

Treatment of Complex PTSD: Results from the ISTSS Expert Consensus Summary Report

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

Keywords: complex PTSD, expert consensus, treatment, PTSD

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

According to the Diagnostic and Statistical Manual of Mental Disorders (4th ed., 1994), PTSD is characterized by the presence of at least one of the following symptoms: (a) re-experiencing the traumatic event, (b) avoidance of stimuli associated with the trauma, (c) negative alterations in mood and cognition, and (d) increased arousal. The symptoms must be present for more than one month and cause significant distress or impairment in social, occupational, or other important areas of functioning. The prevalence of PTSD in combat veterans is estimated to be 15% to 30% (Foa et al., 1999). The prevalence of PTSD in civilian populations is estimated to be 8% to 15% (Foa et al., 1999). The prevalence of PTSD in children and adolescents is estimated to be 1% to 17% (Foa et al., 1999). The prevalence of PTSD in older adults is estimated to be 1% to 10% (Foa et al., 1999).

In addition to the symptoms listed above, PTSD is also characterized by the presence of at least one of the following symptoms: (a) re-experiencing the traumatic event, (b) avoidance of stimuli associated with the trauma, (c) negative alterations in mood and cognition, and (d) increased arousal. The symptoms must be present for more than one month and cause significant distress or impairment in social, occupational, or other important areas of functioning. The prevalence of PTSD in combat veterans is estimated to be 15% to 30% (Foa et al., 1999). The prevalence of PTSD in civilian populations is estimated to be 8% to 15% (Foa et al., 1999). The prevalence of PTSD in children and adolescents is estimated to be 1% to 17% (Foa et al., 1999). The prevalence of PTSD in older adults is estimated to be 1% to 10% (Foa et al., 1999).

Research has shown that PTSD is associated with a number of physical health problems, including cardiovascular disease, hypertension, and chronic pain (Foa et al., 1999). PTSD is also associated with a number of mental health problems, including depression, anxiety, and substance use disorders (Foa et al., 1999). PTSD is also associated with a number of social problems, including isolation, family conflict, and problems in the workplace (Foa et al., 1999). PTSD is also associated with a number of economic problems, including unemployment and poverty (Foa et al., 1999). PTSD is also associated with a number of health care problems, including increased use of health care services and increased health care costs (Foa et al., 1999).

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

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

Treatment of First-Episode and Second-Episode Traumatic Stress

Mental Disorder	First-Episode	Second-Episode
Recurrent	Education about trauma Narrative format	Cognitive restructuring Exposure therapy Adequate aftercare
Acute/chronic	Education about trauma Exposure therapy	Cognitive restructuring Narrative format Medication/meditation Lifestyle adjustments
Hereditary	Education about trauma Exposure therapy Adequate aftercare	Narrative format Cognitive restructuring
Affected family	Education about trauma Exposure therapy	(abuse)-250.4(-)-0.2(a)]TJ16.8001 -1.1997 TD-

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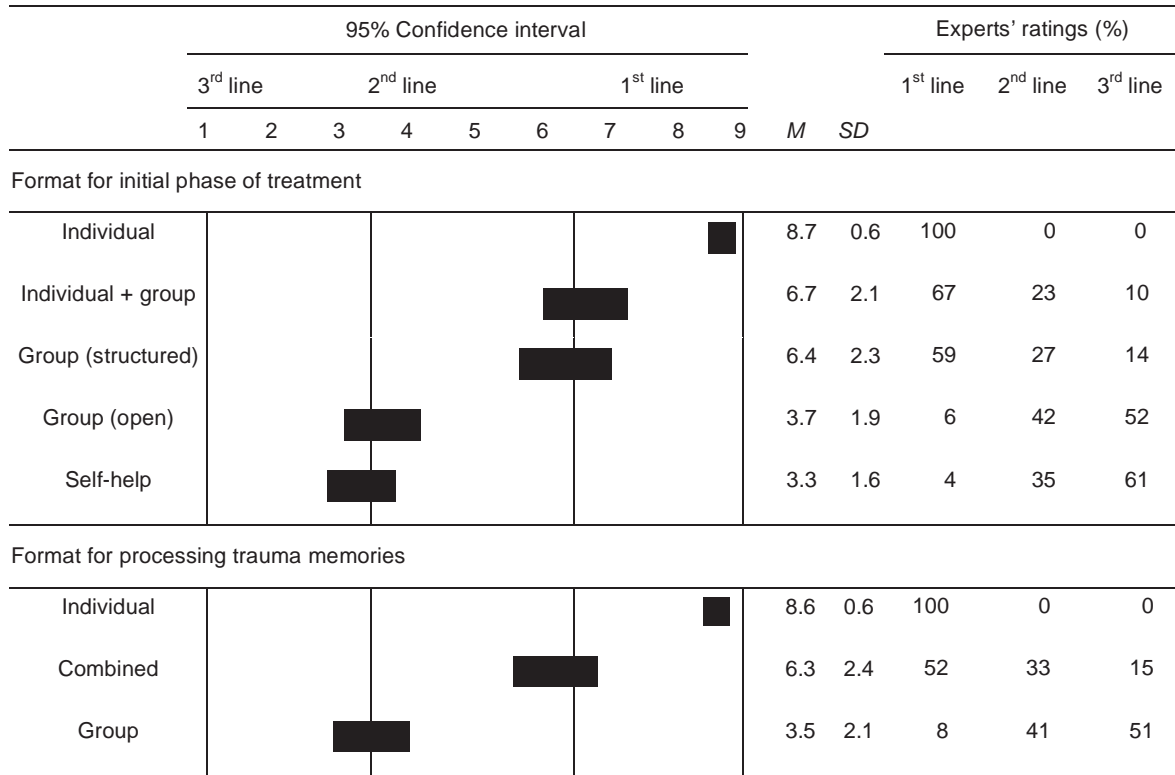


Figure 5. Ratings for effectiveness of different treatment formats for PTSD.

are effective in the long term (Cohen & Wolkstein, 2001; Foa & Keane, 2003).

The first line of treatment for PTSD is individual exposure therapy (Foa & Keane, 2003). A second line of treatment is individual + group exposure therapy (Foa & Keane, 2003). A third line of treatment is group (structured) exposure therapy (Foa & Keane, 2003). A fourth line of treatment is group (open) exposure therapy (Foa & Keane, 2003). A fifth line of treatment is self-help exposure therapy (Foa & Keane, 2003). The first line of treatment for PTSD is individual exposure therapy (Foa & Keane, 2003). A second line of treatment is individual + group exposure therapy (Foa & Keane, 2003). A third line of treatment is group (structured) exposure therapy (Foa & Keane, 2003). A fourth line of treatment is group (open) exposure therapy (Foa & Keane, 2003). A fifth line of treatment is self-help exposure therapy (Foa & Keane, 2003).

Second-line treatments include individual + group exposure therapy (Foa & Keane, 2003). Third-line treatments include group (structured) exposure therapy (Foa & Keane, 2003). Fourth-line treatments include group (open) exposure therapy (Foa & Keane, 2003). Fifth-line treatments include self-help exposure therapy (Foa & Keane, 2003).

Individual exposure therapy is the most effective treatment for PTSD (Foa & Keane, 2003). Individual + group exposure therapy is also effective (Foa & Keane, 2003). Group (structured) exposure therapy is also effective (Foa & Keane, 2003). Group (open) exposure therapy is also effective (Foa & Keane, 2003). Self-help exposure therapy is also effective (Foa & Keane, 2003).

Ratings for effectiveness of different treatment formats for PTSD are shown in Figure 5. Individual exposure therapy is rated as the most effective treatment format for PTSD (8.7/10). Individual + group exposure therapy is rated as the second most effective treatment format for PTSD (6.7/10). Group (structured) exposure therapy is rated as the third most effective treatment format for PTSD (6.4/10). Group (open) exposure therapy is rated as the fourth most effective treatment format for PTSD (3.7/10). Self-help exposure therapy is rated as the fifth most effective treatment format for PTSD (3.3/10).

