

Treatment of Complex PTSD: Results from the ISTSS Expert Consensus Study on Best Practices

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This study provides a summary of the results of an expert opinion survey initiated by the International Society for Traumatic Stress Studies Complex Trauma Task Force regarding best practices for the treatment of complex posttraumatic stress disorder (PTSD). Ratings from a mail-in survey from 25 complex PTSD experts and 25 classic PTSD experts regarding the most appropriate treatment approaches and interventions for complex PTSD were examined for areas of consensus and disagreement. Experts agreed on several aspects of treatment, with 84% endorsing a phase-based or sequenced therapy as the most appropriate treatment approach with interventions tailored to specific symptom sets. First-line interventions matched to specific symptoms included emotion regulation strategies, narration of trauma memory, cognitive restructuring, anxiety and stress management, and interpersonal skills. Meditation and mindfulness interventions were frequently identified as an effective second-line approach for emotional, attentional, and behavioral (e.g., aggression) disturbances. Agreement was not obtained on either the expected course of improvement or on duration of treatment. The survey results provide a strong rationale for conducting research focusing on the relative merits of traditional trauma-focused therapies and sequenced multicomponent approaches applied to different patient populations with a range of symptom profiles. Sustained symptom monitoring during the course of treatment and during extended follow-up would advance knowledge about both the speed and durability of treatment effects.

Keywords: complex PTSD, expert consensus, best practices, treatment, PTSD

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complex PTSD (Keane, 2000). A body of research has demonstrated that complex PTSD is a distinct clinical entity characterized by a range of symptoms including re-experiencing, avoidance, and hyperarousal (Pech, Van Der Kolk, Runtz, Maeder, Kessler, & Resick, 1997). A recent review of DSM-IV criteria for PTSD identified a range of symptoms associated with complex PTSD (Abe-Camacho & Foa, 2008).

American Journal of Orthopsychiatry, 2000, 70, 465). The prevalence of PTSD in combat veterans has been estimated to be 15% to 30% (Foa et al., 1999). The prevalence of PTSD in civilian populations is estimated to be 8% to 15% (Foa et al., 1999). The prevalence of PTSD in children and adolescents is estimated to be 1% to 17% (Foa et al., 1999). The prevalence of PTSD in older adults is estimated to be 1% to 10% (Foa et al., 1999).

Research has shown that PTSD is associated with a variety of physical health problems, including cardiovascular disease, hypertension, diabetes, and chronic pain (Foa et al., 1999). PTSD is also associated with a variety of mental health problems, including depression, anxiety, and substance use disorders (Foa et al., 1999). The prevalence of PTSD in children and adolescents is estimated to be 1% to 17% (Foa et al., 1999). The prevalence of PTSD in older adults is estimated to be 1% to 10% (Foa et al., 1999).

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Approach	95% Confidence interval									Experts' ratings (%)			<i>M</i>	<i>SD</i>
	3 rd line			2 nd line			1 st line			1 st line	2 nd line	3 rd line		
	1	2	3	4	5	6	7	8	9					
Sequenced treatment										8.0	1.6	85	15	0
Primarily coping skills										5.3	2.2	34	40	26
Combine processing and skills										4.3	2.4	27	23	50
Primarily memory processing										4.7	1.2	29	47	24

	95% Confidence interval									Experts' ratings (%)			<i>M</i>	<i>SD</i>	
	3 rd line			2 nd line			1 st line			1 st line	2 nd line	3 rd line			
	1	2	3	4	5	6	7	8	9						
Acceptability															
Education about trauma											8.0	1.4	86	14	0

Treatment of First-Episode and Second-Episode Traumatic Stress

Mental Disorder	First-Episode	Second-Episode
Recurrent	Education about trauma Narrative format	Cognitive therapy Exposure therapy Adequate follow-up
Acute/chronic	Education about trauma Exposure therapy	Cognitive therapy Narrative format Medication / antidepressants Individual therapy
Hereditary	Education about trauma Exposure therapy Adequate follow-up	Narrative format Cognitive therapy
Affected family	Education about trauma Exposure therapy	(abuse)-250.4(-)-0.2(a)]TJ16.8001 -1.1997 TD-

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	95% Confidence interval									Experts' ratings (%)				
	3 rd line			2 nd line			1 st line			M	SD	1 st line	2 nd line	3 rd line
	1	2	3	4	5	6	7	8	9					
Format for initial phase of treatment														
Individual										8.7	0.6	100	0	0
Individual + group										6.7	2.1	67	23	10
Group (structured)										6.4	2.3	59	27	14
Group (open)										3.7	1.9	6	42	52
Self-help										3.3	1.6	4	35	61
Format for processing trauma memories														
Individual										8.6	0.6	100	0	0
Combined										6.3	2.4	52	33	15
Group										3.5	2.1	8	41	51

Figure 5. Ratings for effectiveness of each data format for each phase of treatment.

are more effective than the other formats. The most effective format for the initial phase of treatment is individual, followed by individual + group, group (structured), group (open), and self-help.

The most effective format for processing trauma memories is individual, followed by combined, and group. The most effective format for the initial phase of treatment is individual, followed by individual + group, group (structured), group (open), and self-help. The most effective format for processing trauma memories is individual, followed by combined, and group. The most effective format for the initial phase of treatment is individual, followed by individual + group, group (structured), group (open), and self-help.

Some of the most effective formats for the initial phase of treatment are individual, individual + group, group (structured), group (open), and self-help. The most effective format for processing trauma memories is individual, followed by combined, and group.

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Ratings for effectiveness of each data format for each phase of treatment are shown in Figure 5. The most effective format for the initial phase of treatment is individual, followed by individual + group, group (structured), group (open), and self-help. The most effective format for processing trauma memories is individual, followed by combined, and group.

