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Psychiatric Times

Treating Complex Trauma Survivors

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Complex trauma (CT) encompasses many types of repetitive trauma experiences, often characterized by coercive control over the victim—for example, incestuous/abusive families, sexual trafficking, political torture, destructive cults, concentration/slave labor camps, and genocidal trauma. Combat veterans with multiple trauma experiences, including witnessing or participating in atrocities, may exhibit the dimensional symptoms of the CT survivor, although many of these individuals may also have experienced early life, relational trauma.

Large population studies, including the National Comorbidity Study and its Replication, have identified a wide variety of psychiatric, medical, and behavioral outcomes of psychological trauma.^{1,2} Results from the Adverse Childhood Experiences Study showed that adverse childhood experiences were extremely common; more than 1 in 10 people experienced 5 or more episodes.³ There is a step-wise, dose-related increase in adverse outcomes (including mortality) with each episode of early life trauma and adversity.^{4,5}

Trauma responses manifest differently in every patient and cut across a

variety of diagnostic categories (eg, affect, state, sense of self, body image, relationships, impulse control). DSM-5 diagnostic criteria for PTSD have been revised and now define 5 groups of symptoms rather than the previous 4. Category (D) is added for “negative alterations in cognition and mood,” and additions to the (E) category for arousal symptoms now include reckless, self-destructive, and violent behavior—symptoms that are associated more with CT.

Patients with a history of CT may exhibit or have a history of criminal behavior (eg, prostitution, theft), which is often related to drug abuse and/or exploitation by others; some patients may have long-term involvement in antisocial behavior; and still others may engage in impulsive violence under severe stress or intoxication. Some of these individuals may be perpetuating the abuse they experienced. It is important to hold these patients responsible for their behavior, even when it is experienced during flashbacks, episodes of reported dissociative amnesia, and/or subjective loss of control. A history of trauma or diagnosis of a posttraumatic or dissociative disorder, in and of itself, does not constitute the basis for exculpation from criminal conduct.

Dissociative subtype of PTSD

Dissociation makes it possible to survive trauma. DSM-5 PTSD diagnostic criteria include the dissociative subtype of PTSD (DPTSD) (Table 1). Approximately 12% to 30% of PTSD patients present with DPTSD.^{6,7} Most

ACTIVITY GOAL

This article reviews the many sequelae of complex trauma and offers several treatment strategies.



LEARNING OBJECTIVES

At the end of this CE activity, participants should be able to:

1. Distinguish among PTSD, complex trauma, and the dissociative subtype of PTSD (DPTSD).
2. Explain the distinctive neurobiological subtype of DPTSD.
3. Describe the many manifestations of DPTSD and complex trauma.
4. Understand and use phasic trauma treatment in caring for patients.

TARGET AUDIENCE

This continuing medical education activity is intended for psychiatrists, psychologists, primary care physicians, physician assistants, nurse practitioners, and other health care professionals who seek to improve their care for patients with mental health disorders.

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CATEGORY 1

patients with DPTSD have histories of CT.⁸ Data from a study of more than 25,000 individuals in the World Health Organization World Mental Health Survey show that about 14.4% of those who have PTSD fit this subtype with dissociative symptoms, severe reexperiencing symptoms, a history of multiple early childhood adversities and trauma, earlier PTSD onset, severe role impairment, and suicidality.⁹ Surprisingly, the findings indicate that the preponderance of victims are male.

Patients with DPTSD show a distinctive neurobiological profile, characterized by activation of the anterior cingulate and medial prefrontal cortices. There is a decrease in activation of limbic system areas, such as the amygdala and insula that are related to the experience of fear and negative body/emotional states, respectively.¹⁰

Patients with DPTSD may respond poorly, and may worsen, with unmodified forms of standard PTSD treatment, such as prolonged exposure therapy, particularly if they dissociate during the treatment sessions. In addition, these patients may have a highly adverse response to unmodified eye-movement deprogramming/reprocessing because it has elements of exposure and free association. The therapy can lead to “opening up” of multiple trauma memories, with possible worsening in symptoms, including suicidal and self-destructive behavior. A recent study showed that patients with borderline personality disorder who had significant early life trauma and dissociation responded poorly to dialectical behavioral therapy compared with patients who had impulsive and dysregulated borderline personality disorder without dissociation.¹¹

Attention and state stability/dissociation

Patients with histories of CT may manifest depersonalization/derealization, spontaneous trance, and dissociative amnesia, as well as PTSD intrusive symptoms such as flashbacks. Learn to recognize the signs that the patient is having these kinds of experiences: disengagement, staring off into space, appearing slowed or frozen, fixed posture. In a flashback, the patient’s posture may be frozen but his or her eyes are darting around the room as if seeing intrusive visual images. At other times, the patient’s eyes will close and he loses track of current circumstances, partially or even completely; when this occurs, gently and firmly provide instruction (ie, calling the person’s name and directing him to identify objects in the room). In a flashback, the patient may literally need orienting information: where he is, who the therapist is, the date, etc. This may need to be repeated. The patient is asked to use his senses to regain awareness of the current circumstances (eg, look around the room, feel his feet on the floor). If he has become physically immobile, gently ask him to change position and move in the chair to “break” the flashback posture.

Affective regulation

Helping patients develop awareness and tolerance of emotions is fundamental to treating CT. Trauma elicits strong emotional responses, or in cases of dissociation, numbing of emotion subsequent to being overwhelmed by emotions. During and/or in the immediate aftermath of a traumatic stressor, patients can experience heightened levels of emotional and physiological arousal that typically dissipates gradually. On the other hand, some patients experience dissociative numbing, depersonalization, and derealization, or a mixture of hyperarousal and hypoarousal in the immediate aftermath of a traumatic event.

Classic conditioning contributes to the maintenance of these emotional reactions as previously neutral stimuli (eg, the smell of beer on the breath of an abuser) are paired during trauma with overwhelming emotions (eg, terror experienced during child abuse). Subsequently, these stimuli trigger intense emotional reactivity.

Trauma survivors are often unaware of why they react so strongly to seemingly neutral situations. Avoidance behavior is an attempt to prevent emotional flooding and hyperarousal; it contributes to emotional dysregulation by minimizing exposure and extinction processes. Thus, while both emotional flooding and avoidance, as well as dissociation, are initial adaptations to trauma, these responses may prevent the processing that is necessary to resolve the effects of trauma in the long run.

Patients with a history of CT commonly meet criteria for attachment pathology, such as insecure and/or disorganized attachment. In a study of adults abused as children, 76% of the sample had an insecure attachment style.¹² Insecure and disorganized attachment and trauma are associated with intense emotional reactivity, relationship difficulties, dissociation, and behavioral dyscontrol. Insecure attachment can lead to “excessive help-seeking and de-

Table 1 – Distinctive features of DPTSD

- Significant dissociative symptoms (eg, depersonalization, derealization, flashbacks, dissociative amnesia)
- A history of multiple childhood adversities/traumas often with later adult interpersonal trauma (eg, adult sexual assault)
- Exposure to personal trauma scripts typically demonstrates “overmodulated response” compared with non-DPTSD neurobiological patterns of:
 - Increased activation of frontal systems (anterior cingulate and medial prefrontal cortices)
 - Decreased activation of limbic system (amygdala, insula)
- Poor treatment response to usual forms of cognitive-behavioral therapy and exposure therapy for PTSD, or considerably longer treatment is required to achieve resolution of symptoms

DPTSD, dissociative subtype of PTSD.

pendency, social isolation and disengagement, impulsiveness and inhibition, submissiveness and aggression.”¹³

Patients benefit from treatment that develops their ability to understand and reflect on their own and others’ emotions and behaviors, often referred to as “mentalization.” As mentalization increases, the ability to regulate emotions, maintain safety, and sustain healthy relationships improves. Despite severe symptoms, more resilient patients with DPTSD may show good ability to mentalize when not flooded by traumatic intrusions.^{14,15}

Body image and somatization

Large population studies show that an increased number of episodes of early life trauma and adversity place individuals at higher risk for mortality as well as medical problems, including chronic fatigue syndrome, pain, cardiovascular and GI conditions, and autoimmune disease. Survivors of CT may have a phobia of medical care or may be invested in repeatedly seeking help for medically unexplained physical symptoms.

To improve assessment and treatment of somatization, regular medical checkups from a single medical practitioner familiar with the patient’s medical history are needed. It is important to not view somatoform symptoms as “faking,” but as serious, sometimes disabling psychiatric disorders. Patients with a history of CT benefit from learning healthy self-care practices, mind-body integration, and stress management techniques. It is helpful to develop a referral list of health care providers who are sensitive and competent in treating trauma survivors. Before and during medical and dental appointments, patients may need to practice grounding, relaxing, and separating traumatic past experiences from the present reality of seeking medical care.

Mind-body integration involves being present and conscious in the moment. Because of repeated, inescapable assaults on the body, patients with a history of CT are often phobically avoidant of bodily awareness and need to gradually learn to tolerate physical sensations and emotions. Sensorimotor and meditation-based techniques that emphasize sensation can be useful in overcoming disconnection from one’s body and phobia of physical sensations. However, some patients at the severe end of the CT spectrum may become highly posttraumatically reactive if they focus on their bodies. In this case, body-focused interventions should be avoided until the patient has been stabilized.

Stress management techniques can reduce distress, enabling patients to feel more in control of their body and internal experiences. These techniques include deep breathing; exercise; engagement in healthy distractions that can provide needed relief from painful ruminations; and imagery exercises, such as visualizing oneself “dialing down” the intensity of feelings on an imagined “emotional dial.” Patients may need assistance in learning to distinguish between stress-based symptoms and health concerns that require medical treatment—both can present simultaneously.

Patients with a history of CT need to understand that there is no automatic way to assess definitively whether a symptom is somatic or whether it is so-

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matization. Both clinician and patient will need to accept the uncertainty and ambiguity of this situation while ruling out major medical disorders. Learning to translate stomach upset into words such as “I feel unsafe” allows patients to better comprehend the emotions that may be somatically expressed.

Relationships and attachment

Patients with a history of CT have difficulties with relationships and may vacillate between longing for closeness and fearing intimacy. Focus on the dynamics of the clinician-patient relationship, traumatic transference themes, repair of disruptions in therapy due to posttraumatic reactivity, and/or countertransference.

CT has a powerful impact on how individuals understand themselves, others, and the world. CT survivors may disconnect from relationships with other people because they fear further harm. Disconnection, particularly when combined with a profoundly negative sense of self, can translate into hopelessness, treatment-resistant depression, and a lack of opportunities to examine outdated trauma-based beliefs. Social isolation can fuel patients' hopelessness; they need to be gently pushed to engage in social interactions to test their prediction of harm. Over time, these social interactions will help them learn how to assess trustworthiness in relationships. Patients can learn to objectively assess abusive dynamics and emotional, sexual, and/or physical violence in relationships. Reconnection with caring others helps assuage the fear of others as being dangerous or hurtful.

The clinical setting of working with an “authoritative” clinician may evoke trauma-based relational dynamics involving concern about domination, trust, humiliation, betrayal, and/or manipulation. Development of a strong therapeutic relationship is associated with decreased symptoms and increased treatment retention among traumatized patients. Within this relationship, therapeutic ruptures, traumatic transference, and/or countertransference issues can be openly and safely discussed and resolved. Patients can learn to reconsider their views of relationships and deepen their capacity to engage in collaborative, healthy relationships.

Safety and impulse control

Severe, unstable symptoms are linked to safety problems. Most patients with a history of CT use unsafe and high-risk behaviors in an attempt to regulate and manage severe PTSD, dissociative, and affective symptoms and difficulties. It is critical to recognize this purpose, rather than conceptualizing interventions to “stop bad behavior.” There may be a kind of logic to the patient's self-destructive behavior.

Among the manifold cognitive distortions these patients have is the idea that “I'm going to get hurt no matter what I do, so controlling the timing and intensity of harm is all the control I get.” These beliefs can be reframed as an

attempt to survive the helplessness and unpredictability of repeated maltreatment. The therapeutic goal is to change this “survival skill” to a “recovery skill” by developing non-trauma-based strategies for appraising one's current life situation and level of external danger, gaining a repertoire of skills to keep oneself safe, and creating overall safety and self-protection.

Phasic trauma treatment

In general, a phasic trauma treatment model is considered the standard of care for CT and DPTSD patients.¹⁶ In stage 1, the patient works toward basic safety and stability. In stage 2, the focus is on the detailed narrative and emotionally intense recollection and processing of trauma memories. Stage 3 is directed toward reintegration—that is, living well in the present with traumatic memories relegated more to the status of bad memories, rather than flashbacks, behavioral reexperiencing phenomena, and/or intense post-traumatic reactivity to current situations.

These stages are heuristic, since memory material may need to be addressed, if only in a more cognitive and distanced manner in stage 1 and worked through again from a more integrated perspective in stage 2. Finally, the entirety of trauma treatment is directed toward developing a better adaptation to current life. Many patients will not have the psychological or practical resources for the work in stage 2. The focus will necessarily be on long-term safety and stabilization.

Stabilization and safety are the most important, and most neglected, aspects in the treatment of CT. Without establishment of safety, the patient actually or symbolically lives in a world of ongoing trauma, whether perpetrated on the patient by others or by the patient on himself as a result of repeated self-destruction and high-risk behavior. Patients with CT commonly come to treatment because of problems with safety and/or overwhelming symptoms. It is important to logically prioritize basic life and health over other interventions. As shown in **Tables 2** and **3**, the patient may be affected by a wide variety of symptoms and co-occurring disorders as well as by traumatic brain injury.

Group psychotherapy can be a particularly powerful adjunctive modality for trauma survivors if patients are carefully screened for a group that matches their stage of treatment. In stage 1, educational groups can foster safety and self-understanding. These groups can help reduce a sense of isolation, shame, and related cognitive distortions (eg, “I'm a freak”) and can also help with basic trauma-based relational issues.

In stage 2, carefully selected structured groups can continue and deepen the work on issues that began in stage 1. These groups can also provide support for processing trauma memories that patients are working on more intensively in individual therapy.

In stage 3, group therapy can assist patients with learning skills for negotiating everyday life. In all stages, groups can enhance a sense of community, decrease isolation, and provide support for group members in what is often an arduous and seemingly hopeless task: recovery from severe early life relational trauma.

Table 2 – Psychiatric, behavioral, and medical outcomes of childhood traumas and adversities

Psychiatric	Behavioral	Medical
<ul style="list-style-type: none"> • Depression • PTSD • Dissociative disorders • Alcohol and substance abuse • Non-PTSD anxiety disorders • Suicidal and self-destructive behavior • Completed suicide • Somatic symptom disorders • Eating disorders • Personality disorders (particularly borderline personality disorder) • Multiple DSM diagnoses • Hearing voices • Amnesia for childhood disorders 	<ul style="list-style-type: none"> • Multigenerational victimization and abuse • Victim of repeated sexual assaults • Intimate partner violence • Smoking • Impaired school/work performance • High-risk sexual behaviors • Earlier sexual behaviors • Early pregnancy as either father or mother • More than 50 sexual partners • Increased rate of children with autism spectrum disorders 	<ul style="list-style-type: none"> • Cardiac disease • Lung disease • Liver disease • Autoimmune diseases • Sexually transmitted diseases • Morbid obesity • Greater health care utilization • Early menarche • HPA axis dysfunction

HPA, hypothalamic-pituitary-adrenal.

CATEGORY 1

Many severely decompensated dissociative patients may appear to meet diagnostic criteria for borderline personality disorder when flooded with PTSD intrusive symptoms and dissociative responses. Once stabilized, many of these patients no longer meet criteria for borderline personality disorder, although some borderline features may persist. Many different types of interventions may be needed to protect the patient, including hospitalization, specialized programs for substance use or eating disorders, police assistance and shelter for victims of intimate partner violence, and various social services.

Patients with a history of CT benefit greatly with early psychoeducation about symptoms, the nature of phasic trauma treatment, and the benefits and potential risks of this treatment. Psychoeducation and learning symptom management skills often need to be repeated and can be done in a group format. However, in-depth exploration of traumatic memories is not the goal of these groups, since this usually is destabilizing at this stage of treatment.

Patients with dissociative CT may have difficulty with grounding and staying “present” during clinical interactions. They may experience depersonalization/derealization, spontaneous trance, and/or dissociative amnesia during treatment. This may account for some of the difficulties the patients have with more standard treatments. Clinical interventions commonly involve helping patients recognize that many of these responses are based in fear reactions and attachment problems, particularly insecure or disorganized attachment patterns. In the latter instance, the patient may experience attachment as inherently dangerous or threatening. Such traumatic transference responses may lead to dissociative withdrawal; thus, psychoeducation and cognitive interventions become ineffective.

Dissociative amnesia may mean that patients cannot consistently access information provided in treatment. Gently questioning what the patient learned is usually helpful. Patients frequently recall little of what has just occurred. Clinicians are advised to not only repeat information but also understand what cues or reminders trigger dissociative responses (eg, depersonalization, dissociative amnesia) during therapy.

The Karpman Drama Triangle

The Karpman Drama Triangle¹⁷ (Figure) is a model for understanding the common relationship patterns of persecutor, rescuer, and victim. These roles are enacted within the therapeutic relationship in the context of transference/

countertransference patterns. A non-shaming approach can direct a patient’s attention to each of the roles enacted and explore their history.

Clinicians must model healthy interpersonal behaviors while managing the frequent crises, boundary tests, and/or interpersonal conflicts that are likely to arise during treatment. Therapists need to be firm yet caring if a patient is suicidal or self-destructive—they must be advocates for non-abusive values. Point out that protecting the patient from his self-harm is a caring stance and can include willingness to tolerate the patient’s anger and/or fear of loss of control.

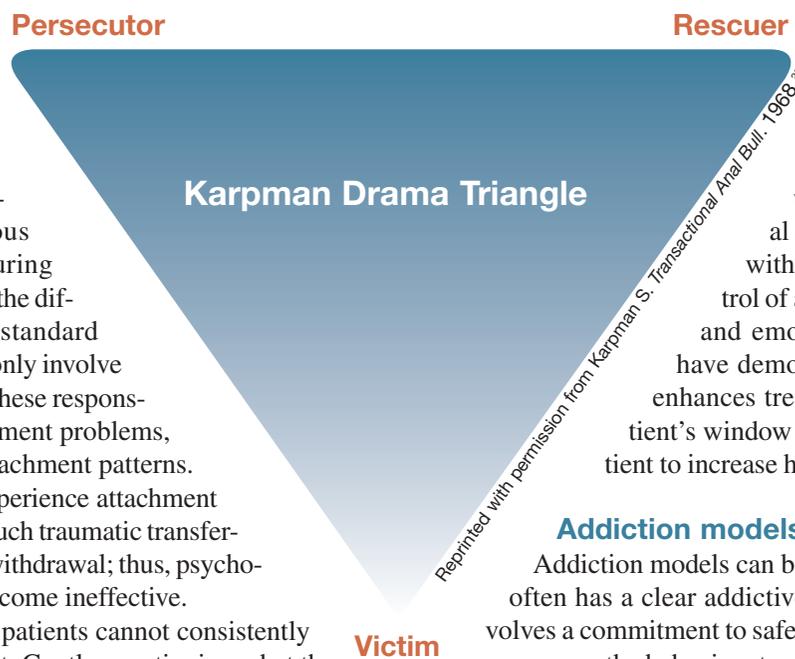
The window of tolerance model

Alternating between hyperarousal and hypoarousal becomes a strongly ingrained response structure for patients with a history of CT. The window of tolerance model of autonomic arousal is useful for understanding difficulties with affect regulation in CT.¹⁸ The model helps the traumatized patient regulate his emotional states within a narrow range (ie, window) of optimal arousal. Going beyond the limits of emotional tolerance can create an overwhelming state of sympathetic hyperarousal or parasympathetic hypoarousal. A patient with a history of CT typically feels out of control of affect shifts that alternate between flooding and emotional constriction/dissociation. Studies have demonstrated that emotion regulation training enhances treatment outcomes.^{19,20} Work within the patient’s window of tolerance while slowly assisting the patient to increase his emotional tolerance.

Addiction models

Addiction models can be helpful because self-destructive behavior often has a clear addictive component. “Sobriety” from danger involves a commitment to safety, realization that symptoms will probably worsen once the behavior stops, and intensive work to find alternatives to help manage intolerable affective states. Conversely, self-injury may be an attempt to “feel something” when in a numb state, or to “put the pain on the outside” where it seems more real, or where (the patient thinks) others may take it more seriously.

Addiction models can help conceptualize the problem of “safety agreements.” Keep in mind that safety agreements are not a substitute for clinical judgment about the patient’s safety; the psychiatrist must act to protect the



(Please see Complex Trauma Survivors, page 44)

Table 3 – Typical complex trauma problems and deficits (categories may overlap)

<p>Problems with affect regulation</p> <ul style="list-style-type: none"> • Anger • Fear • Shame • Sadness/depression • Disgust/revulsion <p>Problems with safety and impulse control</p> <ul style="list-style-type: none"> • Suicidality • Self-injurious behavior • Danger to others • Alcohol and substance abuse • Eating disorders • High-risk behaviors • Criminal behavior 	<p>Problems with attention and state stability/dissociation</p> <ul style="list-style-type: none"> • Depersonalization/derealization • Dissociative amnesia • Spontaneous trance <p>Problems with identity and self-perception</p> <ul style="list-style-type: none"> • Identity confusion • Unstable self-image/sense of self • Body image problems • Dissociative identity disorder <p>Problems with body image/somatization</p> <ul style="list-style-type: none"> • Eating disorders • Somatic symptom disorders • Nonepileptic seizures: other conversion disorder symptoms, somatic symptom disorder • Medical neglect 	<p>Problems with systems of meaning</p> <ul style="list-style-type: none"> • The self is seen as irreparably damaged, bad, shameful, and blameworthy • Pervasive mistrust of others • Belief in responsibility for events one cannot control • Intense focus on control • The world is seen as completely dangerous and untrustworthy • Taking the perspective of the abuser/rationalization of perpetrator behavior <p>Problems with relationships and attachments</p> <ul style="list-style-type: none"> • Insecure or disorganized attachments • Pervasive mistrust of others • Problems with stable attachments • Problems with intimacy • Attachment to/enmeshment with perpetrators • Repeated unsafe or violent relationships
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patient and himself (eg, certification), notwithstanding the safety agreement. However, agreements may be useful as a clinical tool to support the patient's tenuous commitment to safety.

It is useful to think of safety agreements as delaying agreements, where the patient has a hierarchy of interventions to use instead of self-destruction, up to and including going to the emergency department for stabilization. Recovering addicts are taught to think in "day at a time" approaches to sobriety. Recovering trauma survivors may be unable to commit to safety "forever" but may be able to commit to a safety plan for a more manageable period (eg, from therapy session to therapy session).

Psychopharmacological interventions

Many of the dysregulation symptoms have a limited response to medications. Often patients with DPTSD have a less robust response to antidepressants for mood and PTSD symptoms than published clinical trials suggest. In patients with DPTSD, prazosin has been shown to be effective for treatment of nightmares, as long as the patient can tolerate the effect on blood pressure.²¹

Mood and anxiety symptoms

It may be difficult to ascertain where the effects of chronic trauma, posttraumatic sadness and grief, existential despair, and demoralization end and depression begins. A successful antidepressant trial may result in the patient feeling more resilient when faced with life's problems or difficult psychotherapy sessions, rather than having a positive effect on mood. These patients may respond more robustly when they have a "double-depression" picture with distinct worsening of depressive symptoms compared with baseline.

Affective dysregulation symptoms of CT are not isomorphic with symptoms of DSM-5 mood and anxiety disorders, and often have limited response to antidepressant, antianxiety, or mood-stabilizing medications. CT-based distortions may have an almost delusional intensity in some patients. However, these symptoms rarely respond to antipsychotic medications.

Some DPTSD patients may report internal "voices." However, dissociation-/trauma-based voices usually have a cause that is different from that of psychotic auditory hallucinations, and they rarely respond to even very high doses of antipsychotic medication. For example, hallucinations are among the most common symptoms in patients with dissociative identity disorder. These hallucinatory phenomena may be better explained by the fact that many patients have high hypnotic capacity and can generate hallucinations in all sensory modalities in deep trance.

Although many clinicians are reluctant to prescribe benzodiazepines for PTSD patients, the extreme fear/terror symptoms inherent in patients with a history of CT may partially respond to these medications. It must be explained to the patient, however, that these are antianxiety medications, not medications for extreme fear/terror states, and partial responses are the rule. Carefully monitor the patient for tolerance, dosage creep, and overuse of these medications. If the patient does not adhere to the prescribed regimen, the medication must be discontinued. Alprazolam is the least desirable medication for these patients because of its short duration of action, the risk of sudden worsening of anxiety when blood levels fall and the consequent need for more frequent dosing, the rapid development of dependence at comparatively low dosages, and its dangerous withdrawal symptoms.

Psychological issues

Patients with a history of CT may require significant psychoeducation about medications as well as trauma-focused psychotherapy to help with adherence to medication regimens. Some of these patients are medication-phobic; at the other extreme, some seek medications as general anesthesia and may arrive already taking a complex mix of psychotropics prescribed by a variety of physicians. Some are exquisitely sensitive to medication adverse effects at low dosages; others appear impervious to the sedating effects of combinations of high dosages of antidepressants, neuroleptics, benzodiazepines, and opiates, possibly because of PTSD hyperarousal.

The chronic mistrust and trauma-based issues around control may make patients phobic of taking prescribed medications or of taking medications as prescribed. Yet they are often prepared to ingest alcohol, street drugs, and/or

high doses of over-the-counter "supplements," notwithstanding the risks of doing so. They may resist rational psychopharmacology and insist, "I don't want to be controlled by medications"; "I don't want to be drugged." A subset of CT patients may have posttraumatic reactivity to having medications prescribed; ingesting medications; and/or taking medications of certain shapes, colors, or dosages. In patients with DPTSD, conflicts among self states may result in the patient taking varying, often polarized, positions about psychotropic medications and whether there has been a response to the medication.

The collaborative nature of treatment needs to be emphasized: the need to adhere to the medication, report beneficial and problematic effects, and work with the psychiatrist in making decisions about treatment. The prescribing psychiatrist may need to spend considerable time explaining the potential risks and benefits of medications, clarifying any posttraumatic cognitive distortion the patient may have about medications, and helping to separate the present clinical situation from past experiences.

It is likely that medication will not "cure" symptoms, but rather it will function as an effective "shock absorber" for chronic trauma-related symptoms. Clear-cut comorbidities, such as bipolar disorder, generally respond more robustly to psychopharmacological interventions. However, it is important to remember that in CT patients, rapid shifts in mood/affect are usually based in DPTSD rather than bipolar II phenomena, and thus symptoms do not respond robustly, if at all, to mood-stabilizing medication.

It is rarely helpful to switch medications with every symptom exacerbation. Chefetz²² observed that it is best to medicate changes in symptom "climate," not day-to-day fluctuations in symptom "weather." Being empathetic to the patient's suffering often gives rise to pressure to prescribe or change a medication, although psychotherapeutic interventions are likely to be more effective. Treatment is a long and slow process to recovery; it is not a linear process and does not proceed on a straightforward, daily basis. Treatment response should be evaluated over weeks or months because life stress, or even a difficult therapy session, may plunge the patient into acute despair, despite a long-term, overall positive treatment trajectory.

Stabilization of acute posttraumatic symptoms

Patients with a history of CT will frequently manifest posttraumatic reactivity to everyday stimuli as well as to relational triggers that may be present during the clinical interview or psychotherapy. Studies of traumatized populations have shown that the primary transference response to the clinician is a traumatic transference.^{23,24} The clinician is seen as someone who ultimately will exploit the patient or is complicit with and ignores the exploitation of the patient. Alternatively, the patient may experience himself as the one victimizing the therapist.

Some patients may respond fearfully to treatment interventions, especially when they are confused about where they are or when they have lost track of the present (ie, duality of awareness). At times, the transference may literally become flashback transference, with the clinician perceived as someone in the flashback, not someone trying to help. Clinicians trained in hypnotic interventions for PTSD and trauma may be able to provide helpful imagery interventions to assist with separation of past/present and help re-ground the patient in the present reality.

After the cessation of the flashback, it is important to gently attempt to process the event and to help the patient determine what triggered the flashback. Patients may have dissociative amnesia after a flashback, and the clinician should not attempt to break down the amnesia at this point. However, it may help to give the patient a brief summary of what happened during the flashback.

Patients may reproach themselves for not being able to control posttraumatic reactivity and flashback responses. Explain to the patient that the amygdala-based fear-conditioning system fires "faster than the thinking brain" (ie, the cerebral cortex) as a survival mechanism. The initial task is to learn how to "back off" flashbacks and recognize triggers to better anticipate situations and interactions that may precipitate a flashback. Only through more systematic processing of trauma material, usually in phase 2 of phasic trauma treatment, do flashbacks shift from overwhelming, fragmented intrusions to merely "bad memories."

Conclusion

Major challenges in the treatment of patients with a history of CT include repeated crises due to affect dysregulation and engagement in unhealthy re-

relationships and behaviors; entrenched self-destructiveness and suicidality; the tenacity with which these patients hold trauma-based distortions; interpersonal difficulties; fragmented identity and shifting states; and a myriad of somatic issues. These complex difficulties contribute to a long, slow clinical course with gradual response to treatment that may seem like 2 steps forward and 3 steps back. It is important to maintain professional boundaries, employ sufficient self-care, and seek collegial support from and consultation with clinicians well versed in treating CT to maintain effectiveness with this challenging yet rewarding patient group.

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Severely Depressed Most Responsive to Combined Cognitive and Drug Rx

by Kenneth J. Bender, PharmD, MA

A large-scale clinical trial examined outcomes from acute through continuation treatment of depression.¹ Patients with severe, nonchronic MDD were more likely to have symptom remission with a combination of cognitive therapy and antidepressant medication than those with less severe or more chronic illness.

Lead author Steven Hollon, PhD, Department of Psychology, Vanderbilt University, told *Psychiatric Times* that the combination of cognitive therapy with medications had a big effect for patients with severe, nonchronic depression “but was not needed by patients with less severe, nonchronic depression [as] they did well regardless, and did not help patients with chronic depression regardless of severity [as] they did less well regardless.”

Hollon and colleagues recruited 452 patients with chronic or recurrent MDD from 3 university-affiliated outpatient clinics. Participants were randomized to receive personalized antidepressant medication treatment with or without a standardized cognitive therapy. The depressive illness was categorized as chronic if episodes lasted 2 years or longer, or recurrent if an episode had followed another within the past 3 years.

Treatment of both groups continued for up to 19 months to attain remission and for up to 42 months to achieve recovery (defined as remission sustained for 26 consecutive weeks). Changes in depression symptoms were assessed at intervals throughout the study with the 17-item Hamilton Rating Scale for Depression and the Longitudinal Interval Follow-up Evaluation.

Antidepressant medication treatment was personalized for all patients, consistent with best clinical practices. Dosages were increased as rapidly as possible and maintained at maximum tolerated levels for at least 4 weeks. The antidepressant could be switched and/or augmented with adjunctive agents. The Beck model of cognitive therapy was applied following standardized protocol, with 50-minute sessions provided twice weekly for at least 2 weeks, then at least weekly through acute treatment and at least monthly during continuation, with the frequency adjusted to patient needs.

Patients who had severe but nonchronic depression at study entry and received the combination therapy had a better rate of recovery than those who received medication alone (81.3% vs 51.7%). The median recovery rates across all groups who received combination therapy were better than for those who received medication without cognitive therapy (72.6% vs 62.5%). Remission rates were high but were not statistically significantly different between groups, occurring in 63.6% of patients who received combination treatment and 60.3% with medication. Although median time to remission was shorter with the combination treatment, that difference was also not statistically significant.

“The study shows that different people respond to different treatment combinations,” Hollon remarked. “We clearly need to do more for the patients with chronic depression.”

In an accompanying opinion paper, Michael Thase, MD,² called this “one of the most important studies undertaken to evaluate the merits of combining psychotherapy and pharmacotherapy for treatment of major depressive disorder.”

Thase distinguished the scale and scope of this study from previous efforts to compare these treatment conditions in smaller randomized clinical trials with typical durations of 8 to 16 weeks, as well as from meta-analyses of these smaller trials. “Meta-analyses of grouped data were not able to identify the clinically important moderating effects of symptom severity and chronicity,” Thase pointed out.

In their pooled analysis of data from 6 smaller studies, Thase and colleagues had also found a stronger effect from combination treatment in patients with more severe depression symptoms. However, he credits the current randomized clinical trial for providing “much stronger evidence of this clinically meaningful patient-by-treatment interaction.”

According to Thase, this study may also explain why others have found only modest benefit from the combined treatment if their populations had skewed toward patients with more mild or chronic depression. He also noted that the approximate two-thirds of patients who had symptom remission across 1 year of therapy corresponded to the STAR*D study findings with sequentially adjusted pharmacotherapy. “It is reassuring that the outcomes in these two studies were so similar across 12 months, especially given the several differences in study design and research aim,” he observed, adding, “such findings are indeed grounds for therapeutic optimism.”

Most patients have access to medication treatment, although the dosage is often too low and the duration too short. “But good cognitive therapy is still hard to find,” Hollon told *Psychiatric Times*.

Hollon and colleagues acknowledge that the cost is higher for combination treatment than for medication alone. However, they noted that their study did not include a cost-benefit analysis to consider reduced treatment costs from hastening remission and recovery. Even without a formal cost-benefit analysis, however, they suggest that their data support providing combination treatment for patients with more severe and nonchronic depression. “Such a recommendation would be consistent with the goals of personalized medicine,” they write, and “patients are given what they most need, and costly resources are reserved for those likely to benefit from them.”

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