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Cognitive–behavioural therapy for complex post-traumatic stress disorder

ARTICLE

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SUMMARY

Complex post-traumatic stress disorder (CPTSD) was adopted as a new diagnosis in ICD-11. Trauma-focused cognitive–behavioural therapy (CBT) is effective in treating PTSD but with CPTSD being a recently defined diagnosis, the evidence for its effectiveness in that disorder is not as clear, but it is still promising. This article reviews the diagnosis, psychopathology and some key differential diagnoses, and looks at the two CBT approaches that are currently used in clinical practice: the phase-oriented approach and the unimodal approach. The key aims of this article are to clarify the concept of CPTSD, its differentiation from borderline personality disorder and prominent comorbidities, how it develops and how CBT is used to treat it.

LEARNING OBJECTIVES

After reading this article you will be able to:

- explain the concept of CPTSD, and the differentiation of this diagnosis from borderline personality disorder and prominent comorbid conditions
- describe how CPTSD develops
- understand how CBT can be used to treat CPTSD.

KEYWORDS

Trauma and stressor-related disorders; childhood experience; personality disorders; complex trauma; psychological treatment options.

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Complex post-traumatic stress disorder (CPTSD) is a severe mental disorder which was adopted as a new diagnosis in ICD-11 (World Health Organization 2018). In common with PTSD, it emerges in response to traumatic life events. However, individuals with CPTSD have typically experienced sustained or multiple traumas, such as childhood abuse and domestic or community violence. Although CPTSD is characterised by the same three core post-traumatic symptom clusters that make up PTSD, three additional clusters must be present to make a CPTSD diagnosis. These are chronic and pervasive disturbances in (a) emotion regulation, (b) identity and (c) relationships.

Trauma-focused cognitive–behavioural therapy (CBT) is effective in treating PTSD and is recommended as a first-line treatment by the UK's National Institute for Health and Care Excellence (NICE) (NICE 2018). It is also a recommended approach in international guidelines such as those published by the International Society for Traumatic Stress Studies (Cloitre 2002). The evidence for the effectiveness of trauma-focused CBT for treating CPTSD is not as clear as it is for PTSD but is still promising.

A new ICD-11 category

The latest revision of the ICD (ICD-11) has been with us now since July 2018 (World Health Organization 2018). A major change made in this most recent incarnation has been the splitting of the original PTSD diagnosis into two categories: PTSD, pretty much as before, and a new category, so-called 'complex' PTSD, often shortened to CPTSD (Maercker 2013).

Traditionally, PTSD was diagnosed if someone had been exposed to an extremely threatening or horrific event (or a series of them) and if they presented with symptoms from three clusters. These were: (a) the 're-experiencing' symptoms, such as nightmares and flashbacks; (b) the 'avoidance' symptoms, such as avoidance of places or circumstances reminiscent of the original trauma; and (c) the 'hyperarousal' symptoms, such as the heightened startle reflex. Importantly, these three traditional PTSD clusters still need to be present for a CPTSD diagnosis to be made. However, according to the ICD-11 definition, for an individual to be considered to have CPTSD they must have an additional three symptom clusters, so six in total. These additional three symptom clusters are: (d) problems with 'affect dysregulation', such as excessive emotional reactivity; (e) possessing a 'negative self-concept', such as believing themselves to overwhelmingly worthless; and (f) disturbances in the individual's 'relationships with others', for

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example feeling pervasively disconnected from those around them (Box 1). Together, these last three symptom clusters have been referred to as 'disorders of self-organisation' (DSO) (Maercker 2022).

Complex PTSD versus borderline personality disorder

There has been intense debate over the degree to which the CPTSD concept overlaps with others, such as borderline personality disorder (BPD). Several studies have demonstrated that individuals with CPTSD are in fact distinguishable from those with BPD (Cloitre 2014; Knefel 2016). Characteristic differences between the two are as follows:

- Those with CPTSD tend to have a stable concept of themselves. It is likely to be profoundly negative, that is they may believe themselves to be deeply worthless, or unlovable, but that belief is stable. In contrast, those with BPD tend to have self-beliefs that vary remarkably between very negative to very positive, depending on the environment.
- Those with CPTSD tend to have difficulties in their relationships whereby they will avoid intimacy and struggle with strong emotions in relationships, leading to relationship breakdowns. BPD tends to be more associated with idealised relationships, which rapidly become very intense and then just as rapidly, devalued.
- Difficulties with emotion regulation appear to be a problem in both BPD and CPTSD. However, they tend to be less extreme in the latter. Self-harm and suicide attempts are a core element and treatment target in BPD but may not be in CPTSD.

Despite these demarcations, there is still some overlap. Some individuals with a history of prolonged or repeated trauma may present with comorbid BPD and CPTSD.

Comorbidity and dissociation

Comorbidities in general appear to be common in CPTSD (Maercker 2022). In addition to BPD, comorbidity occurs with depressive and anxiety disorders, drug and alcohol use problems, dissociative and somatic symptom disorders (Longo 2019) and, not least, with quasi-psychotic symptoms. In addition, the general tendency towards dissociation appears to be considerably higher in ICD-11 CPTSD than in PTSD (Hyland 2017). Therefore, a familiarity with the features of dissociation is important in the management of someone with CPTSD. Indeed, where the main symptom in a patient's presentation is dissociation, so that the diagnosis is a dissociative disorder, the underlying cause still frequently appears to be 'aversive and traumatic childhood experiences'. In this scenario, the dissociative disorder and CPTSD appear to be 'aetiologically co-determined' (Vonderlin 2018).

Cognitive–behavioural model for CPTSD

Individuals who have CPTSD tend to live significant proportions of their lives with a sense of 'serious and current threat'. This appears to be a consequence of how they initially processed traumatic experiences. Once activated, the perception of current threat is accompanied by re-experiencing and hyperarousal symptoms and strong emotions such as anger, anxiety, shame, sadness or guilt. It is proposed that there are three key processes that lead to and perpetuate a sense of current threat. These are: (a) the way that traumatic experiences are laid down in memory, (b) the personal meaning that arises from the way in which the individual appraised the traumatic event and (c) the adoption of unhelpful cognitive and behavioural coping strategies.

BOX 1 ICD-11 diagnosis of complex post-traumatic stress disorder (CPTSD)

Exposure to a stressor typically of an extreme or prolonged nature and from which escape is difficult or impossible such as torture, concentration camps, slavery, genocide campaigns and other forms of organised violence, domestic violence, and childhood sexual or physical abuse.

Plus the following symptoms:

(a) Re-experiencing: vivid intrusive memories, flashbacks or nightmares that involve re-experiencing in the present, accompanied by fear or horror

(b) Avoidance: marked internal avoidance of thoughts and memories or external avoidance of activities or situation reminiscent of the traumatic event(s)

(c) Hyperarousal: a state of perceived current threat in the form of hypervigilance or an enhanced startle reaction

(d) Problems in affect regulation

(e) Persistent beliefs about oneself as diminished, defeated, or worthless

(f) Persistent difficulties in sustaining relationships and feeling close to others.

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BJPsych Advances (2024), page 1 of 10 doi: 10.1192/bja.2024.29

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How traumatic experiences are laid down in memory

Patients have memories of past trauma in several mental disorders, but the characteristic of the trauma memories in PTSD is that they are experienced as if the trauma were repeating 'here and now'. To understand why this is, we must consider the roles of the hippocampus and the amygdala, and how these structures function at times of very intense stress.

When we are very relaxed neither the hippocampus nor the amygdala is functioning to capacity. With an increasing perception of threat and resulting tension the hippocampus begins to process information and is working optimally. However, as the perception of threat becomes extreme the hippocampus begins to shut down and the amygdala takes over. By the time we are very stressed, as we would be during a traumatic event, the amygdala has taken over processing of information (Helligan 2003). This is clinically extremely important, as autobiographical memories are not being laid down in the normal way owing to the changeover between these two brain structures.

The usual autobiographical memory (hippocampus-mediated) is the declarative memory or the 'cold memory' that we can access when we recall ordinary memories of our life (Helligan 2003). For example, we can deliberately recall the memory of what we did during our last family holiday or what we had for lunch. We can also, with a bit of effort, think about the chronological order of an event, such as what happened last Christmas. This means we can piece together what happened in the morning, what we had for Christmas lunch and so on. Our memories are anchored in context, i.e. stored with a reference to time and a connection to any similar past experiences. We are remembering a cluster of things that make sense of that individual experience at that time. In addition, when we recall these events, we will notice a bodily sense that this is something that happened a while ago. It is not a perfect memory of the sensation, or a perfect indication of when this was, but we will have a felt sense in our body that this happened in the past.

In contrast, in trauma, the amygdala processes information in ways that lay down a very different memory. This is sometimes referred to as a 'hot memory', a form of non-declarative memory (Jelinek 2009). Non-declarative memories tend to be activated automatically by situational cues, rather than by intentional recall (Jelinek 2009). These situational cues may be a particular smell, the sound of a siren, or someone else's facial expression, or they may be internal cues. For example, if someone was in the prone position while being raped, taking a similar posture many years later may be sufficient to trigger the memory of the rape.

In summary then, amygdala-mediated trauma memories are distressing and confusing. They are often: (a) not voluntary, (b) fragmented and (c) without a time 'tag' or contextualisation from the past, so that they feel frozen in time and as if they were happening right now.

Personal meaning from the way the individual appraised the traumatic events

Even if a group of individuals experience the same horrific trauma, only some of the group will interpret those events as having personal meaning. This makes them especially vulnerable to developing PTSD. For people with PTSD, the trauma and its aftermath tend to have highly threatening personal meanings that go beyond what other people would find horrific about the situation (Ehlers 2000). The sequelae of the traumatic events can have a similar importance. For example, perceptions of whether they were treated well by their family, by their partner or employer, or whether they were left in pain or functionally incapacitated, can all contribute to whether someone develops PTSD or not.

A common consequence of repeated trauma is an individual's perception that they are now permanently at risk or damaged. Examples of common beliefs stemming from repeated traumas are 'My life is ruined', 'I could never have a relationship' and 'I will be assaulted again'. These beliefs can be activated by a variety of triggers reminiscent of the original trauma and cause a repeated sense of helplessness and hopelessness. In CPTSD, the appraisal of a situation that may be considered 'neutral' to most, instead is associated with deeply held emotions. Often, they are linked to a 'felt sense' of shame, associated with thoughts such as 'I am inferior' or 'I am a bad person', or of guilt, linked to 'It is my fault'.

Unhelpful cognitive and behavioural coping strategies

The negative appraisals and the problematic nature of trauma memories persist in PTSD in part because of the survival coping strategies that individuals adopt (Ehlers 2020). Although these coping strategies aim to reduce the experienced stress, in the long term they prevent any meaningful change and therefore maintain the disorder. Such unhelpful strategies include ruminating about the trauma, avoiding situations that remind the individual of the trauma and actively suppressing memories of the trauma. They can also include behaviours such as self-medicating with substances, avoiding any

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meaningful relationships, isolating themselves, avoiding attempts at meaningful occupation and engaging in co-dependent relationships or unsafe sex. Often these unhelpful behaviours become habitual, without an awareness of the reason why they are engaging in them.

Other cognitive considerations for CPTSD

Experiencing cumulative trauma events that have a similar theme at different points in life also seems to also predispose to CPTSD (Anda 2006). For example, if someone experiences feeling powerless through sexual abuse as child and is then assaulted as a young adult, this cumulative trauma can lead to CPTSD (Hyland 2017).

In addition to the characteristics of the trauma(s), other factors appear to make people vulnerable to CPTSD. Psychosocial stressors across a patient's lifespan are particularly important, such as not having supportive people around them and not having their trauma acknowledged or validated by their family. These all influence whether the individual develops the capacity to regulate their own emotions and behaviours, whether they have a stable sense of self and whether they can relate to other people in a stable way (Charuvastra 2008).

Key factors that can contribute to the development and maintenance of CPTSD are shown in Fig. 1.

Assessment and formulation

Patient histories that involve many adverse events can raise certain issues at assessment, not least how to make sense of their cumulative effects. When people experience multiple traumas their memory of these may become blurred and entangled, with one memory triggering another. In the assessment the therapist documents the trauma history, but it may be challenging for the patient to think about the worst trauma event, so it can help to talk more generally about the types of trauma experienced or trauma clusters.

In the assessment it often becomes apparent that there are significant current life events, such as an upcoming court case, housing eviction, divorce or deportation. When this is the case, the therapist and the patient should make a collaborative decision whether trauma-focused CBT should be deferred until the patient feels they have received the necessary support for their current social problems. If the individual is preoccupied by the social life event and is unable to focus on the assessment,

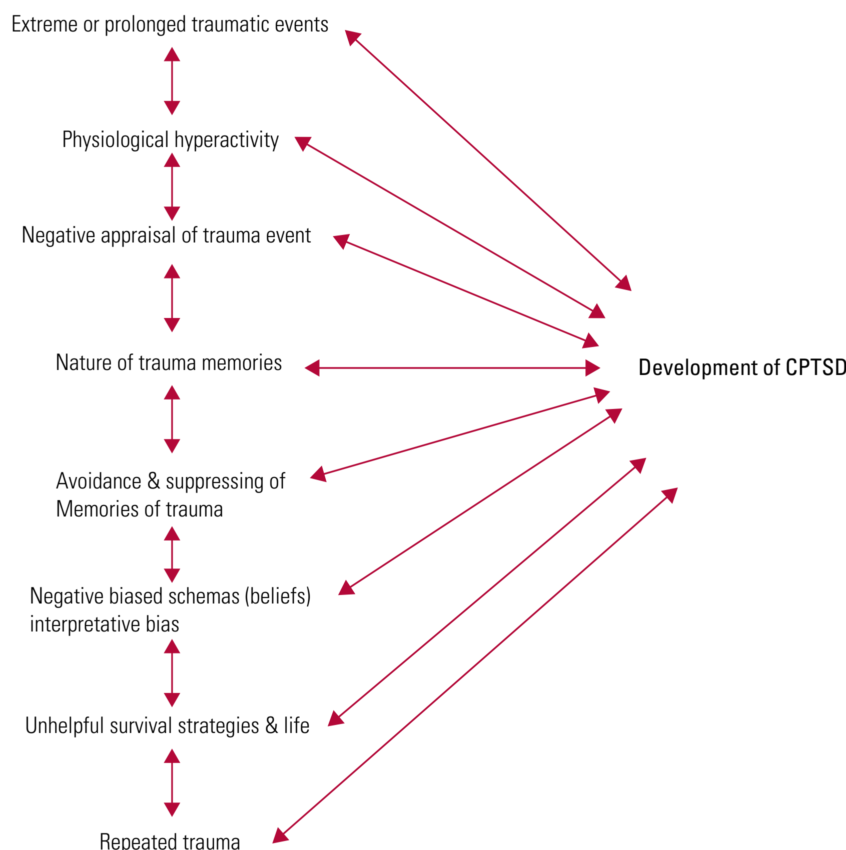

FIG 1 Factors that contribute to the development and maintenance of complex post-traumatic stress disorder (CPTSD).

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then they are likely to have difficulty in engaging with therapy.

Treatment needs to focus on the strengths of the patient – what can they do well and what resources do they have in their life? This is particularly valuable for patients who have a negative sense of themselves and who may not be able to acknowledge their own strengths.

If there is ongoing abuse or violence, such as at the hands of a partner, or risk of suicidal behaviours, safety planning must be carried out early in therapy. It might be appropriate to involve other mental health professionals (such as a social worker) in safety planning to ensure that the external circumstances, such as emergency shelter plans, childcare and crisis mental healthcare plans, are attended to before the work on the trauma memory processing begins.

The therapist and patient need to work collaboratively to develop an 'individualised formulation', which serves as the framework for therapy. This is a shared understanding or map, usually written in diagrammatic form. It needs to explain the maintenance of the presenting symptoms in the context of what has happened in the past. Formulation for CPTSD must capture the nature and maintenance of memory disturbance as well as the impact of any repeated trauma on the patient's sense of who they are, their ability to emotionally regulate themselves and how they relate to other people. A common model of PTSD used by CBT therapists is that of Ehlers & Clark (2000).

The therapeutic relationship

Patients who present with CPTSD have had awful experiences in their life and, understandably, forming a trusting therapeutic relationship is unlikely to be easy. Developing and sustaining the therapeutic relationship is central in trauma-focused CBT (Cohen 2011) for CPTSD.

If the patient has experienced multiple interpersonal traumas this is likely to have an impact on forming and sustaining a therapeutic relationship. Problems with trust, shame, hostility, perceived negative judgement from others and avoidance of difficult emotions are all likely to play out in therapy. The therapist needs to have the capacity to sit with difficult emotions that come up in therapy and, in a non-confrontational manner, try to understand and piece together or 'formulate' these difficulties. This might include understanding the origin of the difficulties, how they now affect the patient's life and how they may affect the therapeutic relationship (Murray 2022a).

It is essential to use both verbal and non-verbal behaviour to express empathy and compassion when the patient is speaking. People with CPTSD may be particularly sensitive to signals of rejection or judgement, and hence the therapist must demonstrate unconditional positive regard. Being present and remembering small details of the person's history and their life is important, as it demonstrates that the therapist is holding them in mind.

CBT approaches

There are two general approaches to the treatment of people with CPTSD. These approaches have been named the 'phase-oriented' or 'multiphase' approach and the 'unimodal' or 'single-phase' approach (Maercker 2022).

The phase-oriented approach

Usually, three phases of treatment are recommended in a phase-oriented approach to the treatment of CPTSD (International Society for Traumatic Stress Studies 2019) (Box 2).

Several psychotherapy models use the phase-oriented approach, and trauma-focused CBT can also be delivered using this approach as long as there is theoretical coherence and it is formulation driven. Cognitive therapy not only constitutes an effective, coherent framework, but also serves as an integrative paradigm for effective psychotherapy (Alford 1998).

BOX 2 The three phases of the phase-oriented approach to the treatment of complex post-traumatic stress disorder (CPTSD)

Phase 1 – Stabilisation phase

- Establishing a safe and trusting therapeutic relationship
- Symptom reduction and skills training:
  - mindfulness
  - interpersonal skills
  - emotional regulation skills
  - distress tolerance
  - self-compassion skills
  - grounding techniques

Phase 2 – Processing unresolved aspects of individual memories of traumatic experience and building an adaptive sense of self, relationships and the world

- Reclaiming/rebuilding your life assignments
- Changing the meaning of trauma memories
- Dropping unhelpful survival strategies

Phase 3 – Consolidation of treatment gains and reintegration or reconnection with life goals, self, family and society

(International Society for Traumatic Stress Studies 2019)

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Phase 1 – Stabilisation

The main aims of this phase of treatment are to: (a) to prepare the patient for the subsequent trauma-processing stage, (b) psychoeducation and (c) the reduction of background symptoms. Sometimes, working towards these aims will involve practical measures, such as sorting out accommodation or childcare. Sometimes prescribing may be involved, such as with severe comorbid depression. Almost always, this phase of treatment has a strong psychoeducational focus, to allow the patient to develop skills to cope with strong emotions and understand how the trauma has affected them. There is usually a focus on CBT models of PTSD (e.g. Ehlers 2000) and how multiple traumas complicate the presentation. Other common elements of this phase are explanation of the impact of developmental trauma and introduction of the concept of the window of tolerance. If the patient has symptoms of dissociation, then teaching them 'grounding skills' becomes paramount at this stage. Finally, re-introducing helpful activities and relationships that have been dropped owing to the trauma, and stopping unhelpful strategies that have been introduced because of the trauma, will also be addressed.

Techniques used to expand the 'window of tolerance'

The 'window of tolerance', a concept originally developed by Daniel Siegel in the 1990s (Fig. 2), refers to the range and intensity of arousal that someone can cope with before they become emotionally dysregulated (Ogden 2006). Someone with CPTSD is far more easily triggered by minor stressful circumstances. They become aroused and sometimes that extends to emotional dysregulation (Cloitre 2002). Sometimes the result is that they shut down and become hypo-aroused (the freeze response), or sometimes they become overstimulated and hyper-aroused (the fight or flight response) (Ogden 2006). Only when someone is within their window of tolerance can they manage everyday stressors well, including planning ahead and defusing perceived 'threats'. For people with CPTSD, this window of tolerance can be very narrow, which may cause them to react to neutral stimuli as threatening. Expansion of the window of tolerance is a common goal across many CPTSD interventions (Lee 2016) using third-wave CBT techniques such as teaching and practising mindfulness, distress tolerance, grounding techniques and self-compassion skills. The last will include techniques using imagery practice to help the patient to self-soothe (Karatzias 2019a).

Phase 2 – Active processing of memory and meaning, and rebuilding

This phase of CBT involves active treatment or 'processing' of the distressing memories of the traumatic experiences. The aim is to work on the memories both to reduce their intrusive nature and to change any unhelpful associated beliefs into new belief systems about themselves, other people and the world, that are less destructive and more 'adaptive'. In general, there are three steps to this process.

Step 1: Accessing 'hot spots' It is important to access the moments during the trauma memory that, when recalled, generate a sense of current threat and of 'nowness', referred to as 'hot spots'. For example, a (fictitious) patient called Mary was experiencing ongoing domestic abuse, but on one occasion she was subjected to non-fatal strangulation. The

HYPER-AROUSAL: Sense of threat. Sympathetic mode.

Anger, Anxiety, Hypervigilance, Fight/Flight, Chaotic.

WINDOW OF TOLERANCE: Social engagement. Parasympathetic ventral vagal.

Grounded, Flexible, Open, Curious, Able to self-regulate.

HYPO-AROUSAL: Immobilised. Parasympathetic dorsal vagal.

Passive, Withdrawn, Freeze, Shame, Depression, Shutdown.

FIG 2 Diagram by the author illustrating Siegel's 'window of tolerance' (Ogden 2006).

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BOX 3 Imaginal reliving

Imaginal reliving (Foa 1998) is a verbal recounting of the traumatic event done in a moment-by-moment way and incorporating not just the facts but also the full experience, including all the senses and thoughts experienced at the time. It is carried out in the present tense to activate emotions.

The patient visualises their trauma, usually with their eyes closed, starting with a first perception that something was wrong and ending when they were safe again. For example, the latter may have been when they arrived at hospital and they realised that they would survive. It usually takes two or three 'sittings' of imaginal reliving to access the hot spots sufficiently.

When a patient has witnessed multiple trauma events it is important to identify the trauma memory where the meaning of the negative appraisal originated as well as the trauma memory that is seen in the flashbacks.

moment she was being choked by her partner, she recalled thinking 'Both my daughter and I are going to die' and 'I'm a bad mother for not saving my daughter'. This was a major hot spot. Identification of the hot spot(s) can be achieved through general discussion of the intrusive memories or using imaginal reliving (Box 3) and narrative writing (Box 4).

Step 2: Identifying and updating information This is an important part of the trauma processing. The patient may be aware of new information that became apparent only after the trauma itself, but they may not have linked it to the meaning of the hot spot memory. A common scenario is that in which the patient experienced a sense that they were about to die. Obviously, they did not die but this truth is somehow separated from the 'felt sense' of being about to die. In the example above, Mary and her daughter did not die. Furthermore, through discussion she also began to realise that she had not been a bad mother – she had saved her own life and the life of her daughter. She was able to acknowledge that she had not actively fought with the perpetrator because he threatened to kill her daughter. Changing and updating new information in the trauma narrative and the patient's belief system involves the well-known CBT approach of cognitive restructuring. It uses generic CBT techniques, such as dysfunctional thought records, behavioural experiments and pie charts.

Step 3: Incorporation of the updated information into the hot spots The patient is asked to bring the hot spot to mind (either through simple imagination or by reading the corresponding parts of the narrative) and to remind themselves of the updated information verbally and by using imagery. By repeatedly linking the hot spot memory with the updated information, the two become linked in the patient's memory, and they will be recalled together in the future. Sometimes, however, this is not enough. In such cases, it can be helpful to manipulate the memory, with the incorporation of alternative events, events that never happened but that can relieve distress when incorporated into a new 'memory' of the events. This approach is called imagery rescripting (Arntz 2012) (Box 5).

Imagery rescripting is an effective way to help patients gain control over otherwise overwhelming negative imagery and traumatic memories. The new rescripted 'memory' competes with the original dysfunctional representation, and hopefully 'wins' the retrieval competition most of the time (Brewin 2006), so that when the patient automatically recalls events, they recall the newly rescripted version of those events.

Individuals who have experienced multiple traumas, especially when they were experienced during childhood, may not have a clear recollection of the trauma and they may have gaps in trauma memories. Some patients with CPTSD do not want to go through the distress associated with reliving those memories. In this scenario, imagery

BOX 4 Narrative writing

Writing a narrative (Resick 2012) is particularly useful if the trauma lasted over an extended period.

The patient writes a narrative, with assistance from the therapist, that covers the entire period and this is used to identify the hot spot moments associated with the greatest emotional significance. In this way, meanings of these events and the perceived role of the individual can be explored.

Narrative writing is helpful for patients who dissociate and lose contact with the present situation when they remember the trauma or for those who show very strong physical reactions when remembering the trauma. The person will gently be 'grounded' back into the current time if dissociation happens, and then re-directed back into the task at hand. This is difficult to do if it is simply conversational but is helped if their place in the trauma narrative is held in the document in front of them.

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BOX 5 Imagery rescripting

Imagery rescripting starts with what the patient can remember about the trauma up to the point of the violence or abuse, i.e. the worst, most distressing moments. At this point the memories can be altered or manipulated so that they are different from what occurred. Often, the person imagines the events unfolding or ending differently. Usually, the new version is imagined in a way that feels better, such as imagining a friend coming into the 'memory' to help and to confront the perpetrator, so the person feels less powerless or alone than they did at the time of the real trauma.

The patient takes a lead in rescripting and altering the narrative; the therapist facilitates the rescripting but attempts to remain as non-directive as possible.

rescripting can still be used as an effective method to provide 'corrective information' about the trauma memory, and in changing the meaning of emotional memories (Arntz 2012).

Reclaiming and rebuilding a life Owing to the devastating impact of the trauma, some people with CPTSD believe that they have been permanently damaged. Consequently, they feel unable to engage in activities and relationships that used to be important for them. Unfortunately, the very act of stopping the set of activities that previously gave a sense of meaning and identity reinforces their belief that their life is permanently, and irretrievably, less worthwhile.

It consequently becomes important to consider what the patient can do to reclaim their life. Some patients who have CPTSD feel that they have had significant losses and hence it is not just about 'reclaiming their lives' but about 'rebuilding their lives'. This is often involves slowly reconnecting with friends and family, going out of the house more and considering their ability to work.

Dropping unhelpful coping behaviours The patient may engage in unhelpful survival/coping strategies that perpetuate a sense of low self-worth. For example, someone who has experienced domestic abuse may subjugate their own needs even after they have left the abusive relationship. This subjugating behaviour perpetuates their sense of self as someone who is weak and helpless. Learning, trying out and then practising new, more helpful behaviours is an important part of trauma-focused CBT.

Phase 3 – Consolidation of treatment gains and life re-engagement

This final phase, sometimes termed 'reintegration' or 'reconnection', focuses on the individual's wider development beyond their traumatic experiences and their presenting symptoms. It centres on re-establishing their life goals and on reconnection with friends, family and wider society. An attempt is made to increase the patient's autonomy, by developing new roles in employment, education and their personal lives.

This third phase is not very clearly described in the literature, and in practice, most therapists focus on phase 1 and phase 2. This third phase, however, is important as the patient needs to continue with rebuilding their lives and integrating their new perspectives on the world and their own value of themselves in it. If this is not done, the earlier therapy can be a mainly intellectual endeavour and can fail to be embedded into the lives of patients.

This phase-oriented approach is not static, if the patient becomes overwhelmed with emotions, or feels suicidal because of life events or because of what the trauma has brought up, it may be essential to go back to stabilisation. The optimal duration of treatment is undecided, but most treatments appear to be in the range of 4–12 months' duration (Brewin 2020).

The unimodal approach

The so-called unimodal approach does not include a separate phase of stabilisation (phase 1 of the phase-oriented approach), nor a separate phase of reintegration (phase 3 of the phase-oriented approach). In contrast, the unimodal approach begins the processing of the trauma memories (phase 2 of the phase-oriented approach), early in treatment. The unimodal approach can be understood as the integrated trauma-focused CBT approach which is used in the treatment of PTSD.

Advocates of the unimodal approach state that the psychoeducation work and emphasis on a safe therapeutic relationship can be a part of treatment throughout and can directly offer stabilisation without the need for separate 'phases of treatment'. They also state that they do not have to do a specific 'reintegration' phase 3, as 'reintegration' is a strand that should run throughout therapy (Murray 2022b).

The multiphase approach versus the unimodal approach

Several clinical consensus guidelines, including those of the International Society for Traumatic Stress Studies (Cloitre 2011; 2012; ISTSS Guidelines Committee 2019) and the UK Psychological Trauma

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Society (McFetridge 2017) advocate phase-oriented treatment approaches. In the UK, the NICE guidelines do not specifically endorse a phase-oriented approach, although they still advocate a longer period of treatment for CPTSD, to develop trust and to stabilise the person (NICE 2018). Nevertheless, several individual studies have shown that the unimodal approach can be effective in CPTSD (Resick 2012; de Jongh 2016). De Jongh and colleagues (2016) found that the additional complexities associated with CPTSD, such as dissociation and comorbidities, do not in general impede treatment using a unimodal approach. Murray et al (2022b) also challenge the notion that it is important to have a separate stabilisation or reintegration phase, as this is already a part of trauma-focused CBT.

The research on unimodal approaches is credible, but in clinical practice many people with CPTSD struggle with emotional dysregulation and present with other complicating factors (e.g. suicidal ideation, dissociative identity disorder, substance misuse, an ongoing relationship with an abusive partner), which make it harder for them to tolerate trauma processing unless some preliminary stabilisation work is conducted. Concerns have been raised that these patients are often excluded from studies into treatment approaches for CPTSD, which limits the extent to which findings can be translated into real practice (Karatzias 2019b; Coventry 2020). Furthermore, few of the randomised controlled trials of treatments for CPTSD have reported affect dysregulation data (Karatzias 2019).

Although CPTSD is a new diagnostic classification, the concept has been around for over 30 years, and in practice CBT therapists with a wealth of experience in treating CPTSD use aspects of the phase-oriented approach in their treatment (e.g. Lee 2016; Hegarty 2022).

Further research is essential to gain robust evidence in terms of comparing the efficacy of the unimodal and phase-oriented approaches and to establish whether there are factors that can determine which approach would be more effective for specific patient groups.

Conclusion

The development and evaluation of treatment approaches for CPTSD is still at an early stage, and there are several key questions that are not yet settled. A much-discussed controversy is whether a multicomponent, phase-oriented approach or a unimodal approach is more effective for people with CPTSD. Currently there is emerging evidence that both approaches work. In the literature there is a lack of randomised controlled trials that compare the efficacy and acceptability of the phase-oriented approach with those of the unimodal approach.

Cognitive–behavioural therapy for CPTSD is flexible and is based on individualised formulation. Building a safe therapeutic alliance and having a longer early phase of treatment to assist in the patient's stabilisation is essential, particularly in the most severe CPTSD presentations and when the trauma has been endured very early in life.

Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

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Declaration of interest

None.

MCQ answers
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MCQs

Select the single best option for each question stem

1 Which of the following is not a core diagnostic presentation in CPTSD?

a experiences re-experiencing in the form of flashbacks and nightmares
b can sometimes experience somatic flashbacks
c can experience a negative self-concept
d presents with self-harming as a core feature
e can struggle with relationships.

2 Which of the following is not true of trauma memories?

a they are declarative
b they are not presented with a time tag and not contextualised
c they are processed by amygdala
d they are fragmented
e they have a sense of 'nowness'.

3 In CPTSD it is not true that:

a early adverse experience can cause CPTSD
b the cumulative effect of repeated trauma can be causal
c lack of social support and adverse reactions can add to the vulnerability
d unhelpful survival strategies further add to the sense of persistent threat
e there is always an early life onset trauma.

4 Which of the following is a helpful skill in CPTSD?

a suppression of memories
b avoidance of any cues that act as a reminder of the traumas
c drinking alcohol to numb the emotional pain
d excessively trying to people please and subjugating their own needs
e being able to be assertive.

5 As regards the treatment of CPTSD, it is not true that:

a the therapeutic relationship is key
b trauma memory processing can be done via imaginal reliving or writing a narrative
c imagery rescripting can create an ending that is being different from what happened
d assignments are planned to rebuild lives
e patients must avoid thinking about the trauma, as it can be retraumatising.

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