLICATIONS (CLOITRE ET AL., 2012)

ISTSS Treatment Guidelines:

Phase 1: stabilization and skills strengthening

Phase 2: review and reappraisal of trauma memories

Phase 3: consolidate gains and transition to engagement in community

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STABILIZATION PHASE (CLOITRE ET AL., 2012)

- Priorities:
  1. Safety
  2. Strengthen emotional, social, and psychological skills
- Insufficient evidence on duration
  – 6 months suggested
- Markers of completion
  – Reduction in symptoms
  – Reduction in impulsive behaviors
  – Reduction in risk of harm to self/others
  – Increase in functioning

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CLINICAL IMPLICATIONS (JONGH ET AL., 2016)

- These guidelines suggest the following but for which there is no rigorous research supporting these views:
  - A phase-based approach is necessary for positive trauma-focused treatment outcomes
  - Trauma-focused treatments have unacceptable risks
  - Adults with CPTSD do not respond well to trauma-focused treatments
  - Outcomes are significantly improved when trauma-focused treatments are preceded by a stabilization phase
- Potential negative consequences of stabilization phase:
  - Patients are denied or delayed evidence-based treatments
  - Risk of treatment dropout

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CPTSD IN PRACTICE

- Assessment tools
  - International Trauma Questionnaire (Cloitre et al., 2018)
- Problematic beliefs about CPTSD: “incurable”, “damaged”, “hard to fix”
- Focus on getting a “proper diagnosis”
- Recommended to use an idiosyncratic approach (Dyer & Corrigan, 2021)

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AVAILABLE TREATMENTS

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EFFECTIVENESS OF TREATMENTS FOR CPTSD SYMPTOMS (KARATZIAS ET AL., 2019)

	Affect Dysregulation	Negative Self-Concept	Disturbances in Relationships	PTSD Symptoms
CBT	-1.42	-0.82	-0.66	-0.90
Exposure alone	-	-0.73	-0.59	-1.05
EMDR	-1.64	-0.61	-0.76	-1.26

<u>Effect size interpretation:</u>

Small = > 0.2 < 0.5

Moderate = > 0.5 < 0.8

Large = > 0.8

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EFFECTIVENESS OF TREATMENTS FOR CPTSD SYMPTOMS

- PTSD treatment (PE and Sertraline) has medium to large effects on affect dysregulation among those with and without a history of childhood abuse (Jerud et al., 2016)

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DBT-PE (HARNED ET AL., 2014)

- Developed to treat PTSD among clients with suicidal or self-injurious behavior, co-occurring disorders (e.g., substance use disorders), or treatment interfering behaviors
- Includes 3 phases:
  - DBT treatment to achieve behavioral control
  - Exposure-based trauma-focused treatment
  - Return to DBT to address remaining treatment goals

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STAIR-PE (CLOITRE ET AL., 2010)

- 16 session weekly individual therapy
  - Sessions 1-8: skills training in emotion regulation and interpersonal effectiveness
  - Sessions 8-16: prolonged exposure protocol with interpersonal skills training instead of in vivo exposure
- Online training in STAIR is available at: https://www.ptsd.va.gov/professional/continuing_ed/STAIR_online_training.asp

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KEY TAKEAWAYS

- Not everyone with a history of CA has poor emotion regulation
- Trauma history is a risk factor for CPTSD rather than a requirement
- Communicating hope for symptom reduction is key
- Client-centered approach to treatment recommendations and referral

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