Moving Forward: New frontiers in treatments for psychological trauma

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Historically, the positioning of trauma as an entity was the start of a new kind of conceptualisation within mental health, termed the 'trauma-focused turn' (Kerr, 2015). The diagnostic category of 'Post Traumatic Stress Disorder' (PTSD) as a medical condition was first included in the third edition of American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980 (Lasiuk and Hegadoren, 2006). The inclusion of PTSD as a new discrete category in the DSM-III effectually placed it on the map as an "official medical psychiatric reality" (Scott, 1990, p. 294). Currently in its fifth edition, the DSM, and its counterpart the International Classification of Diseases (ICD), now in its eleventh version (ICD-11), both firmly embed PTSD (and complex PTSD in the ICD-11) within the category of a mental health disorder. Although not without their critics, these volumes represent the product of a substantial amount of consultation, and provide the foundation for thousands of medical assessment decisions as well as the basis for many empirical research initiatives.

Whilst these classification instruments offer specified criteria by which a person may or may not fall within the parameters of a PTSD, or complex PTSD diagnosis, they do not go so far as to offer guidance for treatment. Different organising bodies in different countries undertake the task of recommending evidence-based treatment options. For example, in the UK, the National Institute for Health and Care Excellence (NICE) recommends individual "trauma-focused CBT" for both adults (NICE, 2018, 1.6.17) and children (NICE, 2018, 1.6.12) suffering from PTSD or 'clinically important' symptoms of PTSD. These CBT interventions include, cognitive processing therapy, cognitive therapy for PTSD, narrative exposure therapy, and prolonged exposure therapy (NICE, 2018). The only other treatment

recommendation, which is advised for “non-combat-related-trauma” (NICE, 2018, 1.6.19) is Eye Movement Desensitisation and Reprocessing (EMDR). Similarly, in the US the current primary recommended evidence-based treatments for PTSD from the American Psychological Society are CBT, cognitive processing therapy (CPT), cognitive therapy (CT), and prolonged exposure therapy (PE); with EMDR, narrative exposure therapy (NET) and brief eclectic psychotherapy (BEP) as secondary options (APA, 2017).

In terms of the evidence for the efficacy of these recommended treatments, meta-analysis indicates improvements for most clients who complete either CBT or EMDR treatment (Bradley, Greene, Russ, Dutra and Westen, 2005). However, even for those who experience improvements, they continue to experience substantial residual symptoms post treatment (ibid). For military populations where CPT and PE have been the primary interventions, a meta-analysis of randomised controlled trials indicated that although clients experienced improvements in their symptoms, post-treatment outcome measures scores were often still at or above clinical criteria for PTSD (Steenkamp, Litz, Hoge and Marmar, 2015). So, one question that remains is, whether it is possible to find alternative treatments that may have longer lasting and more thorough positive outcomes for PTSD clients.

Additionally, a further concern raised about the generalisability of the currently recommended cognitive-based treatment options is their reduced effectiveness for those who are polysymptomatic. A clinical challenge is that co-morbidity of other conditions is more “the rule rather than the exception in PTSD” (Bradley, Greene, Russ, Dutra and Westen, 2005, p.214). In many cases where limitations to these

cognitive based approaches have been identified, adaptations have necessarily been made, especially when being used with certain groups of clients such as those with comorbid conditions (Conrod and Stewart, 2005), or intellectual disability (Taylor, Lindsay and Willner, 2008). This points to the possibility that current treatment options may be adapted for specific client groups. However there is also a growing body of evidence to suggest the efficacy of some alternative approaches as viable options alongside the currently advised treatments, especially for clients with co-morbidity or other potential 'exclusion' characteristics.

This special section of *Counselling and Psychotherapy Research* is in the enviable position of being able to showcase some of these cutting edge approaches to working with psychological trauma. The first paper by Kip and Finnegan introduces a therapeutic approach called Accelerated Resolution Therapy (ART), a brief intervention protocol that is showing promising early results, particularly with military veterans suffering from PTSD and co-morbid traumatic brain injury (TBI). This approach may particularly spark interest in its prospects, as individuals with TBI generally receive a poorer prognosis regarding PTSD recovery than those without a TBI (Vanderploeg, Belanger and Curtiss, 2009). Although there is some evidence for PTSD symptom reduction in military veterans with co-morbid TBI in residential settings engaging in cognitive–behavioural therapy (Chard, Schumm, McIlvain, Bailey and Parkinson, 2011), residential programmes tend to be very resource intensive. Thus, the potential for an alternative community-based brief intervention may have considerable social and economic advantages.

The second paper by psychiatrists Frank Corrigan and Alistair Hull, considers how the Comprehensive Resource Model (CRM) may prove to be particularly valuable for the treatment of complex post-traumatic stress disorder (CPTSD). They suggest that the unique aspect of this treatment that may differ from other approaches is that it also works with the more pervasive and persistent impairments in relational and emotional functioning that distinguish CPTSD. According to the new ICD-11, these additional criteria fall under the heading of 'disturbances in self-organization', and include affective dysregulation, negative self-concept, and disturbances in relationships (Maercker et al., 2018). Additionally, Corrigan and Hull present a compelling rationale as to why there is a clinical need in relation to treatment, to differentiate PTSD clients who are diagnosed the dissociative subtype of PTSD (in DSM 5) from those who have PTSD without dissociation. Previous research indicates that PTSD treatments that centre on re-exposure may actually be contra-indicated for clients with dissociative disorders (Chu et al., 2011).

Interestingly, both ART and CRM utilise within their protocol elements of bi-lateral stimulation. Bi-lateral stimulation initially via eye movement and more latterly via auditory or tactile mechanisms, have been a key component of EMDR (Shapiro, 1994). Apart from its primary use in EMDR, the adjunctive use of bilateral audio has also been utilised as a way to enhance PTSD work in other therapeutic approaches such as art therapy (Tripp, 2007). It has been suggested that alternating bilateral activation of the right and left hemispheres increases their functional connectivity (Nieuwenhuis et al., 2013), and in so doing can reduce the vividness of negative memories (Van den Hout et al., 2011), and reintegrate information (Herkt et al., 2014). Research into this 'adjunctive' use of bilateral stimulation in other kinds of therapy is still in its early stages, as is research into the differentiation of the effective

components of therapies that, like ART and CRM, have bilateral stimulation as integral to their practice.

Our third paper in this special section investigated the important area of working in groups with those who have experienced trauma. In particular, this sequential mixed methods design by Brochmann et al. based in Denmark raises some valuable questions about working with groups of refugees, many of whom have experienced multiple traumas. This study does not aim to identify which kinds of therapeutic interventions may be more or less effective in working with refugees, due to the heterogeneity of experiences and cultural perspectives of different groups. However, it does contribute some valuable learning points about general principles of group work with particular awareness of cultural sensitivity when working with people who have experienced multiple traumas.

One of the key issues that Brochmann et al. highlight is the essentialness in groups of creating a sense of safety as a basic starting point. Creating a felt sense of safety for traumatised clients is often considered to be a pre-requisite to engaging in the specific 'trauma processing' elements of a therapeutic intervention, and has been one of the foundational premises for working both individually and in groups with clients. The key components identified by Brochmann et al. for creating a safe environment were to ensure a degree of *predictability*, such as by providing suitable information and establishing agreed group rules, being transparent about the boundaries of *confidentiality*, and structuring clear *expectations* that specific trauma narratives would not be addressed. Typically, a phased approach to working with complex PTSD is recommended (Cloitre et al., 2011), which initially focuses on supporting

affect regulation, management of dissociation through grounding and stabilisation, and enhancing a sense of safety (Bisson, Cosgrove, Lewis and Roberts, 2015). This stabilisation phase is considered a necessary pre-curser to the "arduous challenges of integrating traumatic memories" (van der Hart, 2012, p.8459), which typically involves the 'processing' of trauma memories more directly. Notably, in the group work discussed by Brochmann et al., the specific work of trauma processing was considered to be best addressed in conjunctive individual therapy. One of the things that perhaps marks out CRM from this traditional 'phased' approach, is that developing safety, stabilisation and resourcing are considered integral to the model itself, with these being intertwined throughout therapy (Schwarz et al, 2016). Certainly, it is crucial when working with clients with PTSD, who by definition were *not safe* peri-traumatically, to carefully consider the variety of ways in whichever therapeutic approach is being used, that client safety (both objectively and subjectively) can be achieved.

In terms of our impetus towards *moving forward* in tailoring treatments for sufferers of PTSD, the papers showcased here offer us an extremely helpful starting point for considering how we might support different sub-populations. For those with comorbid PTSD and TBI, who have experienced multiple traumas, the use of ART may be a potentially economically viable and effective brief intervention that does not rely as heavily on cognitive processing as CBT approaches. Given the unfortunate increase in both natural and man-made disasters that affect trauma upon large groups of people, considerations about how to work sensitively and safely with these groups is also most welcome. For individuals who have CPTSD or PTSD with dissociation, there holds great promise for the emerging utility of CRM as a treatment modality that can

accommodate the complexities that are inherent to working with this client group. In all of these ways, it is exciting to be involved in exploring new frontiers in treatments for psychological trauma.

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