Treatment of Complex PTSD: Results of the ISTSS Expert Clinician Survey on Best Practices

Marylene Cloitre
National Center for PTSD and New York University Langone Medical Center

Christine A. Courtois
Washington, DC

Anthony Charuvastra
New York University Langone Medical Center and Nathan S. Kline Institute for Psychiatric Research

Richard Carapezza
New York University

Bradley C. Stolbach
La Rabida Children's Hospital Chicago Child Trauma Center and University of Chicago Pritzker School of Medicine

Bonnie L. Green
Georgetown University Medical College

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

[illegible] (Kessler, 2000). [illegible] 1992). [illegible] DSM-IV [illegible] (DESNOS) [illegible] 1997). [illegible] DSM-IV [illegible] PTSD [illegible] PTSD [illegible]

Marylene Cloitre, [illegible] National Center for PTSD [illegible] New York University Langone Medical Center; Christine A. Courtois, Washington, DC; Anthony Charuvastra, New York University Langone Medical Center, Nathan S. Kline Institute for Psychiatric Research; Richard Carapezza, New York University; Bradley C. Stolbach, La Rabida Children's Hospital Chicago Child Trauma Center, University of Chicago Pritzker School of Medicine; Bonnie L. Green, Georgetown University Medical College.

Correspondence [illegible] Marylene Cloitre, [illegible] National Center for PTSD, NC-PTSD/334, VAPAHCS, 795 W[illegible] Road, Me[illegible] Park, CA 94025. E-mail: [illegible]

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a e c e PTSD . E b ed d e
a e bee de ed e e fe c e a a a
a e e e f e e a d e c e PTSD -
e e e e f ea e . A e de e a ed
e a ced a e-ba ed a a ea e de . T ee a -
a ed e be f ab a e ab a e a
e e f a a-f c ed c e (B ad e & F ad,
2003; D e aa e a ., 2010; Z c e a ., 1997); f c ded
a a a-f c ed c e e a ed a e e ced (C e,
K e e , C e , & Ha , 2002; C e e a ., 2010; S e , D e ,

Usually appropriate: a first-line treatment you would often use; 4(6 = *Reasonable: a second-line treatment, a treatment you would sometimes use under certain conditions (e.g., due to patient preference or if first-line treatment is ineffective, unavailable, or unsuitable)*

[illegible]

F [illegible] F [illegible] (1999) [illegible] Ka[illegible] (1997), [illegible] 9(7) [illegible] 6(4) [illegible] 3(1) [illegible] A[illegible] effec[illegible] afe[illegible] acce[illegible] We[illegible] (CI)

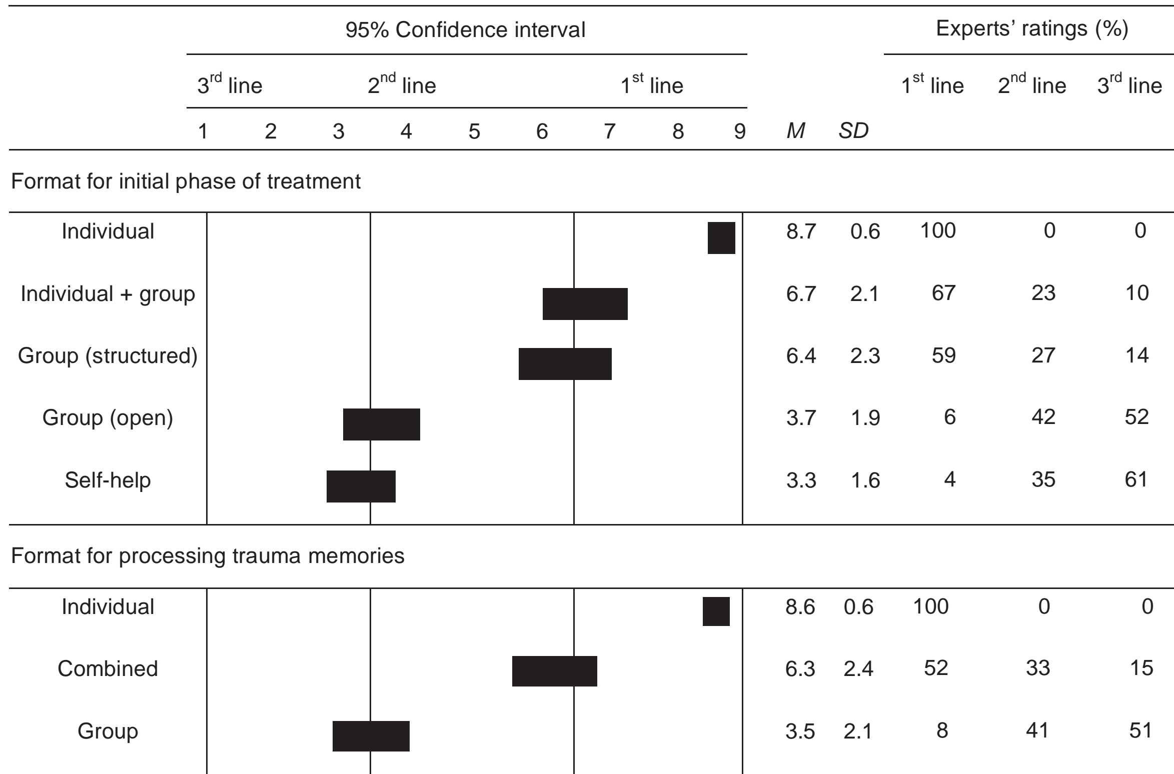
	95% Confidence interval											Experts' ratings (%)		
	3rd line			2nd line			1st line					1st line	2nd line	3rd line
Approach	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	*M*	*SD*			
Sequenced treatment										8.0	1.6	85	15	0
Primarily coping skills										5.3	2.2	34	40	26
Combine processing and skills										4.3	2.4	27	23	50
Primarily memory processing										4.71298.m123642c5(4.71298.85907[7.292554)-316en04.				

F i g u r e 2 .

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

T 1. F -L e I e e a d T Sec d-L e I e e Ta e ed S Se

M e e	F e e e	T ec d- e e e
Ree e e c	Ed ca ab a a Na a f a a e	C e e c E e a e e A e / e a a e e
A da ce/c c	Ed ca ab a a E e a e e	C e e c Na a f a a e Med a / df e I e e a a
H e a a	Ed ca ab a a E e a e e A e / e a a e e	Na a f a a e C e e c
Affec d e a	Ed ca ab a a E e a e e	C (ab)-250.4( )-0.2(a a)]TJ16.8001 -1.1997 TD-



F 5. [illegible]

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