

BRIEF REPORT

Treating Adults With Complex Posttraumatic Stress Disorder Using a Modular Approach to Treatment: Rationale, Evidence, and Directions for Future Research

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ICD-11 complex PTSD (CPTSD) is a new condition, and, therefore, there are as yet no clinical trials evaluating interventions for its treatment. In this paper, we provide the rationale for a flexible multimodal approach to the treatment of CPTSD, its feasibility, and some evidence suggesting its potential benefits. The approach highlights flexibility in the selection of empirically supported interventions (or a set of interventions) and the order of delivery based on symptoms that are impairing, severe, and of relevance to the patient. The approach has many potential benefits. It can incorporate the use of interventions for which there is already evidence of efficacy allowing the leveraging of past scientific efforts. It is also consistent with patient-centered care, which highlights the importance of patient choice in identification of the problems to target, interventions to select, and outcomes to monitor. Researchers on modular treatments of other disorders have found that, compared to disorder-specific manualized protocols, flexible multimodal treatment programs are superior in resolving identified problems and are associated with greater therapist satisfaction and reduced patient burden. We briefly identify types of interventions that have been successful in treating trauma-exposed populations as well as emerging interventions that are relevant to the particular problems associated with exposure to complex trauma. We conclude with examples of how such treatments can be organized and tested. Research is now urgently needed on the effectiveness of existing and new intervention approaches to *ICD-11* CPTSD treatment.

In November 2018, The International Society of Traumatic Stress Studies (ISTSS) released its third revision of treatment guidelines, which included a position paper for complex post-traumatic stress disorder (CPTSD; ISTSS Guidelines Position Paper on Complex PTSD in Adults, 2019). The paper noted past critiques of the CPTSD construct, particularly the lack of a consensus concerning its definition and the consequent difficulties in providing treatment guidelines. As noted in the position paper, the first of these issues—the absence of an established definition of the construct—has been resolved. Complex PTSD was formally introduced into the diagnostic nomenclature in the eleventh revision of the *International Classification of Diseases and Related Health Problems (ICD-11*; World Health Organization [WHO], 2018), the diagnostic system of the WHO. Given that CPTSD is a new disorder, there are as

yet no treatment studies assessing interventions that would be effective for the disorder or which possible available treatment interventions will prove to be optimal for treatment. The purpose of the present paper is to present the rationale for offering a patient-centered approach to the treatment of and research on CPTSD as well as its feasibility and potential benefits. We conclude with a broad description of research methods and implementation science practices to guide future research in the treatment of CPTSD.

CPTSD: Patient Characteristics and Central Symptoms

The diagnosis of CPTSD is organized into two overarching groups of symptoms: those related to traumatic stimuli (i.e., PTSD) and those related to disturbances in self-organization (DSO). The three PTSD symptom clusters in the *ICD* diagnostic criteria (i.e., reexperiencing, avoidance, and sense of threat) have been derived from decades of research (see Brewin et al., 2017). The DSO symptoms are organized into three categories that describe three conceptually distinct problem domains: problems with affect regulation, problems with self-identify,

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and problems in relating to others. The two-factor formulation of CPTSD appears to allow clinicians to easily and correctly identify the disorder, as demonstrated by high rates of accurate differential diagnosis between CPTSD and PTSD and as compared to normality among over 1,700 clinicians in 73 countries (Keeley et al., 2016).

An important step in identifying interventions that are particularly or more precisely relevant to the treatment of CPTSD is to explore patient characteristics that are associated with CPTSD as compared to those associated with PTSD and to understand the associations among symptoms and symptom clusters. Regarding patient characteristics, Karatzias and colleagues (2018) assessed the predictive strength of emotion regulation strategies, negative trauma-related cognitions, and attachment style on the diagnosis of *ICD-11* CPTSD as compared to PTSD. All three patient characteristics were differential predictors of CPTSD versus PTSD. The most significant differential predictor of diagnosis was negative cognitions about the self, characterized by a generalized negative view about one's self and one's trauma symptoms. This was followed by attachment anxiety, characterized by a fear of interpersonal rejection or abandonment and/or distress if one's partner is unresponsive or unavailable. The third differential predictor was expressive suppression, characterized by efforts to hide, inhibit, or reduce emotional expression.

These results indicate that negative self-concept is a highly salient characteristic of CPTSD. Indeed, using a very different analytic approach, two network analyses of CPTSD symptoms in community clinical samples (Knefel, Lueger-Schuster, et al., 2019) and population-based trauma samples (Knefel, Karatzias, et al., 2019) found similar results indicating that negative self-concept was the most central aspect of the CPTSD formulation. Network analysis allows for visual representation of symptoms and can identify which symptoms are central regarding strength and number of interactions with other symptoms. In theory, identification of these symptoms can mark the most significant symptoms of the disorder and, potentially, the most important treatment targets. In the analysis of CPTSD symptom data from four nationally representative samples (Germany, Israel, the United Kingdom, and the United States), negative self-concept, specifically "feelings of worthlessness," was central across all four samples regardless of differences in language, culture, and the types of traumas to which the populations had been exposed (Knefel, Karatzias, et al., 2019).

Given these data, Karatzias et al. (2018) concluded that negative self-concept, specific types of attachment-based fears, and emotion dysregulation in the form of inhibited emotional expression were differentially associated with CPTSD compared to PTSD. Interventions that address each of these problems in ways that are relevant to their particular content and dynamic may enhance treatment benefits. For example, it has been argued that severely negative views of the self may be particularly responsive to compassion-focused interventions (Gilbert & Irons, 2004). Furthermore, although emotion regulation difficulties are indirectly addressed in many treatments (e.g., train-

ing patients in using focused breathing before exposure), direct psychoeducation on the impact of chronic trauma on emotion regulation and skills training in emotional expression may be helpful. Finally, inclusion of psychoeducation regarding the impact of trauma on attachment and relational capacities may help "normalize" problems, whereas interventions focused on increasing social engagement, relationship satisfaction, and satisfaction in social engagement may help resolve interpersonal difficulties.

In this section, we have identified problems that are particularly salient to individuals with CPTSD and provided suggestions for interventions that might be of benefit. However, this does not answer questions concerning how to introduce new interventions into existing treatments. If new interventions are to be integrated into existing treatments, how might this work? The following sections address these questions by introducing the treatment frame of "patient-centered care" as a guide for future research.

The *ICD-11* formulation of posttraumatic reactions into two disorders rather than one is consistent with a personalized medicine approach to treatment care. The *ICD-11* CPTSD diagnostic criteria includes a larger number of different kinds of symptoms than PTSD, and the disorder typically results from a higher number of and more chronic traumatic exposures. Studies comparing *ICD-11* PTSD to *ICD-11* CPTSD have consistently found that CPTSD is associated with significantly worse functioning, more comorbidity, and worse quality of life compared to *ICD-11* PTSD (e.g., Brewin et al., 2017; Cloitre et al., 2019; Karatzias et al., 2017). These data suggest that CPTSD is more severe than PTSD in clinically meaningful ways and that CPTSD treatment may require more treatment interventions and/or a longer duration than treatment for PTSD. The difference between the two disorders in terms of their complexity and severity is expected to translate into treatment plans that personalize interventions specific to each disorder and will help optimize outcomes for the individual patient while efficiently deploying limited mental health resources.

The development of different treatments is motivated by the presence of different disorders with different symptoms and associated levels of impairment. However, it is possible that patient populations with two different disorders could use the same treatments and have equally good outcomes. In the next section of this paper, we report on the results of two meta-analyses investigating this question.

Limitations of Current Evidence-Based Treatments

To date, the vast majority of evidence for the treatment of psychological trauma has been based on PTSD as presented in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, which is a condition of three symptom clusters resembling to a high degree the new *ICD-11* PTSD criteria. Existing treatment guidelines for PTSD propose psychotherapeutic approaches as the first line of support for psychological trauma and recommend trauma-focused

psychological therapies, such as cognitive behavioral therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR) for PTSD (e.g., Australian Centre for Posttraumatic Mental Health [ACPMH], 2007; National Institute for Clinical Excellence [NICE], 2005). Trauma-focused treatments typically include repeated in vivo and/or imaginal exposure to the trauma, reappraisal of the meaning of the trauma and its consequences, or some combination of these techniques. These therapies have been identified as efficacious for a range of PTSD survivors, including rape victims, survivors of childhood abuse, refugees, combat veterans, and victims of motor vehicle accidents (Foa, Keane, Friedman, & Cohen, 2009). Nevertheless, two recent meta-analyses have suggested that certain subgroups of patients may experience less of a benefit than others. Additionally, the effectiveness of the treatments may vary by type of outcome.

In the meta-analysis completed by Karatzias and colleagues (2019), the authors reviewed randomized controlled studies of PTSD that included not only measures of the three PTSD symptom clusters but also the clusters specific to CPTSD, namely affect dysregulation, negative self-concept, and disturbances in relationships. Analyses assessing outcomes for each of the six specific symptom clusters, as they were available across studies, revealed that as compared to waitlist or treatment-as-usual, cognitive behavioral therapies, exposure alone, and EMDR yielded superior outcomes. However, this effect was negatively moderated by childhood abuse, where outcomes for each of the six symptom clusters were consistently less positive for the subgroup of participants who had experienced childhood trauma.

A second meta-analysis that followed a similar strategy to estimate the benefits of current therapies for CPTSD was conducted by Melton and colleagues (2019). The investigators found that both trauma and non-trauma-focused therapies provided substantial benefits for PTSD symptoms but noted that the positive effects for the DSO symptom clusters (i.e., affect dysregulation, negative self-concept, and interpersonal problems) were modest. There was some suggestion that multicomponent therapies provided better outcomes, particularly among survivors of childhood sexual abuse.

Overall, these two meta-analyses suggest that although current therapies are effective, they proved to have fewer benefits for individuals likely to have CPTSD and that multicomponent therapies might be one approach by which to improve outcomes. The evidence indicates that current therapies may serve as the basis for or comprise one component of CPTSD treatment. Identifying which treatment interventions or components might be integrated into existing therapies requires better understanding of the disorder and of characteristics of individuals who have the disorder.

Patient-Centered Care for CPTSD

The core principle of patient-centered care is recognition that symptoms or problems that are important to one individual with a particular condition are not necessarily important for another

individual with the same condition. Patient-centered care also acknowledges that the needs of the individual change over time as he or she receives care from services (Health Foundation, 2014). The meta-analytic analysis described earlier (Melton et al., 2019) revealed that patients likely to have CPTSD have higher attrition rates than other patients. One means by which to reduce attrition is to create treatment programs that are tailored to the specific concerns for which the patient seeks treatment. Similarly, ongoing assessment of symptoms or patients' concerns provides the basis for reasoned shifts in treatment focus and interventions, potentially strengthening patient engagement and leading to increased benefits.

The Health Foundation (2014) has identified a framework comprising four principles of person-centered care, including affording people dignity, compassion, and respect; offering coordinated care, support, or treatment; offering personalized care, support, or treatment; and supporting people to recognize and develop their own strengths and abilities to enable them to live an independent and fulfilling life. In this framework, the role of the health care professional is to enable individuals to make decisions about their own care and treatment on the basis of their needs. A number of health and economic outcomes have been associated with person-centered care, including less use of emergency services (De Silva, 2011), more treatment adherence (De Silva, 2012), and higher levels of patient satisfaction (Rathert, Wyrwich, & Boren, 2012). Patient-centered care has also been associated with increased staff performance and morale (De Silva, 2012).

Patient-centered care is central to the policies of the United Kingdom and the United States. For example, in the United Kingdom, the Health and Social Care Act of 2012 imposes a legal duty for the National Health Service (NHS) England and clinical commissioning groups (CCGs) to involve patients in their care (The Kings Fund, 2012). Similarly, in the United States, the recent mandate for patient-centered care, associated with the Patient Protection and Affordable Care Act of 2010, has articulated that patient-centered care requires the identification of outcomes about which patients' care, the development of treatments that address these concerns, and research routinely include patient preference as a relevant factor in the selection of the optimal treatment. This theoretical framework and commitment to patient-centered care supports the selection of a treatment approach for future research, namely the evaluation of flexible modular and sequential treatment programs in which treatment goals and interventions are ordered according to patient recovery stage, needs, and preferences.

Modular Treatments

The presence of a CPTSD diagnosis is expected to enhance treatment outcomes by facilitating the development of treatment plans that tailor the selection of interventions and their delivery more closely to the needs of a patient with CPTSD versus PTSD. However, as suggested earlier, the "lessons learned" about personalizing care extend beyond matching a manualized

treatment program to a specific trauma disorder. The movement from manualized treatment to personalized care suggests treatment planning attends to the individual per se and not just an individual with CPTSD rather than PTSD. Although the general notion of personalized care is not new to mental health practice (see British Psychological Society, 2011), there has been little to no research of this approach in the trauma field.

We propose a flexible modular approach to the treatment of CPTSD, where patient and therapist collaborate on the selection of a set of empirically supported treatment modules or interventions intended to resolve specific problems of concern. This treatment strategy is viable for several reasons. First, CPTSD has two relatively distinct symptoms clusters (i.e., PTSD and DSO), which allow therapists and clients to assess which problems are of greater concern and select interventions accordingly. Second, there is precedent for the successful use of a flexible modular treatment approach in mental health, albeit with pediatric populations. Third, there is indirect evidence of the success of multimodal treatments in trauma populations. Relevant research is presented as follows.

The use of a flexibly applied, multimodal treatment approach is new to the trauma field, signaling a treatment innovation and paradigm shift in clinical research methodology. However, there is a good rationale for its application and a successful precedent in mental health that lays out a methodological road map for its testing. First, such approaches have been found to be more effective compared to the usage of full protocols for a single disorder (Daleiden, Chorpita, Donkervoet, Arensdorf, & Brogran, 2006) or to the sequencing of full protocols for different disorders (Weisz et al., 2012). Second, the treatments appear to benefit patients in that they tend to be shorter, thus reducing patient burdens regarding time and expense (Weisz et al., 2012). Third and relevant to treatment uptake of evidence-based therapies (EBTs), clinicians trained in a modular therapy versus those trained in disorder-specific manualized therapy have shown improved attitudes about evidence-based practices (Borntrager, Chorpita, Higa-McMillan, & Weisz, 2009). Moreover, clinicians have reported more satisfaction with modular treatments as compared to standard EBTs and have assessed modular treatments as being more effective as compared to usual care, suggesting that modular treatments provide the “best of both worlds,” with high ratings in both practitioner satisfaction and effectiveness (Chorpita et al., 2015).

Several trauma-focused therapies have used forms of modular or sequenced approaches. They differ from the current proposal in that modules have been used in a specific sequence, whereas the current proposal suggests that the selection of modules be flexibly ordered and applied based on patient symptoms and preferences. The benefits of these approaches, however, demonstrate their feasibility and potential success among trauma patients. Some of these therapies include Skills Training in Affective and Interpersonal Regulation (STAIR) narrative therapy (formerly STAIR plus modified exposure), EMDR, and brief eclectic psychotherapy for PTSD (BEPP; see Schnyder & Cloitre, 2015, for descriptions of these treatments). In addition,

there has been formulation of modular or sequenced treatments for addressing comorbid BPD and PTSD, developed by Harned, Korslund, and Linehan (2014), in which dialectical behavior therapy is initiated to resolve suicidal and self-injurious behavior and, once controlled, is followed by prolonged exposure therapy (PE; see Schnyder & Cloitre, 2015).

At least one randomized controlled study has applied a modular approach to a complex trauma population (childhood abuse survivors) and provided specific attention to emotion regulation and interpersonal difficulties (Cloitre et al., 2010). In that study, the test condition sequenced a module focused on improving emotion regulation and interpersonal problems using STAIR, followed by a module that added an intervention aimed at trauma memory processing (narrative therapy). The study compared the sequenced treatment with two other conditions whereby in each condition, one or the other module was removed and replaced with generic, active, nonspecific supportive counseling. Results indicated that overall, the combination treatment—STAIR narrative therapy—provided more improvement in PTSD symptoms, emotion regulation, and interpersonal problems than the two comparator conditions. The attrition rate in the combination treatment was lower than that in narrative-focused condition, whereas attrition for the skills-focused condition fell in the middle. The reasons for this differential attrition rate cannot be identified but may relate to the presence of multiple interventions that were of interest and relevant to patients, supporting patient engagement throughout the treatment.

These findings suggest the potential benefits of modular sequenced treatments in terms of attrition rates and outcomes relevant to CPTSD symptom clusters. Further research is needed to determine whether additional or different modules might be of equal or greater value. The treatment did not address nor measure issues related to negative self-concept, which has been identified as a central symptom of CPTSD. To our knowledge, no studies engaging trauma populations have tested the differences in the order of modules or the benefits of allowing for flexibility in the order of the modules based on patient symptoms and preferences. It might be suggested that most patients would prefer to start with skills training as a strategy to avoid discussing their trauma history, although this hypothesis remains to be tested. Patients may be willing and may desire to discuss their trauma once they are given the freedom to choose and evaluate the potential pros and cons of different types of sequencing strategies.

Existing Therapies and Treatment Modules

The previously mentioned literature suggests the feasibility of multimodal treatment approaches and offers some evidence that suggests its potential benefits for trauma populations. There are several types of interventions or modules that might be developed and considered as relevant to the CPTSD population. These include, for example, emotion regulation intervention modules (e.g., focused breathing, emotional awareness, self-soothing exercises), interventions aimed at addressing

negative self-concept (e.g., cognitive reappraisal of self-worth, self-compassion), and modules targeting interpersonal difficulties (e.g., communication skills, cognitive flexibility around interpersonal expectations, interventions addressing problems with anger and intimacy), as well as potentially developmentally informed strategies to reset attachment representations (Liotto, 2004). The PTSD symptom clusters, which are an equally important part of CPTSD, can be addressed via exploring and making meaning of the trauma (e.g., exposure, narratives, cognitive processing).

In the most flexible version of the multimodal approach, there is no fixed ordering of sequences at the outset of treatment. Rather, the selection of the module or intervention is adjusted according to the patient's treatment response over time (Lei, Nahum-Shani, Lynch, Oslin, & Murphy, 2012). Assessment of CPTSD symptoms would be routinely made through the course of therapy as more than one problem may resolve with the use of a single module or intervention. Selection of the sequence of modules or interventions would be based on updated symptom reports, evaluated in a collaborative fashion between therapist and patient.

Limitations of a flexible multimodal approach must also be considered. First, there may be several interventions and modules appropriate for the CPTSD patient population, which may in turn create a burden on therapists to be informed about and skilled in the use of several different techniques. This might be resolved through the use of technology whereby apps or Internet-based programs provide guidance to both the provider and patient. Second, there may be more reliance on the clinician's skill in building a therapeutic alliance with the patient and resolving conflicts when differences regarding which interventions to use and their order emerge between therapist and patient. The resolution of this problem would require discussion very early in the course of treatment to identify treatment goals, symptom targets, and interventions likely to be used in the program. Third, the use of adaptive treatment requires routine assessment of symptoms for feedback and decision making, a dimension of the treatment process that is not routine and which may be viewed as burdensome. The use of brief assessments and an explanation of their key role in the treatment may help resolve resistance to this task. Finally, the application of modular therapy will require therapists to make judgments of what treatments to choose, when to choose, how to communicate choices and make the decision with the clients, and how to assess the outcome of different sequences and module selection. Appropriate support at service level, including the use of clinical supervision, can be particularly useful in supporting clinicians to make these choices.

Directions for Future Research in the Treatment of CPTSD

Complex PTSD is a debilitating condition associated with severe functional impairment. There is now an urgent need for research in the area of CPTSD treatment. In this paper, we have identified a promising treatment approach—the

flexible modular approach—and provided the rationale for and emerging evidence regarding this treatment. However, there are several directions for future research that can be considered and deserve mention. The simplest randomized controlled trial may involve comparing the differential effectiveness of established treatment in patients with *ICD-11* CPTSD compared to PTSD and assessing the relative benefits of as-needed increases in the treatment dose (e.g., increased number of sessions or the addition of booster sessions following treatment). A second design would include the addition of interventions or modules to an existing PTSD treatment in which additions explicitly target DSO symptoms. In this design, treatment conditions could test the potential benefit of the additional component compared to the standard treatment (e.g., STAIR + CPT/PE vs. CPT/PE alone) or ordering effects (e.g., STAIR + CPT/PE, CPT/PE + STAIR vs. CPT/PE alone). The use of established treatments as benchmark comparators is important as it remains unknown whether sequential or integrated treatments are superior to established treatments for CPTSD. The feasibility and efficacy of novel treatments compared to a waitlist condition are also to be considered. These might include the adaptation of treatments for other disorders or from other traditions, as has been conducted with interpersonal psychotherapy (IPT) and mindfulness therapy.

More complex designs might include comparison of different kinds of sequencing strategies where, for example, in one condition, patient choice drives the sequencing of treatment in comparison to a condition with a fixed sequence, with both conditions then compared to an existing treatment. Lastly, the most complex design would involve a condition in which treatment sequences are open-ended at the beginning of treatment and the selection of each new module is determined by the patient's response after each module, an approach that is called "sequential, multiple assignment randomized trials" (SMART; see Lei et al., 2012). However, it should also be acknowledged that such designs require large samples, and this can only be achieved through multicenter studies.

In all of these designs, symptom assessment should occur at regular intervals throughout the course of treatment to determine whether, when, and how much symptom change is occurring. The relative speed of change for PTSD as compared to DSO symptoms is unknown, as is the way in which these symptoms may influence one another over time. Adaptive designs such as SMART require periodic assessment of treatment outcomes and processes so that clinicians and patients can receive feedback about patient progress and make informed treatment decisions, otherwise known as "measurement feedback systems." These assessments need to be psychometrically sound, sensitive to clinical change, and brief enough for frequent administration (Ng & Weisz, 2016). To date, there is at least one brief, validated measure of CPTSD, which includes symptom assessment of all six symptom clusters (Cloitre et al., 2018).

Finally, the evaluation of the effectiveness of treatments for CPTSD might best be considered in the context of real-world clinics, implemented by community clinicians and provided

to clinic patients with fewer inclusion and exclusion criteria. The use of pragmatic trials can facilitate the transition from evaluation to implementation and dissemination of a treatment if it is found effective. Moreover, research indicates that even when a treatment is identified as effective, clinician uptake can be limited if the treatment delivery is rigid and does not appear to be adaptable to the needs of individual patients (Nelson, Steele, & Mize, 2006). Collection of qualitative data, such as interview data, from clinicians about perceptions regarding the flexibility or adaptability of the program will help identify and resolve trouble spots in a treatment protocol and facilitate dissemination of the protocol if successful.

The advent of the CPTSD diagnosis has arrived at a time of a paradigm shift in clinical trial methodology. Research is moving away from traditional randomized controlled trials, which have provided useful information about the average outcomes of a treatment, to a personalized medicine approach that evaluates the potential benefits of tailoring treatment goals, interventions, and outcomes specific to the individual patient. Given that highly traumatized patients have experienced a substantial loss of autonomy, mastery, and perceived support, a treatment paradigm in which the patient directs the treatment content and goals, supported by a knowledgeable provider, would likely be empowering for patients and ultimately lead to optimal outcomes. Future research will determine whether this is the case.

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