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Complex Trauma and Associated Diagnoses

Greg Brack & Catherine J. Brack
Georgia State University

Description of Complex Trauma

Definition and Identification

"Complex Trauma" is both a description of the horrific experiences a person has survived, as well as a diagnostic term for the overwhelming stress reactions that a person experiences. The reactions are usually "…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 (Cloitre, Courtois, Ford, Green et al., 2012, p.3, http://www.istss.org/AM/Template.cfm?Section=ISTSS_Complex_PTSD_Treatment_Guidelines&Template=/CM/ContentDisplay.cfm&ContentID=5185.

The types of traumas "…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" (Cloitre, et al., p. 3).

Currently, there are several terms related to severe trauma reactions beyond PTSD: Complex Trauma (see Courtois, 2008), Disorders of Extreme Stress (DESNOS) (see Luxenberg et al. 2001a&b, http://www.aisjca-mft.org/desnos.pdf), Complex PTSD (see Cloitre, et al.; Herman, 1992), and with minors Developmental Trauma Disorder (see van der Kolk, et al., 2005, http://dx.doi.org/10.1002/jts.20047). According to Courtois and Ford (2013), there are "… three core domains of complex traumatic stress reactions and disorders: (1) emotional dysregulation, (2) the loss of self-integrity, and (3) disturbances in the ability to relate to and to be intimate with others." (p. 28). Morina and Ford (2008) stated that complex trauma reactions include "…disabling alterations in several domains of biopsychosocial functioning, including dysregulation of: (1) affect and impulses (i.e., extreme and unmodulated states of emotion, distinct from mania); (2) attention or consciousness (i.e., dissociation); (3) self-perception (i.e., viewing self as fundamentally damaged); (4) interpersonal relationships (i.e., impaired relational boundaries); (5) bodily self-regulation (i.e., somatization); and (6) sustaining beliefs (i.e., spiritual alienation)." (p.426). In children and adolescents, "…domains of impairment include: (I) Attachment; (II) Biology; (III) Affect regulation; (IV) Dissociation; (V) Behavioral regulation; (VI) Cognition; and (VII) Self-concept." (Cook, Blaustein, Spinazzola, & van der Kolk, 2003, p. 6, http://www.nctsnet.org/nctsn_assets/pdfs/edu_materials/ComplexTrauma_All.pdf).

While Complex PTSD has a rather long history as a diagnostic category for researchers and some practitioners (Sar, 2011, http://www.eurojnlofpsychotraumatol.net/index.php/ejpt/article/view/5622/html_100), it is not a current DSM-IV-TR diagnosis (American Psychiatric Association, 2000). The proposed DSM-5 will include a dissociative subtype of PTSD which, according to Cloitre et al. (2012), will recommend treatments similar to those recommended for Complex PTSD or Complex Trauma. The proposed ICD-11 (World Health Organization, n.d., http://apps.who.int/classifications/icd11/browse/f/en) includes a diagnosis of Complex PTSD, which has similar symptoms to those proposed by Cloitre et al. (2012). Not everyone supports the use of Complex Trauma-related diagnoses. The National Center for PTSD of the U.S. Department of Veterans Affairs stated, "Because results from the DSM-IV Field Trials indicated that 92% of individuals with Complex PTSD/DESNOS also met diagnostic criteria for PTSD, Complex PTSD was not added as a separate diagnosis classification…However, cases that involve prolonged, repeated trauma may indicate a need for special treatment considerations." (National Center for PTSD, 2012).

Prevalence

Most sources indicate that Complex Trauma is common among individuals with profound repeated trauma, especially trauma beginning early in the life span. According to Morina and Ford (2008, http://isp.sagepub.com/content/54/5/425), while "full DESNOS rarely occurred [among Kosovar Civilian War Victims] (2% prevalence)... clinically significant DESNOS symptoms of somatization, altered relationships, and altered systems of meaning were reported by between 24–42% of respondents. Although DESNOS symptoms were correlated with PTSD symptoms, DESNOS symptoms were associated with poorer overall psychological functioning, self-evaluations, satisfaction with life, and social support independent of the effects of PTSD." (p.425). They concluded that DESNOS may need to be considered, in addition to PTSD, when working with survivors of war and/or genocide. It appears that Complex Trauma also is "…highly prevalent among youth in secure juvenile justice facilities." (Ford, Chapman, Connor, & Cruise, 2012, p.697, http://cjb.sagepub.com/content/39/6/725) as well as in child welfare systems. (Greeson, et al., 2011).

INTERVENTION/ASSESSMENT STRATEGIES

Assessment Strategies

According to Briere and Spinozzola (2009), there are multiple ways to assess Complex Trauma, including structured interviews, paper and pencil general assessment instruments, and trauma-specific paper and pencil instruments. The structured interviews include the Clinician-Administered PTSD Scale (Blake et al., 1995) (measuring current and lifetime PTSD), the Structured Interview for Disorders of Extreme Stress (Pelcovitz et al, 1997, http://dx.doi.org/10.1002/jts.2490100103) (assessing current and lifetime presence of DESNOS), and the Structured Clinical Interview for DSM-IV Dissociative Disorders (Steinberg, 1994) (assessing the existence and severity of dissociative symptoms). The general instruments include the Personality Assessment Inventory (Morey, 1991) with its trauma subscale, the Millon Clinical Multiaxial Inventory-III (MCMI-III; Millon, 1994), the MMPI2 with its PTSD scale (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989), and the Symptom Checklist-90-revised (Derogatis,1983). The trauma-related instruments include the Trauma Symptom Inventory (Briere, 1995), the Posttraumatic Stress Diagnostic Scale (Foa, 1995), and the Detailed Assessment of Posttraumatic Stress (Briere, 2001). To measure issues with affect regulation, interpersonal relationship, and identity, Briere and Spinozzola (2009) recommend the Bell Object Relations and Reality Testing Inventory (Bell, 1995) and the Inventory of Altered Self-Capacities (Briere, 2000b). To measure the cognitive disturbances, Briere and Spinozzola (2009) recommended the Cognitive Distortions Scale (Briere, 2000a) and the Trauma and Attachment Belief Scale (Pearlman, 2003). The recommended measures of dissociation include the Dissociative Experiences Scale (Berstein & Putnam, 1986) and the Multiscale Dissociation Inventory (Briere, 2002). Because Complex Trauma is often the result of early trauma, Brown (2009) recommended measuring attachment issues relevant to assessment and treatment using the Adult Attachment Inventory (Main, Goldwy & Hesse, 2002).

There also are assessment instruments for children and adolescents recommended by Briere and Spinozzola (2009): Child Behavior Checklist (Achenbach, 1991) or the updated version as part of Achenbach System of Empirically Based Assessment (Achenbach, 2002), Trauma Symptom Checklist for Children (Briere, 1996) for ages 8-16,Trauma Symptom Checklist for Young Children (Briere, 2005) for ages 3-12, Child Sexual Behavior Inventory (Friedrich, 1998), and Trauma Symptom Inventory (TSI; Briere, 1995) for older adolescents 18-21. According to Briere & Spinazzola (2009), assessment of other reactions related to Complex Trauma in children include the Behavioral Assessment System for Children (Reynolds & Kamphaus, 2006), the Children's Depression Inventory (Kovacs, 1992), the Connors Rating Scale (Conners, 1989), and the Personality Inventory for Children (Lachar, 1982).

Intervention Strategies

Many different approaches have been used to treat survivors of Complex Trauma including Contextual Therapy (Gold, 2009), Cognitive-Behavioral Therapy (Jackson, Nissenson, & Cloitre, 2009), Contextual Behavior Trauma Therapy (Folletter, Iverson, & Ford, 2009), Experiential and Emotional-focused therapy (Fosha, Paivio, Gleiser, & Ford 2009), Sensoriomoter Psychotherapy (Fisher & Ogden, 2009), and Pharmacotherapy (Opler, Grennan, & Ford, 2009). Whatever theoretical orientation used, a three phase or stage integrative treatment approach is commonly recommended for adolescents and adults (see Briere & Lanktree, 2012; Cloitre et al., 2012; Courtois, 2009;

Herman, 1992, 2009). The three phases or stages were identified by different labels by different authors. Utilizing the recent ISTSS expert consensus guidelines, the phases include stabilization and skills strengthening, review and reappraisal of trauma memories, and transition out of therapy to greater community engagement (Cloitre et al, 2012). The goals of Phase 1 are client safety and strengthening the client's "…capacities for emotional awareness and expression, increase positive self-concept and address feelings of guilt and shame, and increase interpersonal and social competencies (Cloitre et al., 2012, p.8). This phase ends with the reduction of symptoms and unhealthy coping behaviors, the increase in coping skills, and the agreement between the client and counselor to move forward. The goals of Phase 2 are to re-experience the trauma through telling the story in a safe environment and to reappraise the meaning of the trauma while maintaining functioning (Cloitre et al, 2012). For clients who are dissociative, this phase of treatment should be entered cautiously due to the potential for destabilization (Steele & van der Hart, 2009). Finally, transition out of counseling to greater community engagement during Phase 3 involves developing and consolidating interpersonal and social relationship skills in order to move into the community (Cloitre et al., 2012). For highly dissociative clients, this phase is called "Integration of the Personality and Rehabilitation" (Steele & Hart, 2009, p. 160). In fact, Steele and van der Hart (2009) suggested that the grieving that is commonly part of Phase 2 continue into Phase 3 for dissociative clients.

Specific Interventions Based on Empirical Research

Researchers of adults with Complex Trauma from childhood abuse found that therapies focused upon stabilization and memory processing are particularly effective in lowering symptoms related to PTSD, emotion regulation and social/interpersonal issues. (Bradley & Follingstad, 2003; Chard, 2005; Classen et al., 2011; Cloitre, Koenen, Cohen, & Han, 2002; Cloitre et al., 2010, http://dx.doi.org/10.1176/appi.ajp.2010.09081247 ; Dorrepaal et al., 2009, http://dx.doi.org/10.1016/j.chiabu.2009.07.00); Ford, Steinberg, & Zhang, 2011, http://dx.doi.org/10.1016/j.beth.2010.12.005; Zlotnick et al., 1997; Steil, Dyer, Priebe, Kleindiest, & Bohus, 2011, http://dx.doi.org/10.1002/jts.2490100103). A study with adults comparing exposure-focused treatment and skills training followed by memory processing provided the best results followed by the skills focused treatment with exposure-focused treatment the least effective (Cloitre et al, 2010). Researchers and counselors working with Complex Trauma agree that both the specific interventions and the therapeutic relationship are equally important for treatment outcome with adults (Cloitre, Stovall-McClough, Miranda & Chemtob, 2004; Kinsler, Courtois, & Frankel, 2009). Intervention strategies recommended by Cloitre et al. (2012) included stress management and cognitive restructuring (stress inoculation training; SIT), which are empirically based treatments for PTSD and can be helpful in stabilization and skills strengthening work with Complex Trauma (Meichenbaum, 1985; 1994). Cloitre et al. (2012) also recommended emotion regulation skills training. Courtois and Ford (2013) recommended Dialectical Behavior Therapy (Linehan, 1993; Wagner, Rizvi, & Harned) Skills Training for Affect and Interpersonal Regulation (Cloitre et al., 2010), Trauma Affect Regulation: Guide for Education and Therapy (TARGET; Ford et al, 2012), Seeking Safety (Najavits, 2002), and Emotion-Focused Therapy (EFT; Paivio, Jarry, Chagigiorgis, Hall, & Ralston, 2010; Paivio & Nieuwenhuis, 2001). Meditation and mindfulness also are "… important but insufficient skills" (Cloitre et al, 2012, p. 8). Courtois and Ford (2013) suggested that Acceptance and Commitment Therapy (ACT; Hayes, Luoma, Bond, Masuda & Lillis, 2006, http://dx.doi.org/10.1016/j.brat.2005.06.006) can help clients tolerate and regulate emotions. It is important to note that the therapeutic relationship is very important during any of these interventions and can assist traumatized clients in developing interpersonal skills (Cloitre et al., 2012, Herman, 1992; Courtois & Ford, 2009). Another important intervention during stabilization and skills strengthening, particularly for those who are dissociative, is grounding (Steele & van der Hart, 2009), sometimes called mindfulness (e.g., Linehan, 1993) or mental focusing (Ford & Russo, 2006). Pharmacotherapy, particularly using serotonin reuptake inhibitors (SSRIs), often is used to reduce symptoms of PTSD, although it may be less effective with other symptoms associated with Complex Trauma (Briere & Scott, 2006; Opler et al., 2009). The only anti-anxiety medication recommended is buspirone (Briere & Scott; Opler et al.).

According to Courtois and Ford (2012), evidence based treatments for trauma memory and emotion processing included prolonged exposure, (Foa, Hembree, & Rothbaum, 2007) and cognitive processing therapy (Resick, Nishith, & Griffin, 2003). Other methods that have shown promise in research, according to Courtois and Ford (2012) and Cloitre et al. (2012), included eye movement desensitization and reprocessing (EMDR; Hart, Nijenhuis, & Solomon, 2010; Shapiro, 2001, 2012; Shapiro & Solomon, 2012), emotion focused therapy for complex trauma (Paivio et al, 2010) , narrative exposure therapy (Hensel-Dittman et al., 2011), imagery rehearsal/imagery rescript-

ing therapy (Smucker, Dancu, Foa, & Niederee, 2012), and narrative therapy (Schauer, Neuner, & Elbert, in press). Despite the success of prolonged exposure with PTSD, many have suggested that graduated exposure (based on systematic desensitization) is a less intense approach for clients with Complex Trauma (Briere & Scott, 2006; Courtois, 1988, 1999; Courtois & Ford, 2013). EMDR was effective in reducing the symptoms of PTSD and a modified version has been found to assist some survivors of complex trauma (Gelinas, 2003; Korn & Lwwsa, 2002; Shapiro, 2001, 2012).

The goals for working with children and adolescents with Complex Trauma are basically the same as those for adults (Ford & Cloitre, 2009). Ford and Cloitre (2009) stated that trauma focused cognitive behavioral therapy (TF-CBT; Cohen, Mannarino & Kliethemesb, & Murray, 2012, http://dx.doi.org/10.1016/j.chiabu.2012.03.007) was validated for sexually or physically abused children with PTSD. If symptoms are severe or there is lack of adult support, Ford and Cloitre (2009) recommended stabilization first. According to Ford and Cloitre (2009) other therapy models to consider for working with children include child parent psychotherapy (CPP; Van Horn & Lieberman, 2008), parent child interaction therapy (Ford & Gurwich, 2008), interaction guidance (McDonough, 2000), a psychodynamic model to help parents understand their child's emotions and motivations (Watch, Wait, & Wonder; Cohen et al., 1999), and Real Life Heroes (Kagan, 2008). Another evidence based approach for young children is Attachment, Self-Regulation, and Competency (ARC; Arvidson, et al., 2011, http://dx.doi.org/10.1080/19361521.2011.545046). According to Ford and Cloitre (2009), therapy models for working with adolescents included structured psychotherapy for adolescents responding to chronic stress (SPARCS; DeRosa & Pelcovitz, 2008), Trauma Affect Regulation: Guidelines for Education and Therapy (TARGET; Ford & Russo, 2006; Ford et al., 2012), Life Skills/Life Story which was adapted from Skills Training in Affect and Interpersonal Regulation (STAIR; Cloitre et al., 2006), and Seeking Safety (Najavits et al., 2006) adapted from the adult model.

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