

Review

CRITICAL ANALYSIS OF THE CURRENT TREATMENT GUIDELINES FOR COMPLEX PTSD IN ADULTS

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According to current treatment guidelines for Complex PTSD (cPTSD), psychotherapy for adults with cPTSD should start with a “stabilization phase.” This phase, focusing on teaching self-regulation strategies, was designed to ensure that an individual would be better able to tolerate trauma-focused treatment. The purpose of this paper is to critically evaluate the research underlying

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these treatment guidelines for cPTSD, and to specifically address the question as to whether a phase-based approach is needed. As reviewed in this paper, the research supporting the need for phase-based treatment for individuals with cPTSD is methodologically limited. Further, there is no rigorous research to support the views that: (1) a phase-based approach is necessary for positive treatment outcomes for adults with cPTSD, (2) front-line trauma-focused treatments have unacceptable risks or that adults with cPTSD do not respond to them, and (3) adults with cPTSD profit significantly more from trauma-focused treatments when preceded by a stabilization phase. The current treatment guidelines for cPTSD may therefore be too conservative, risking that patients are denied or delayed in receiving conventional evidence-based treatments from which they might profit. Depression and Anxiety 00:1–11, 2016. © 2016 Wiley Periodicals, Inc.

Key words: *treatment guidelines; PTSD; complex PTSD; phase-based treatment; stabilization*

In 2012, the Complex Trauma Task Force of the International Society of Traumatic Stress Studies (ISTSS) released “The Expert Consensus Treatment Guidelines for Complex PTSD in Adults,” which was intended to reflect best practice guidelines for managing Complex PTSD (cPTSD) in adults. The Guidelines defined cPTSD as the occurrence of core DSM-IV symptoms of PTSD (i.e., reexperiencing, avoidance, hyperarousal), in conjunction with a range of self-regulation problems including: (1) emotion regulation difficulties, (2) disturbances in relational capacities, (3) alterations in attention and consciousness (e.g., dissociation), (4) adversely affected belief systems, and (5) somatic distress or disorganization.^[1] Based on a survey of trauma experts^[2] and a review of relevant literature, the Guidelines recommended a phase-based approach as the “optimal treatment strategy” (ISTSS, 2012, p. 12) for cPTSD.

According to the Guidelines, psychotherapy should begin with a stabilization phase (Phase I) aimed at ensuring the individual’s safety by reducing self-regulation problems and improving emotional, social, and psychological competencies. This should then be followed by a phase focusing on the trauma and the processing of the trauma memories (Phase II). A final reintegration phase (Phase III) consolidates treatment gains and helps the person adapt to current life circumstances.^[1] The recommendation to begin with a stabilization phase is based on several assumptions, including: (1) PTSD and cPTSD are distinct disorders, (2) evidence-based treatments for PTSD are not effective for people with cPTSD,^[3,4] and (3) patients with cPTSD are not sufficiently stable when initiating treatment to tolerate trauma-focused interventions.^[2,5] To address the perceived need for stabilization in people with cPTSD, a variety of approaches to emotion regulation skills training were utilized.^[5–7]

The purpose of this paper is to critically review the research related to the “The Expert Consensus Treatment Guidelines for Complex PTSD in Adults.” We were unable to find any other specific treatment guide-

lines for cPTSD. The review begins with a brief evaluation of the evidence for the validity of the construct of cPTSD. This is followed by examination of research on the efficacy of the stabilization phase alone, stabilization followed by trauma-focused treatment, and trauma-focused treatment without prior stabilization in persons with cPTSD. We also discuss the effects of providing trauma-focused treatment to a variety of other vulnerable populations with PTSD, such as patients with childhood abuse histories and severe comorbid conditions, but who were not formally diagnosed with cPTSD. Finally, future recommendations for research and clinical practice are discussed.

In this paper we use the term *trauma-focused therapy* to refer to evidence-based psychotherapies for PTSD that involve direct discussion of the traumatic event, such as prolonged exposure, written autobiographical narratives, cognitive restructuring aimed at modifying trauma-related beliefs, and Eye Movement Desensitization and Reprocessing (EMDR) therapy. We do not examine all treatments with evidence in PTSD (e.g., pharmacotherapy), because we focused on the question of whether a stabilization phase is needed before providing trauma-focused therapy for PTSD in more vulnerable populations.

VALIDITY OF THE cPTSD CONSTRUCT

cPTSD has been hypothesized to occur after the experience of severe, prolonged, or repeated stressors, and to be comprised of the classic PTSD symptoms as well as additional symptoms including disturbances of affect, self, and interpersonal relationships.^[1] The validity of cPTSD as a disorder or subtype distinct from PTSD has been a topic of considerable debate.^[8] The internal consistency and validity of cPTSD has been questioned based on inconsistent research findings on the symptoms comprising the diagnosis, the nature and the type

of events that give rise to the diagnosis, and the relationship of cPTSD to other established diagnoses such as major depressive disorder and borderline personality disorder.^[9–11]

Overall, studies comparing cPTSD with non-cPTSD have concluded there may be a difference in symptom severity rather than a difference in associated symptoms.^[10] Symptoms previously thought to be unique to cPTSD (i.e., problems with affect regulation, self-referential processing, impaired social functioning, and dissociation) were recognized to be common in PTSD. These symptoms have been incorporated into the current conceptualization of PTSD in the Diagnostic and Statistical Manual 5 (DSM-5).^[12] These changes would appear to further reduce the difference between cPTSD and the DSM-5 criteria for PTSD, which makes the efforts at establishing the validity of cPTSD as a distinct clinical disorder or subtype of PTSD even more difficult in the future.

EXPERT CONSENSUS TREATMENT GUIDELINES FOR cPTSD IN ADULTS: GENERAL STRENGTH OF THE EVIDENCE

The Complex Trauma Task Force used the results from an expert survey^[2] and nine published studies to support their recommendations. The survey used a panel of high-profile individuals in the field of traumatic stress (i.e., 25 individuals recognized as expert clinicians in the treatment of PTSD and 25 in the treatment of cPTSD), although the procedures for selecting the panel members were not clearly delineated. Among the panel members, 85% reported that they would use a phase-based approach as their first line of treatment for persons with cPTSD, and only 7% considered a treatment approach that focused “primarily on memory processing” as appropriate.

With regard to the nine studies used to support the Guidelines, no information was provided on how these were selected, including the search strategies used or the inclusion/exclusion criteria. In addition, no uniform definition of cPTSD was used to select the studies that are supposed to support the Guidelines. Specifically, cPTSD was formally assessed in only one study,^[7] and PTSD diagnosis was not even required for inclusion in three studies.^[13–15] Although the definition of cPTSD used by the Task Force did not require the experience of childhood trauma, all studies except one^[14] used a history of childhood physical and/or sexual abuse as an inclusion criterion. Across the nine studies, cPTSD sometimes only referred to the nature of the trauma itself (e.g., childhood sexual abuse), rather than the trauma-related symptoms used to define the construct (e.g., emotion regulation problems).

The methodological rigor of the studies was also problematic. Two studies were not randomized controlled trials (RCTs),^[7,16] only three studies included an active

control group,^[2,13,14] and three studies lacked follow-up assessments.^[6,15,16] According to the Clinical Trials Assessment Measure (CTAM),^[17] an index for the quality of RCTs based upon the CONSORT guidelines, only four of the nine studies scored above the cutoff (65 on a scale from 0 to 100) designating “fair” or better methodological rigor. Thus, the lack of a clear definition of cPTSD to select the studies reviewed for the Guidelines (and use of validated instruments to measure it), combined with methodological limitations of the studies included, limit the conclusions that can be drawn about the effectiveness of treatments on individuals of this target group.

THE EFFECT OF STABILIZATION ALONE (PHASE I)

Four out of the nine studies reviewed for the Guidelines investigated the efficacy of some form of stabilization for patients with cPTSD. Three of these studies evaluated the benefits of stabilization alone, without elements that explicitly focus on trauma memory processing,^[6,7,14] while the fourth study examined stabilization combined with trauma narrative writing assignments.^[15] See Table 1 for an overview of these studies.

The four studies provided limited support for the feasibility of a stabilization phase for cPTSD and its potential effects on cPTSD symptoms. Two of the RCTs did not employ intent-to-treat analyses.^[6,15] This is particularly problematic given that in both studies the dropout rate was very high (50% and 49%). The third RCT^[14] employed an intent-to-treat statistical analysis, but found that the affect regulation program and the active control intervention (present-centered therapy) did not differ in reducing PTSD symptoms and improving affect regulation compared to the waitlist control group.

THE EFFECTIVENESS OF PHASE-BASED TREATMENTS

Two RCTs from the same research group^[5,18] investigated the effects of an integrated treatment consisting of stabilization followed by a trauma-focused phase (see Table 2; a third study^[16] was not an RCT and therefore is not discussed here). Cloitre et al.^[5] developed a treatment program consisting of eight sessions of “Skills Training in Affect and Interpersonal Regulation” (STAIR), followed by eight sessions of “Imaginal Exposure” (IE). Compared to a waitlist group, STAIR combined with IE resulted in significant reductions in PTSD symptoms and improvements in mood regulation skills.^[5] Although there was a 29% dropout rate in the STAIR group, the results of the study demonstrated the feasibility of the STAIR/IE program, and provided evidence for its efficacy in decreasing symptoms. As Cloitre et al. noted, this study did not directly compare this

TABLE 1. Studies investigating the efficacy of Phase I

Author, year	Setting	Reported demographics	Inclusion	T x Conditions (N)	N sessions (duration)	Attrition	Outcome & dependent variables	Follow-up	Study quality
Bradley & Follingstad, 2003	Medium security prison	All women 62% African-American, 38% White Ages 34–54	Self-reported childhood sexual abuse (intercourse, oral sex, or touching) under 18 years and in adulthood and/or being hit with an open hand harder than a slap or spank at least three times. Significant impairment	Dialectical Behavior Therapy skills and writing assignments (24)	18 (2.5 hrs)	50%	Dialectical Behavior Therapy skills and writing assignments > Wait-list: arousal, depression, intrusive experiences, avoidance, anger and irritability, dissociation, and self-reference	-	No description of randomization/blind ratings. No intention-to-treat analysis (very poor)
Dorrepal et al., 2010	Outpatient clinic	All women Mean age: 34.1 (SD = 8.3)	Sexual ^a and/or physical abuse ^b before the age of 16 years. PTSD according to the SCID-I. Complex PTSD according to the SIDES	Wait-list (25) Stabilizing Group Treatment (36)	20 (2 hrs) + TAU	28% 33%	22% loss of PTSD diagnoses and 64% loss of cPTSD diagnoses. Improvements on PTSD and borderline symptoms, but not on dissociation	6 months	Not a Randomized design
Ford, Steinberg, & Zhang, 2011	Health clinics, family service centers, community centers, and residential treatment centers.	All women 40% African-American, 18% Latina, 41% White not Hispanic, 1% Other Ages 18–45; Mean age: 30.7 (SD = 6.9)	Mother or primary caregiver of a child 5-years-old or younger, current full or partial PTSD, and past exposure to victimization or incarceration	Affect regulation skills (48)	12 (50 minutes)	24%	Affect regulation skills = PCT > Wait-list: PTSD remission (i.e., affect regulation skills, 34%; PCT, 29%; Wait-list, 0%). PTSD symptoms and affect regulation	3 months and 6 months	Randomized and Blind intention-to-treat analysis Small N (fair)
Zlotnick et al., 1997	Psychiatric hospital and outpatient clinic	All women 98% White, 2% Native American; Mean age: 39.0 (SD = 9.59)	A diagnosis of PTSD based on past childhood sexual abuse (i.e., history of sexual contact before the age of 17 years)	PCT (53) Wait-list (45) AMT (16)	15 (2 hrs)	34% 22% 49%	AMT > Wait-list: PTSD symptoms and dissociation	—	Randomized Blind no intention-to-treat analysis (poor)

PTSD, Posttraumatic stress disorder; SCID-I, Structured diagnostic interview for DSM-IV Axis I disorder; SIDES, Structured interview of disorders of extreme stress; TAU, treatment as usual; PCT, present-centered therapy; AMT, affect management treatment.

^ai.e., repeated, forced, sexual contact with a perpetrator in an intimate relationship.

^bi.e., severely repeated maltreatment such as confinement, battering, or being pushed from the stairs.

TABLE 2. Randomized controlled studies investigating the efficacy of a combination of Phase I and Phase II (phase-based treatment)

Author, year	Setting	Reported demographics	Inclusion	T x Conditions(N)	N sessions (duration)	Attrition	Outcome and dependent variables	Follow-up	Study quality
Cloitre et al., 2002	Community	All women 46% Caucasian, 20% African American, 15% Hispanic, 19% Other Mean age: 34.0 (SD=7.22)	PTSD related to childhood sexual abuse ^a and/or physical abuse ^b At least one clear memory of the abuse	STAIR + PE (31)	8 STAIR (1.5 hours) + 8 PE (1.5 hours)	29%	STAIR/PE > Wait-list: PTSD severity, depression, general anxiety, dissociation, anger expression, and alexithymia, plus an increase in mood regulation skills	3 and 9 months	Randomized Blind No intention-to-treat analysis ('poor')
Cloitre et al., 2010 ^c	Not reported	All women 33-37% Caucasian, 21-39% African American, 18%-30% Hispanic, 9-11% Other Ages 18-65	A primary diagnosis of DSM-IV ^d -defined PTSD related to childhood sexual abuse and/or physical abuse by a caretaker or person in authority over them before the age of 18 years	Wait-list (27) STAIR + PE (33)	8 (1.5 hours) STAIR + 8 PE (1.5 hours)	11% 24%	STAIR/PE = STAIR/SC = SC/PE STAIR/PE > SC/PE at 3 and 6 months follow-up: severity of PTSD, interpersonal problems, negative mood, anxiety and anger expression	3 and 6 months	Randomized Blind Intention-to-treat analysis ('fair')
				STAIR followed by supportive counseling (33)	8 STAIR + 8 client-directed discussion of life problems related to abuse history	33%			
				Supportive counseling (SC)+ PE (38)	8 client-directed discussion of life problems related to abuse history followed by 8 PE	39%			

^a i.e., at least one episode of sexual contact initiated by a caregiver or individual in a position of authority to the participant when she was under the age of 18.

^b an action by a parent or other adult in charge of the participant when she was under the age of 18 in which the adult purposefully hit, pushed, punched, or cut the participant leaving bruises, scratches, broken bones or teeth, or making her bleed.

^c number of dropouts in both phase I and phase II of treatment was lowest in the STAIR/PE condition (4, 1), highest in the SC/PE condition (9, 4), and fell in the middle in the STAIR/SC condition (7, 3)

PTSD = Post Traumatic Stress Disorder, STAIR = Skills Training in Affect and Interpersonal Regulation, PE = Prolonged Exposure, SC = Supportive Counseling

phase-based approach with a trauma-focused treatment alone.

In a second study, Cloitre et al.^[18] evaluated the efficacy of the same approach in adults with a history of childhood abuse by comparing STAIR/IE to either supportive counseling (SC) followed by IE (SC/IE) or STAIR followed by SC (STAIR/SC). STAIR/IE led to significantly greater improvements in PTSD and other symptoms than the other two conditions at the 3- and 6-month follow-up, but not at posttreatment. These findings were interpreted in the Guidelines as supporting “the superiority of phase-based treatment over exposure-based treatment” (ISTSS, 2012, p. 6).^[1] However, the lack of an exposure alone condition in this study precludes drawing conclusions about the relative benefits of the phased-treatment approach over conventional trauma-focused PTSD treatment. Furthermore, in all conditions a significant number of patients dropped out in Phase I, limiting potential conclusions about later intervention effects.

THE EFFICACY FOR EVIDENCE-BASED TREATMENT WITHOUT PRIOR STABILIZATION (PHASE II ONLY)

Two studies cited in the guidelines (see Table 3) examined the efficacy of a trauma-focused treatment of victims of childhood sexual abuse without a preceding stabilization phase. None of these studies provided support for phase-based treatment. One study examined the efficacy of cognitive processing therapy for sexually abused women.^[19] The participants, who received 17 weekly sessions of trauma-focused cognitive therapy, reported significantly less severe trauma-related symptoms, with a large effect size reduction in symptoms and diagnosis, than the control group who received a supportive phone call every week. This difference was found both immediately after treatment and 1 year later. Attrition was low (18%) and none of the participants reported symptom worsening.

Similar results were found in a study of victims of sexual abuse.^[13] Participants took part in 24 weekly sessions of either cognitive group psychotherapy with a specific focus on their traumatic events or counseling group psychotherapy without targeting the traumatic memories. The results of both treatments were compared with a waitlist control group. Both treatments resulted in a significant reduction in PTSD severity compared to the waitlist condition, with trauma-focused treatment reducing anger significantly more. Dropout rates between the trauma-focused and nontrauma-focused groups did not differ significantly (23% vs. 14%, $P = .06$). These studies suggest that trauma-focused treatment without a prior stabilization phase is feasible and clinically beneficial for cPTSD, contrary to the recommendations of the Guidelines.

FURTHER EVIDENCE FOR THE EFFECTIVENESS OF TRAUMA-FOCUSED TREATMENTS IN ADULT PTSD PATIENTS WITH CHILDHOOD ABUSE HISTORIES AND SEVERE COMORBID CONDITIONS

We now turn to articles that were not included among the nine studies cited in the Guidelines.^[1] These studies were selected from a growing body of research consisting of secondary analyses of data from RCTs comparing the treatment outcomes with nonphase-based trauma-focused treatments on symptoms of PTSD patients with and without childhood abuse histories and/or severe comorbidities.

With regard to treatment outcome, Resick and colleagues^[20–23] found that cognitive processing therapy and prolonged exposure produced large improvements in adult female rape victims. The effect size of this treatment did not differ for women with or without childhood abuse histories and there was no difference in dropouts.^[21,22] Similarly, in a study of prolonged exposure with or without cognitive restructuring, no differences in posttreatment outcome were found between those with index trauma of child sexual abuse, adult sexual assault, or adult nonsexual assault.^[23]

There is also little evidence that comorbidity or severe dissociative symptoms affect the efficacy of trauma-focused treatments.^[24–27] To the contrary, evidence is mounting that trauma-focused therapies for PTSD can be safely and effectively used with patients with comorbid diagnoses of substance abuse, borderline personality disorder, and those suffering from nonacute suicidal ideation.^[25–28] The hypothesis that comorbidity negatively affects the efficacy of trauma-focused treatments is perhaps most strongly refuted by the results of research on the treatment of PTSD in people with schizophrenia or other severe mental illnesses, a group that is generally known as being extremely vulnerable to symptom relapses.^[29] Results of controlled studies without prior stabilization showed that patients with PTSD and a psychotic or other severe mental disorder, who were randomized to either usual services or treatment with prolonged exposure, EMDR therapy,^[30] or cognitive therapy,^[31,32] generally benefited from trauma-focused treatment without evidence of iatrogenic effects such as suicide attempts or symptom exacerbation. Further, although it has been found that the presence of major depressive disorder reduced the treatment response to prolonged exposure^[33] evidence from other studies, including a recent meta-analysis,^[34] shows that depression symptoms generally improve following trauma-focused psychotherapy,^[21,23] and that the treatment response to prolonged exposure is unrelated to depression symptom severity.^[24]

A related argument for using a phase-based treatment approach is the clinical impression that, for those

TABLE 3. Randomized controlled studies investigating the efficacy of Phase II only

Author, year	Setting	Reported demographics	Inclusion	T x Conditions(N)	N sessions (duration)	Attrition	Outcome and dependent variables	Follow-up	Study quality
Chard, 2005	Community, local mental health facilities	All women 81.4% White, 14% African American, 3.5% Hispanic, Latin or Mexican American, 1% other Mean age: 32.8 (SD=8.9) Ages 18-56	A diagnosis of PTSD, at least one incident of child sexual abuse ^a , and at least one memory of the abuse	CPT (36)	17 group (1.5 hours) + 10 individual (1 hour).	18%	CPT > Minimal attention control group: PTSD severity, depression, and dissociation	3 months and 1-year	Randomized, Blind Intention-to-treat analysis ('fair')
Classen et al., 2011	Community	All women 36-35% White, 4-6% Black, 3-5% Other Hispanic/Latino, 1-5% Asian American, 0-5% Mexican American, 0-3% Native American, 4-6% Other Mean age: 36.2 (SD=10.3)	At least one explicit memory of childhood sexual abuse ^b	Minimal attention waitlist control group (35)	A supportive phone call 5-10 minutes every week	21%			
			In addition, within the previous year: (a) having been sexually victimized ^c , (b) having been engaged in risky sex	TFGT (55)	24 (1.5 hours)	23%	TFGT = PFGT > wait-list: PTSD severity, anger, and impaired self-reference TFGT > PFGT > wait-list: anger	3 and 6 months	Randomized Blind Intention-to-treat analysis ('fair')
				PFGT (56)	24 sessions (1.5 hours) in which no attention was paid to the traumatic memories	14%			
				Wait-list (55)		16%			

^a i.e., "as defined by state law".

^b i.e., involving genital or anal contact, at least one such event between ages 4 and 17, perpetrator at least 5 years older, and ability to talk about the abuse in group therapy.

^c i.e., having experienced sexual coercion, attempted rape or rape, or having otherwise engaged in unwanted sex.

PTSD = Post Traumatic Stress Disorder, CPT = Cognitive Processing Therapy, TFGT = Trauma-focused group psychotherapy, PFGT = Present-focused group psychotherapy

suffering from cPTSD, premature confrontation with emotionally charged memories may lead to undesirable effects such as symptom worsening, emotional dysregulation, and suicidal behavior.^[35,36] However, in a study that examined the influence of a history of childhood sexual abuse on PTSD treatment response among 110 female veterans, history of childhood sexual abuse (55.5% of the sample) was not associated with severity of initial PTSD symptoms, symptom reduction, the rate of change, or number of sessions needed.^[37] This is in line with results from a meta-analysis of prolonged exposure showing that trauma history, including type of trauma and repeated traumatization, did not influence benefit from treatment.^[38] One of the most important arguments against a direct trauma-focused treatment approach is the assumption that individuals with PTSD and a history of childhood abuse have greater emotion regulation deficits than those without such a background, and that improving emotion regulation skills will increase the likelihood of successful processing of traumatic memories. Jerud et al.^[39] compared emotion regulation and trait affect in 200 patients with versus without a history of childhood abuse and examined their response to 10 weeks of PTSD treatment with either prolonged exposure or sertraline through 6-months follow-up. Before treatment, they found no differences in PTSD severity, emotion regulation, or positive and negative trait affect between those with and without a history of childhood abuse. Their results also showed comparable outcomes for emotion regulation and trait affect between both groups.

Taken together, the results of research on patients with histories of interpersonal trauma who received trauma-focused treatments for PTSD converge to suggest that neither trauma history nor comorbidity appear to influence response to trauma-focused treatment. Further, these studies do not support the view that symptom exacerbations are more common in individuals who receive trauma-focused treatment than in those who do not receive any treatment.^[24–26,39–42] The research also fails to support the view that trauma-focused interventions precipitate dropout from treatment for those suffering from symptoms of cPTSD. Data from multiple RCTs consistently show that dropout is similar across child sexual abuse and adult trauma groups.^[21–23,43,44] In an effort to predict prolonged exposure outcome and dropout in a mixed trauma sample, Van Minnen et al.^[42] found that none of the trauma characteristics (including childhood trauma, multiple trauma, personal trauma, and time since trauma) predicted dropout. They argued that dropout from treatment is most likely due to patient-related reasons, such as travel time, caring for young children, or stressful life events such as illness, marital problems, or the death of a loved one.

DISCUSSION AND CONCLUSIONS

According to the ISTSS Expert Consensus Treatment Guidelines for cPTSD in Adults “the use of a

phase-based treatment approach for adults with Complex PTSD has excellent consensus as well as two Level A (randomized controlled) studies supporting its use” (ISTSS, 2012, p. 12).^[1] However, as discussed above, there was a great deal of heterogeneity in the patients included in these studies in terms of trauma history, symptom presentation, and impairment. Furthermore, given the lack of consistent diagnostic assessment procedures, many patients potentially did not have symptoms consistent with current formulations of cPTSD. Contrary to the hypothesis that trauma-focused treatments pose significant risks for patients with cPTSD or those with childhood sexual abuse or other comorbid disorders, the available evidence indicates that these patients benefit from trauma-focused psychotherapy without a stabilization phase and do not show adverse effects from these interventions.^[21–23,29,45–48]

In our view, the evidence arguing for special stabilization procedures prior to trauma-focused treatment for patients referred to as having cPTSD is weak. Theoretically, some have argued that affect dysregulation as a result of chronic childhood abuse differentiates cPTSD from PTSD and that the presence of affect dysregulation impairs engagement with and efficacy of trauma-focused treatment. However, the results of Jerud et al.^[39] suggest that affect dysregulation is a trauma-related symptom that *improves* after trauma-focused treatment. It may well be the case that prolonged exposure and EMDR therapy improve emotion dysregulation often seen in PTSD by reducing the high sensitivity and distress associated with trauma-related stimuli. Untreated, such stimuli trigger the negative emotions and dysfunctional behaviors characteristic of emotion dysregulation. Cognitive therapy may improve these emotion regulation impairments through changing negative trauma-related appraisals, thereby diminishing cognitively mediated emotions.^[49]

As noted earlier, there are currently no studies that directly examined whether trauma-focused treatments for PTSD are actually superior to phase-oriented treatments for cPTSD (or more complicated or severe PTSD). Given the dearth of studies directly addressing the question as to how phase-based treatments compare to single-phase treatments, this type of research is greatly needed. In addition, it is well-established that a substantial minority of PTSD patients, with cPTSD or not, remain symptomatic despite receiving empirically supported treatments for this disorder. The available research on both phase-based and trauma-focused interventions alone has excluded certain subgroups of patients, such as those with severe dissociative disorders, acute suicidality, actively substance dependence, or current psychotic symptoms, though RCTs on some of these subgroups are emerging in which trauma-focused treatment is provided concurrently with treatment for the severe comorbid condition.^[28,30] Therefore, an important recommendation for future research is to examine symptom-level treatment response, including the full range of symptoms that encompass severe PTSD and common comorbidities, using the broadened

definition of PTSD in DSM-5. This should be done with sufficiently powered studies with fewer exclusion criteria that are designed to identify whether or not there are types of patients for whom a stabilization phase may be necessary.

In conclusion, the evidence does not currently support the recommendation for a stabilization phase prior to providing trauma-focused treatment in persons with cPTSD, or related severe or complicated presentations of PTSD. For patients with more cPTSD presentations, the recommendation for an initial stabilization phase has the potential to result in a delay or restriction of access to effective trauma-focused treatments. Delaying trauma-focused treatment could also be demoralizing to patients by inadvertently communicating to them that they are not capable of dealing with their traumatic memories, thereby reducing self-confidence and motivation for more active trauma processing. Labeling a patient as “complicated” or “complex” has a potential iatrogenic effect of giving the patient the impression that “traditional” treatments will not be effective or that special or longer treatments are necessary. Given the absence of well-designed studies directly comparing trauma-focused treatments, with and without a preceding stabilization phase in cPTSD, and the evidence that trauma-focused therapies can be effective in many PTSD patients with complex presentations, we conclude that the current ISTSS Guidelines provide an incomplete view of the extant literature. We suggest instead that trauma-focused therapies should routinely be offered to individuals with complex presentations of PTSD—such as multiple or severe comorbidities—in an adequate dose, consistent with current general PTSD treatment guidelines.

Conflict of Interest

Ad de Jongh receives fees from teaching and supervising clinical psychologists and psychiatrists in psychological trauma and its treatment by means of seminars, workshops and conferences, and royalties of books (Harcourt). He is the Member of the board of EMDR Europe. Patricia Resick receives fees for presenting workshops on Cognitive Processing Therapy and royalties from Guilford, Sage, and Taylor and Francis Publisher for books she has written or edited. Lori Zoellner receives royalties from Guilford Press. Agnes van Minnen receives fees from teaching and supervising clinical psychologists and psychiatrists in psychological trauma and its treatment by means of seminars, workshops and conferences, and royalties of books (Boom). Christopher Lee receives fees for providing training in trauma therapies at workshops and conferences. Edna Foa receives royalties from the sale of Prolonged Exposure Therapy for PTSD: Emotional Processing of Traumatic Experiences Therapist Guide and Effective Treatments for PTSD (2nd edition). Kathleen Wheeler receives royalties from book, and fees for teaching and consultation. Erik ten Broeke receives fees from teaching ac-

tivities, books about trauma and its treatment (EMDR and CBT), outside the submitted work. He is a member of the Dutch EMDR Association and the EMDR Europe Association and the Dutch Association for Cognitive Behavioural Therapy. Norah Feeny received royalties from Guilford Press. Sheila A.M. Rauch receives Wounded Warrior Project grant support. Mark van der Gaag receives fees for teaching and supervision in CBT and royalties of books (Routledge). Kim Mueser receives royalties from Treatment of Posttraumatic Stress Disorder in Special Populations: A Cognitive Restructuring Program (American Psychological Association). Barbara Rothbaum owns equity in *Virtually Better, Inc.*, which is developing products related to virtual reality. She is a consultant for *Virtually Better, Inc.* The terms of this arrangement have been reviewed and approved by Emory University in accordance with its conflict of interest policies. She also has funding from Wounded Warrior Project. Dr. Rothbaum receives royalties from Oxford University Press, Guilford, APPI, and Emory University and received one advisory board payment from Genentech. Frank Neuner receives fees from training trauma therapists at workshops and receives royalties of the manual of Narrative Exposure Therapy. Carlijn de Roos receives fees from teaching and supervising clinical psychologists and psychiatrists in psychological trauma and its treatment by means of seminars, workshops, and conferences. Iva Bicanic receives fees from teaching activities, and books about the treatment of the impact of sexual trauma.

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