**Complex PTSD following child abuse, the impact on identity and adult re-victimisation**

The purpose of this research essay is to explore how child abuse effects the development of self identity and adult re-victimisation. Initially outlining cPTSD (Complex ptsd) and how it has come to be included yet not defined in the DSM5, I will briefly discuss neurological disturbances from trauma and how they effect affect regulation. Exploring affect as a salient feature of emotion dysregulation which is an underpinning feature for Borderline personality disorder (BPD) (Hall, 2016), I highlight different attachment disorders which stem from interpersonal abuse and how they correlate to identity disturbances. I will further discuss the comparative view of BPD as trauma reenactment rather than a personality disorder while highlighting the overlapping symptom clusters of cPTSD.

Due to limited space I do not explore Dissociative Identity Disorders (DID) in depth, however I am aware they can be co-morbid to cPTSD. Included is a table highlighting the percentages of adult re-victimisation following different types of abuse and how many times more likely they are to experience different types of adult abuse, this section is brief yet elucidates the longterm problems of chid abuse and future re-victimisation. To complete the essay I have outlined three stages to treating cPTSD and discuss different approaches which can be used. I am aware there are currently no guidelines within the DSM5 or ICD10 manuals, therefore I have explored Prolonged Exposure (PE), and Image Rescripting and Reprocessing Therapy (IRRT), I do acknowledge other processes used yet focus on these two models.

**<u>Complex PTSD following Childhood abuse</u>**

cPTSD can be following "*multiple, repeated and or overlapping victimisations and traumatic exposure's in childhood in insecure and abusive attachment relationships" (*Courtois & Ford 2016).

However, in addition to the core PTSD symptoms three further clusters of dysregulation were recognised and added to the PTSD criteria, these are:

1. emotion processing,
2. self organisation, including bodily integrity
3. relational security

(Ford & Courtois, 2014) (DSM5).

These additions were added as PTSD models were unable to explain the full range of symptoms presented in adult victims who experienced traumatic interpersonal victimisation (Ford & Courtois, 2014) in previous childhood trauma (Courtois & Ford, 2016). cPTSD was suggested for conceptualising and treating the symptoms of adults who had experienced prolonged and severe personal trauma (Ford & Courtois,2014). The complex symptoms included issues of identity, affect regulation and relationships, which came to form the additional three symptom clusters. However, symptoms also included substance abuse, dissociation, somatisation and self injurious behaviour (Brier, 2004; Van der Kolk, 2005. Cited in Courtois & Ford, 2016). Although the DSM5 criteria for PTSD has been revised and the complex symptoms added, they are not distinguished as cPTSD (DSM5,2013 & Ford & Courtois, 2014), yet will be added to the next Dsm and the ICD11 (UKPTS REF). These symptoms are often due to early life interpersonal trauma and abuse within 'primary care giving relationships' (Van Dilke et al 2011).

Van Dijke has noted trauma and cPTSD often compromise affect regulation (Van Dijke et al 2001), due to disturbances within the neurological development of children. Early life trauma can create abnormal activation of the HPA axis leading to an over-secretion of cortisol which induces hyper-responsivity (Wieland, 2015). Over time this increases sensitivity to stress (Wieland, 2015) and low levels of cortisol can lead to an intolerance to intrusive thoughts when experiencing stress (Wieland,2015).

High cortisol levels may lead to a blocking of past and present events, which could be the underlying cause for dissociation (Wieland,2015). McCrory (McCrory et al 2010, cited in Wieland, 2015) noted a lower density of neural connections between the frontal cortex, the anterior temporal lobe and the amygdala within early abuse victims (McCrory et al, 2010, cited in Wieland 2015); lower density indicates reduced conscious control over negative emotions (Wieland, 2015). Further to this, reduced emotional processing abilities have been found in children who experienced maltreatment in childhood, this was due to a decreased cerebellum volume (Carrion et al 2013, McCrory et al, 2012, Cited in Wieland,2015). Dysfunctional brain activity ultimately contributes to *"emotional responding or non responding outside conscious control"* (Wieland, 2015), this highlights the correlation between child abuse and emotion processing.

Schore underpinned the failure of the right orbital frontal cortex, the right anterior cingulate and the right insula to regulate the amygdala to pathological dissociation (Schore, 2012). Wieland (Wieland, 2015) quotes Schore (Schore, 2012, Cited in Wieland,2015) in saying *"The symptomology of pathological dissociation can thus be conceptualised as a structural impairment of right brain regulatory system and resultant functional deficit of affect regulation"* (Schore, 2012. Cited in Wieland, 2015). Affect dysregulation is an impaired ability to moderate the affect, and when resulting in emotions being expressed in intense and pure forms, which overwhelm normal reasoning ( Koeningberg et al, 2002, cited in Van Dijke et al, 2011), is classed as 'under-regulation of affect' (Van Dilke et al, 2011). Schore correlates these affect disturbances to a mother's inability to serve as a regulator for the infant/child's affect states (Schore,1994 cited in Baird 2008), however this form of under-regulation has also been linked to severe sexual, physical and emotional abuse.

Over-regulation of affect has also been associated with childhood abuse (Bermond et al 2008, cited in Van Dijke, 2011), however over-regulation of affect includes suppression and numbing and

is called Alexithymia (Waller & Scheidt, 2006, cited in Van Dijke, 2011), and includes symptoms such as

1. difficulty identifying emotions,
2. difficulty describing emotions to others
3. limited imaginal capacity.

Over-regulation has been connected to some symptoms of cPTSD, BPD, psychoform dissociation and Somataform (Van Dijke, Van der Heart et al,2010, cited in Van Dijke, 2011). Exposure to traumatic events induces a sensitised response (Baird,2008), neural pathways become kindled and a 'state' becomes a 'trait', hyperarousal, increased anxiety and decreased cognitive processing occurs due to the failure of information reaching the highest orbitolcorticol level (Barbas & Teasdale, cited by Schore, 1994, cited in Baird,2008). The orbitolcorticol is central to affect regulation and processes cognitive emotional interactions and affect regulated meanings (Barbas & Teasdale, cited by Schore, 1994, cited in Baird,2008). Nathansen distinguished affect essentially as a biological aspect to emotion (Nathanson, 1992, cited in Rothschilds, 2000).

Children with affect dysregulation due to early relational and familial abuse often experience relationships synonymous with trauma (Trippany,Helm, Simpson,2006), repeatedly experiencing strong emotions as a result of relational triggers. Sexual abuse interrupts the attachment process, leaving children with inadequate interpersonal skills which lead to disruptive behaviour (Liem & Boudewyn 1999, cited in Trippany, Helm & Simpsom 2006). Finkelhor & Browne (Finkelhor & Browne, cited in Dunkett,2015) proposed a four factor model to understand the traumagenic dynamics of CSA survivors, which also correlate with some BPD symptoms yet define the circumstances of sexual abuse as unique, causing a more intense traumatic experience. These are:

1. Betrayal
2. Stigmatisation

3. Traumatic sexualisation
4. Powerlessness

(Finkelhor & Browne, cited in Dunkett,2015)

There are strong links between trauma and the disorganised disorientated attachment pattern, which are characterised by the disorganised behaviour of a child towards a parent, such as linking and turning away (Trippany, Helm & Simpson,2006); these patterns are often found in neurologically impaired children (Schore,1994 cited in Baird,2008). Unresolved attachment issues such as these often result in a "*short - circuited reception and encoding of relational stimuli in the child"* (Trippany, Helm & Simpsom 2006*)*. Courtois and Ford (Courtois & Ford 20116) identifies how even when a perpetrator is excessively cruel a child will still seek comfort due to the need for attachment (Courtois & Ford 20116). This has been identified as bi-directional bonding (Graeham 1994 cited in julich,2005) within a traumatic relationship. Although mostly related to hostage victims, sexually abused children could be defined as captives (Julich,2005). The term "attack-ment" has been used to describe the relationship developed through a caregiver who repeatedly abuses a child or does not stop abuse from occurring, yet isolates the child from others through exploitative methods (Courtois & Ford, 2016). This term encapsulates the complex issues which prohibit's the child from trusting anyone, and leads to feelings of isolation (Courtois & Ford, 2016), which is a key feature of BPD. These early traumatic events become integrated into the totality of a child's personality organisation (Baird,2008). Therefore, it would seem dysfunction within emotional processing following early trauma, especially relational trauma, contributes as a foundation for the formation of self identity. Van de Kolk (Van de Kolk, 1996 cited in Baird,2008) posits that 80 % of abused children are more likely to develop psychopathology including BPD and DID, yet it does not mean that all sexual abuse survivors will develop BPD (Yen et al 2002, cited in

Elzy, 2011). Previous research suggests that 60 - 90% of women with BPD had experienced childhood sexual abuse (Yen et al 2002., Zennari et al 2005, cited in Elzy, 2011).

**The impact of childhood abuse on identity**

The term identity is understood as a way of making sense of the self (Oyserman, Elmore & Smith, 2012 Cited in Agnew et al 2016) and is often characterised by the context of sociocultural environments, role relationships, self representations and explicit and implicit world views (Westen & Cohen, 1993 Cited in Agnew et al 2016). Our ability to relate to ourselves and form identity is governed by our subjective experiences, a phenomenological view of self has been described as "lifeworld" which incapsulates "*The inseparability between the world which forms the setting for ones life and the subjective experience of that life*" (Holloway in Collins & Folley ,2008). Sexual violation upon the immature self impacts the ability to create any sense of positive self identity (Dunkett,2015), therefore victims are forced to create adaptive schemas (Courtois & Ford,2016). These adaptive schema's are also in response to the negative feelings about the abuse which have been communicated to the child through others (Dunkett,2015), including the adapted cognitive schemas and negative self belief (Dunkett,2015).

The adolescent stage is defined by the ability to understand that abuse is occurring and have an increased ability to recognise the meaning of abuse (Goodyear-Brown, 2011, cited in Dunkket, 2015) . Some children do not display the symptoms of abuse, such as cPTSD or depression (Dominguez, Nelke & Perry, 2002, cited in Dunkett,2015) until adolescence. The developed awareness to their abuse can increase their already vulnerable position and further impact on inappropriate identity formation (Dunkett,2015), including highly avoidant coping strategies which inhibits the natural exploration of identity and results in a diffused identity status (Dunkett,2015), as children are not born with a unified identity. Levy (Levy, 2005, cited in Elzy, 2011) posits the

development of BPD in relation to attachment theory by outlining the importance of secure attachment in the development of a healthy self concept and a positive view of interpersonal relationships (Levy, 2005, cited in Elzy, 2011). Therefore, an unhealthy interpersonal relationship with a care giver, such as bidirectional bonding, would act as a contributing factor to an unhealthy self concept. Levy also suggests that child sex abuse could be a proxy for emotionally invalidating environment as the experiences lead to shame, guilt, fear and confusion (Lineham, 2003, cited in Elzy, 2011).

Identity disturbance has been an integral aspect of understanding identity disorders such as BPD (Agnew eta al 2016). People with BPD are mostly described as people suffering with identity disturbances and poor integrated self image (Paris, 2005. Cited in Agnew,2015). Interestingly, the symptoms of cPTSD are also identified as symptoms from the DSM5 BPD criteria (DSM5,2015), which include affect dysregulation, altered core beliefs about oneself, self harm, reckless and dangerous impulsive behaviour, intense and volatile relationships, social detachment and dissociation (Cloitre et al 2013, cited in Courtouis & Ford, 2014 & DSM5,2013). However, BPD is characterised by fear of abandonment, shifting self image and concept, changeable idealisation and devaluation of relationship and frequent and impulsive behaviours (Cloitre et al , 2014). Fear of abandonment is not a criteria requirement for cPTSD and self identity is consistently negative not constantly shifting (Cloitre et al , 2014). DIDs have also been related to severe CSA, physical and emotional abuse. It has been documented that 98 - 99 % of DID diagnosis have experienced severe CSA (Luxenberg, Spinazzola, van der Kolk, 2001). They are characterised in the DSM5 as "*a disruption of and / or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control and behaviour".* Dissociative symptoms can potentially disrupt every area of psychological functioning (DSM5,2013) and are frequently found as a result of trauma (DSM5, 2013).

The characteristics of some identity disorders such as BPD have also been described as symptomology of a traumatic response and perhaps more indicative of trauma reenactment (Tippany, Helm, Simpson, 2006). Some believe BPD in sexual abuse survivors is a misdiagnosis of PTSD with trauma reenactment rather than a BPD criterion (Miller, 1994 cited in Trippany, Helm, Simpson, 2006). Renaming BPD as an emotion regulation disorder would probably benefit people with a BPD diagnosis due to the stigma it carries (Trippany, Helm, Simpson,2006). Van der Kolk, (Van der Kolk,1987 cited in Trippany, Helm & Simpson 2006) suggested that trauma survivors reenact their trauma due to an addiction to trauma, although this suggestion appears basic, Miller (Miller,1994, cited in Trippany, Helm & Simpsom 2006) further explores this concept by highlighting trauma victims need for arousal levels as an "impetus for reenactment behaviours" (Trippany, Helm & Simpsom 2006). Baird (Baird,2008) states some victims repeatedly reenact scenarios where they feel threatened, attacked and abused but then become enraged. These interpersonal behaviours are an attempt to cope with the unbearable feelings of rage, shame, guilt and terror associated with the encoded experience of relationships (Baird,2008). Children who have experienced interpersonal traumas are more likely to be re-victimised as adults (Amstadter et al, 2011. Cited in Brier & Scott,2015).

**Adult re-victimisation of child abuse victims**

Adult re-revictimisation has been studied extensively and often appears within intimate relationships (Campbell, Greeson, Bybee & Rla,2008. cited in Chan2011). Physical violence is 1.6 times more likely to happen to a previously abused woman than a non abuse victim (Noll et al 2003, cited in Chan,2011). A study by Russel in 1986 found that 63% of women who had experienced interfamilial sexual abuse prior to the age of 14 also experienced rape after the age of 14 (Russel, 1986) compared to 35% of those who did not report childhood sexual abuse. This suggests that

early abuse nearly doubles the risk of adult sexual abuse. Although Russel's research was decades ago, recent studies replicate these original findings with variations between 13.7 % to 27 % of re-victimisation (Stele & Herlitz,2003). A further study in 2003 found CSA survivors are between 2-11 times more likely to experience adult abuse of some kind (Stele & Herlitz,2003). I have included a table which simply demonstrates the probabilities / likelihood of re-victimisation over a lifetime from either physical, sexual, or multiple abuse and neglect (Widom, Czaja,Dutton,2008).

| | Description | Physical only | Neglect only | Sexual only | Multiple | p |
|---|---|---|---|---|---|---|
| 1 | Lived in war zone | 0.00 | 7.2 | 10.2 | 6.0 | .87 |
| 2 | Physically harmed | 86.5 | 74.0 | 67.3 | 90.0 | .02 |
| 3 | Threatened with weapon | 54.1 | 54.0 | 51.0 | 56.0 | .97 |
| 4 | Threatened face-to-face | 64.9 | 57.9 | 57.1 | 60.0 | .86 |
| 5 | Assaulted with weapon | 40.5 | 36.3 | 36.7 | 42.0 | .85 |
| 6 | Physically harmed as child | 67.6 | 49.6 | 40.8 | 72.0 | .00 |
| 7 | Physically abused as child | 51.4 | 29.9 | 42.9 | 62.0 | .006 |
| 8 | Coerced into unwanted sex | 35.1 | 32.7 | 42.9 | 56.0 | .01 |
| 9 | Attempted forced sex | 18.9 | 17.2 | 28.6 | 24.0 | .22 |
| 10 | Private parts touched | 13.5 | 11.6 | 14.3 | 8.0 | .78 |

(Widom, Czaja,Dutton,2008)

**Evidence based treatments for cPTSD**

There are currently no NICE guidelines for cPTSD or trusted evidence based review of effective psychological and pharmacological treatments in the UK, however, for treating cPTSD The UK psychological trauma society has proposed a review of published evidence and clinical practice in order to develop guidelines for practice (UKPTS,2016). cPTSD has been associated with structural and functional changes to the emotional centre of the brain (UKPTS,2016), therefore

NICE guidelines propose trauma focused therapy for treating PTSD due to the overlap of diagnosis with BPD and other dissociative disorders.

An approach underpinned by trauma treatment literature suggests childhood trauma should be approached by a "*phase orientated, multi modal, skilled focused, titrated, and aimed at symptom relief and functional improvement"* (Briere & Scott, 2006; Brown, Scheflin, & Hammond, 1998; Courtois, Ford, & Cloitre, 2009; Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005; van der Hart, Nijenhuis, & Steele, 2006, cited in Korn,2009). The approach detailed on the UKPTS site entails three phases which are in succession yet defined within the treatment process ( UKPTS, 2016). Three domains have generally been agreed upon which need treatment within cPTSD, which include affective and sensory motor (UKPTS,2016). These phases do not normally transpire linearly, they are more dynamic and require revisiting different trauma based themes and beliefs throughout the process (Courtois,1999 cited in Korn,2009), sometimes reactivating coping responses, resources and considering challenging issues again and again (Courtois & Ford, 2016). Essentially, the key difference for treating cPTSD is the duration of the therapy; cPTSD requires a longer intervention than PTSD due to a longer safety and stabilisation phase, although this is not to say all clients take the same amount of time in each phase (Korn,2009).

**Phase one : Safety and stabilisation (symptom management, improving emotion regulation and addressing current stressors)**

Phase one focuses on the safety and stabilisation, dealing with "*issues of personal safety and development of self and ego capacities (i.e., tolerating and modulating strong affect)"* (Korn, 2009). This initial phase focuses on the clients inner experiences, addressing memories, emotions and sensations (Korn,2009). This phase also occurs within the preparation phase of Shapiro's eight phase model of EMDR, (Shapiro, 2001) to reduce self injurious behaviour, addictions, pathological

dissociation and extreme emotional dysregulation (Korn,2009). CBT and Interpersonal Affect Therapy (IAT) programmes are also sequenced and phase orientated, highlighting the importance of self regulation, interpersonal skills and psychoeducation (Rothbaum & Schwartz, 2002 cited in Korn, 2009) with the aim of creating internal and external safety to disengage the 'emergency' brain (limbic system) and to activate the thinking brain (prefrontal cortex) (Courtois & Ford,2016). Although CBT has proven highly successful for PTSD it has been questioned for the use of cPTSD with co-morbid Axis I and Axis II disorders (Korn,2009), However, successful treatment has been reported for complex cases with CBT, yet the clients did not have a cPTSD diagnosis. PTSD symptoms were reduced yet poorer end state functioning was recorded in clients who had co-morbid personality disorders, therefore it appears CBT can be beneficial yet is not an ideal treatment for cPTSD.

Empirically validated models such as Linehan's Dialectal Behaviour Therapy (DBT) model (Linehan, Tutek, Heard, & Armstrong, 1994), have successfully addressed co-morbid issues of BPD. Reducing trauma related dysregulation, improving functioning and further preparation for trauma processing (Korn,2009). Cloitres Skills Training in Affect and Interpersonal Training (STAIR) has been recommended as a model that *"integrates all that we have come to understand about the unique needs of individuals with complex PTSD and/or post traumatic dysregulation"* (Korn,2009). Van de kolk identifies emotional regulation as key for treating BPD (Van de Kolk, 2013), these approaches are aimed at tackling the maladaptive defences so clients can increase affect tolerance without becoming overwhelmed. A number of trials examining the use of EMDR and Resource Development Installation (RDI) in phase one treatment of cPTSD with a co-morbid diagnosis of BPD recorded significant changes to negative self statement, self injurious behaviour and angry outbursts (Korn,2009). This indicates the importance of phase one treatment

prior to trauma processing as increasing personal resources appears to interrupt negative behaviour patterns and reduces affective and cognitive distress.

**Phase two : Trauma processing (focused processing of traumatic memories)**

Evidence based treatments such as PE therapy and trauma focused CBT have been recommended by NICE guidelines for the second phase of treatment, however, there is not one treatment recommended over another for cPTSD. The most accepted therapies for treating ptsd are CBT, CPT, PE and EMDR (Friedman et al,2007). Each of these processes are aimed at restructuring the maladaptive cognitions, emotions and behaviours, and reducing symptoms connected to the traumatic experience on a physiological level (Matto, Gotzman, Ballan, 2014). CBT, CPT and PE have a similar approach, functioning from a top down process (driven by the neocortex), yet PE has an extra component of exposing the client to the stimulant. EMDR phases, relative to processing, are phase 3 through to 8 (Shapiro,2001), reprocessing trauma at the neurophysiological level by focusing on both executive functioning and the limbic system (Shapiro,2001).

PE focuses on a full traumatic memory during an imaginal exposure (Hall,2016), the therapist works with the client focusing on one or two “hot spots’ which have particular meaning to the client and is based on the expressed affect during the imaginal exposure (Foa, Hembree,Rothbaum,2007, cited in Hall,2016). Repeating the hot spots until the end of the process when the traumatic memory is reviewed, the aim of repetition is to create a faster processing of the trauma memory. The learning model demonstrates how habituation or anxiety reduction when a client remains in a fear provoking situation is one method for achieving symptom reduction in PE. Hall highlights how PE possesses a strong efficacy in treating a variety of traumatic experiences (Hall,2016) and further notes a study by Rothbaum (Rothbaum et al 2005), on women who had been sexualy assaulted, that demonstrated

that the victims responded significantly to PE and EMDR treatment. However, people treated with PE demonstrated superior results 6 months after the treatment concluded (Hall,2016).

Another study investigating PE and complex trauma, by Van Minnen et al. (Van Minnen et al, 2002) found that clients showed positive improvement from PE after having been exposed to childhood abuse or adult trauma. McDonagh (McDonagh et al 2005) found that for women who had PTSD from childhood sexual abuse, who received PE and Cognitive Processing Therapy (CPT), were more likely to no longer meet PTSD criteria than those who received person centred therapy (PCT). However, combining PE, CPT, and PCT was found to be more effective (Morkved et al 2014).

Although PE has been found effective in cPTSD, IRRT is a model designed specifically for sexual abuse victims. IRRT aims to reduce PTSD symptoms and traumagenic schemas of survivors of sexual abuse (Smucker, Foa, dance, niederre 1995). "*To achieve this it combines* i*maginal exposure, mastery imagery, self nurturing imagery and cognitive reprocessing, which are designed to go beyond extinction models in order to alter recurring traumatic images, create adaptive schemas and enhance the clients capacity for self nurturance"* (Hall,2016). Each of these phases needs to occur for successful emotional processing (Hall,2016). This bottom up process incorporates socratic questioning during the imagery rescripting, which helps the client to identify, challenge and modify maladaptive beliefs tied to the trauma while empowering them to take mastery of the imagery (Smucker, Foa, dance, niederre 1995 ). Unlike PE, imagery rescripting employs imaginal exposure "not for habituation, but for activating the images, emotions, and beliefs associated with the traumatic memories" (Hall,2016). This difference may be more appropriate for adult survivors of child abuse with PTSD who are unable or unwilling to process their childhood traumas through intensive prolonged imaginal exposure (Smucker, Grunert, & Weis, 2003). Rescripting helps change the traumatic memory with an emphasis on positive, corrective cognitive

changes to previous negative secondary beliefs and pathogenic schemas (Grunert et al.; Smucker & Niederee, 1995). Therefore, it would appear that IRRT in the treatment of childhood sexual abuse could be far more beneficial than a Prolonged Exposure.

- **Phase three : Reintegration (re - establishing social and cultural connection and addressing personal quality of life)**

Phase 3 focuses on increasing self esteem, self respect and increasing healthy connections and exploring and integrating ones sense of identity (Korn,2009). This phase is as important as the other two and gives opportunity to re-evaluate current triggers and anticipatory fears towards change (Courtois & Ford, 2016), role playing to address problem solving has been recommended (Korn, 2009). Success of the phases is measured throughout he client having the ability to effectively cope with previous triggers and move towards the desired goals of everyday life (Courtois & Ford, 2016).

**Pharmacology**

Some clients who are unable or not ready to engage in a therapeutic process may be prescribed specific medication to help reduce the symptoms. Typically these demographics have been defined by the UKPTS as

- Adult sufferers who prefer not to engage in a trauma
- focused psychological treatment
- Adults who cannot start a psychological treatment because of serious ongoing threat of further trauma (ongoing domestic violence)
- Adults who have gained little or no benefit from a trauma focused psychological treatment.

In the UK there are currently only two licensed drugs for treating PTSD, these are paroxetine and sertraline (UKPTS 2016). NICE guidelines recommends that drug treatments for PTSD should not

be used prior to trauma focused therapy (NICE 2016), yet should be used in conjunction with psychological therapy for adults who suffer with severe co-morbidities such as depression or hyper - arousal or where it is severe enough to interfere with a therapeutic treatment approach (PTSUK 2016). Brier & Scott note a number of difficulties with medication, such as trauma victims who often struggle to remember to take medication (Brier, Scott,2015). Medication can increase anxiety, fear of sleep loss and benzodiazapines may interfere with the psychological processing of traumatic memories (Brier & Scott,2015).

## Conclusion

Treating cPTSD with a phased approach, utilising adapted PTSD models and having good clinical judgement demonstrates that positive outcomes can be achieved. However, it does appear that the onus is on phase one in order for phase two to be successfully achieved and, whilst not fixed, time scales do change depending upon the client. Earlier I mentioned that the phased approach is not linear, therefore it is possible to run phase 1 and phase 2 concurrently, however excellent clinical judgement would be needed to manage this safely. It is also evident that although CBT has its place in treatment it is not entirely effective for cPTSD, yet a trauma focused approach is recommended and PE therapy, IRRT, CPT have all been referred to in different trials as successful, however a combined treatment approach has also proven effective and again good clinical judgement is needed to assess which processing models are appropriate and which ones inspire the most post traumatic growth. Medication is available for PTSD and evidence demonstrates the benefits of some drugs, yet it is clear that medication does not cure PTSD or cPTSD and a phased approach of therapy is recommended (UKPTS 2016). Therefore medication may be beneficial to prepare the client for trauma focused treatment yet is not always necessary. The studies of PE, EMDR and IRRT demonstrate that applying a top down and bottom up process addresses the different symptoms related to cognitions, emotional and sensorimotor elements of

cPTSD, therefore it requires a proper analysis and treatment plan to ensure the needs of the client are met in line with their symptoms.

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