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RESEARCH ARTICLE

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When one tool is not enough: An integrative psychotherapeutic approach to treating complex PTSD

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Abstract

Complex posttraumatic stress disorder (CPTSD) is a term representing the psychopathological implications of exposure to chronic, inter-personal trauma. These include the main symptoms of PTSD, as well as changes in identity, emotion regulation, and inter-personal relationships. Self-harm and dissociation (i.e., disintegration of mental processes) are also quite common in CPTSD. Considering this complex and often severe clinical picture, mental health professionals often find it difficult to effectively treat CPTSD. In this paper, we present an integrative approach to the treatment of CPTSD based on a combination of techniques from several psychotherapy approaches. The case described here illustrates the need for therapeutic flexibility and eclecticism when treating individuals exposed to chronic trauma. We show the advantages of flexible therapeutic attunement, which enables the therapist to respond to the changing need of the patient, as well as her fluid clinical picture and symptom manifestation. The case also illustrates how interventions taken from psychodynamic therapy, Dialectical behavior therapy, and Eye Movement Desensitization and Reprocessing may be applicable in

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various stages of treatment, alleviating the patient's distress in several psychological and physical domains.

KEYWORDS
case study, complex PTSD, psychotherapy integration, trauma

1 | INTRODUCTION

Complex trauma refers to traumatic experiences that occur on a chronic, continuous basis. As opposed to single-event traumas (e.g., motor vehicle accidents, terror attacks), complex traumatic experiences are mostly continuous experiences, that very often have a clear interpersonal nature (Bryant, 2010; Lewis-Herman, 1992). In many of these experiences, one individual exerts coercion or control over another, and power dynamics are highly apparent. The relationship between aggressor and victim is usually very complex, and may contain seemingly paradoxical characteristics, including mixed emotions such as love and hate, as well as complicated forms of identification (Lahav et al., 2022; Lahav et al., under review; Van Nieuwenhove & Meganck, 2019). In addition, the complex and chronic nature of this type of trauma exposure often yields symptoms that go beyond the core clusters of posttraumatic stress disorder (PTSD; reexperiencing, avoidance, hyperarousal, negative affect, and cognitions) to include "disturbances in self-organization" manifested in (1) severely dysregulated affect, (2) identity disturbance, and even fragmentation, and (3) a wide variety of changes in interpersonal relations (Cloitre, 2021). While complex PTSD (CPTSD) has not yet entered the Diagnostic and Statistical Manual of Mental Disorders (DSM), it was included as a formal diagnosis for the first time in the 11th and most recent edition of the International Statistical Classification of Diseases and Related Health Problems (ICD-11; World Health Organization, 2019).

1.1 | Treating CPTSD: a professional challenge

The treatment of CPTSD poses a significant challenge to therapists. The sheer breadth and severity of symptoms often impedes recovery, and requires not only patience, but also creativity and flexibility on the part of the therapist. For years, the clinical literature focusing on complex trauma was mostly psychoanalytic (e.g., Davies & Frawley, 1992), examining the unique transference-countertransference dynamics that tend to characterize psychotherapy with survivors of childhood trauma and abuse. Over the years, however, the variety of interventions in this field significantly increased, and several interventions were developed to specifically treat survivors of chronic trauma. These interventions are based on various schools of thought (CBT, third wave psychotherapies, somatic techniques) and arguably target different underlying mechanisms of the disorder.

For example, Skills Training in Affective and Interpersonal Regulation is an approach focusing on emotion regulation in interpersonal contexts (Cloitre & Schmidt, 2015). It has been studied in the context of CPTSD, with positive results (e.g., MacIntosh et al., 2018). Other interventions have found interesting ways to borrow from established PTSD therapies while adapting those to CPTSD. These include specific applications of Eye Movement Desensitization and Reprocessing (EMDR; de Jongh et al., 2019) and Prolonged Exposure (PE; Hendriks et al., 2017) for CPTSD patients. Finally, other interventions, such as Dialectical behavior therapy (DBT), which were primarily developed for personality disorders (e.g., Bohus & Priebe, 2018), were also found beneficial for difficulties associated with CPTSD. As a result, a field that was predominantly psychoanalytically driven, is now more pluralistic and varied than ever.

A question does remain, though: are those approaches solely meant to be practiced as standalone therapies, or can (and should) they be combined to align with the complicated reality of CPTSD treatment?

2 | CPTSD TREATMENT AS AN INTEGRATIVE PSYCHOTHERAPEUTIC EFFORT

The notion of "integrative psychotherapy" has been receiving gradual attention in recent decades (Zarbo et al., 2016). As knowledge about psychopathology, on one hand, and psychotherapy, on the other hand, has been massively increasing, the necessity of therapeutic combinations began to be acknowledged.

There are several notable models of integrative psychotherapy (Eubanks et al., 2019). Some have defined integration as the craft of combining techniques from several treatment approaches to meet the dynamic and changing needs of the patient (see case study in this paper). Others, however, have emphasized the craft of blending several approaches into one new gestalt, that is, an intervention that draws elements from several therapeutic domains. Other definitions of integration also exist, differing in their emphasis on content, technique, and process (Ziv-Beiman & Shahar, 2014).

The notion of integrative therapy in the general field of trauma has become increasingly popular. Bomyea and Lang (2012), for example, argue in favor of combining evidence-based approaches for the treatment of PTSD, to improve outcomes. Others have argued for integration as a guiding principle in trauma treatment that affects assessment, diagnosis, and case formulation (Zilberstein, 2022). According to this principle, our understanding of trauma and its effects needs to take into account a variety of factors, from both the pre- and posttraumatic period (e.g., personality, previous traumatic events, coping mechanisms). These, in turn, can also serve as important therapeutic targets. An integrative approach was also deemed important for rehabilitative processes that require clinicians to adopt a broad, community-based approach to trauma recovery (Kagan & Spinazzola, 2013).

A good starting point from which one may view psychotherapy integration in the context of complex trauma is the International Society for Traumatic Stress Studies (ISTSS) Expert Consensus Treatment Guidelines for CPTSD (Cloitre et al., 2012). In the report, the ISTSS has clearly outlined a "phase-based approach" to CPTSD treatment. The three phases of treatment (ensuring safety, work on traumatic memory, and consolidation of treatment gains) form an inherently integrative framework for intervention. The integrative nature of these phases stems from the fact that they serve as a broad psychotherapeutic infrastructure on which several different approaches can work.

Further examples for the integration of therapies for individuals with a history of trauma (while not necessarily a CPTSD diagnosis) may be seen in unique combinations of otherwise separate therapy modules. Notable examples are the adaptation of DBT to treat posttraumatic symptoms (Bohus et al., 2020), as well as the successful combination of DBT and PE for the treatment of PTSD (Harned, 2022), which has been found to be effective in reducing PTSD symptoms, anxiety and depression symptoms, suicidal ideation, and dissociation (Harned et al., 2012).

In what follows, we will describe a CPTSD case in which various therapeutic techniques were combined to carefully adapt therapy to the patient's needs and presenting symptoms. As will be seen, the case presented here represents an eclectic form of therapy integration, namely an intervention that combined techniques rooted in varied therapies (psychoanalytic, DBT, EMDR). Furthermore, CPTSD therapy here did not originate from a specific *predetermined* model of therapy integration but rather followed a bottom-up, ever-evolving route of therapy, in which established techniques were applied at various junctions and stages of treatment.

3 | CASE ILLUSTRATION[1]

3.1 | Presenting problem and client description

Sharon was a talented medical student in her early 30 s. She was living alone in a one-bedroom apartment and was working a part-time job as a private tutor. Sharon sought therapy to treat her difficulties in forming intimate relationships. In the preceding 10 years, she dated several men but has not been able to form a significant romantic

partnership. She described feelings of disgust and aversion toward men, which, in her words, "pushed her away" and rejected her. Although these feelings arose in specific situations, Sharon found it hard to describe or explain them in therapy. She often struggled to find words for her emotions, instead describing a broad, distressing feeling of alienation, loneliness, and unworthiness.

Looking back at her past, Sharon described herself as a sad and lonely child. She was, in her words, "the black sheep" of the family, subjected to continuous insults, humiliation, and rejection by her parents and two younger sisters. While she succeeded in her academic work, she had substantial difficulties in the social realm and was bullied for long periods of time, from elementary school to high school.

Sharon also mentioned what she viewed as a "weird" relationship with an older cousin during her childhood and a feeling that something "wrong" had occurred between them. When the therapist asked her what she meant, she added that she sought treatment from the therapist, knowing her specialization in treating abuse survivors and that she may have experienced one, although she has no clear recollection of it. This was a vague and unclear feeling she described, with a blurred line between knowing and not knowing what had happened. The therapist nonetheless felt a strong traumatic presence in session, and was attuned to the undercurrents of posttraumatic feelings and cognitions. She felt deep sorrow and helplessness and had an image of Sharon as a fearful and defenseless child who cannot escape nor ask for help.

In therapy, Sharon often reported substantial fluctuations in her mood and functioning. At work and at school, she excelled, felt satisfied and stable, and viewed herself in a positive manner, being a competent and ambitious person. Yet, when she was alone, particularly during weekends, she was extremely depressed and anxious. At those moments, she viewed herself as weird, rejected, and unlovable. She blamed herself for her difficulties and for "what may have happened" with her cousin. She felt "ugly and physically gross," had suicidal thoughts (without a concrete plan for execution), and engaged in self-injurious behaviors (cutting, burning cigarettes in various body areas). Those were difficult, tormenting days, where she simply felt unable to tolerate her distress.

3.2 | The therapist

The therapist is female and in her forties. She is a licensed clinical psychologist and has been practicing psychotherapy for 20 years. She has extensive training in psychodynamic psychotherapy, but over the years, she had also extensively studied a variety of trauma-focused treatment methods, including somatic experiencing, DBT, and EMDR.

3.3 | Case formulation

From the very early stages of therapy, it became clear to the therapist that Sharon's personality, experiences, and presenting symptoms would require a highly flexible and broad therapeutic toolbox. This was strongly felt through the therapist's experience (i.e., her counter-transference reactions), as she found herself very naturally employing several parallel modes of listening to the patient. First, the therapist was very attentive to information related to Sharon's early, introjected object relations and childhood history, and their implications. Thus, she clearly noticed Sharon's difficulties to reflect on her mental states and find words for her feelings toward men (i.e., impairment in mentalization), her feelings of knowing-and-not knowing what had happened with her cousin (i.e., dissociative memory), as well as the disconnected opposite views of herself (i.e., dissociative self-states). At the same time, the therapist found great interest in Sharon's presenting symptoms and overt distress. Those were very hard to miss, as they frequently appeared not only in Sharon's life, but also in session. Thus, integration was already present at the onset of treatment—if not already in therapeutic technique, then in case formulation and conceptualization, as well as in the therapist's emerging, intuitive treatment plan.

In terms of urgency, the first therapeutic goal was reducing suicidal thoughts and self-injurious behaviors, as well as depressive episodes and their intensity. The second treatment goal was reducing potential obstacles that could hinder the treatment. One of those obstacles was the possibility that Sharon will feel detached from her difficulties and therefore feel the urge to drop out of therapy—an experience that she had in the past. Lastly, additional treatment goals included strengthening her self-esteem and improving her ability to form intimate relationships.

3.4 | Course of treatment

In line with the abovementioned "phase-based approach," keeping Sharon safe and secure was initially a top priority for the therapist. To promote stabilization and to reduce her suicidal thoughts and self-injurious behaviors, several elements of DBT were applied in Sharon's treatment. Specifically, a contract was established, and treatment goals were presented based on a hierarchical ranking. DBT was selected as it very directly targets emotion regulation, as well as the enhancement of reflective functions—both of which were thought to be highly relevant for Sharon.

The first year of treatment focused on monitoring Sharon's suicidal thoughts and self-injurious behaviors (by recording on report sheets) while utilizing chain analysis and functional analysis, as well as putting a strong emphasis on validating Sharon's experience. Chain analysis is a technique designed to help one understand the function of a particular behavior. During a chain analysis of a particular problem behavior (in Sharon's case, suicidality and self-injurious behaviors), the patient attempts to uncover all the factors that have led to that behavior. In addition, behaviors can serve multiple functions. Thus, it was useful for Sharon to try and understand all the functions suicidal ideation and self-injurious behaviors had served for her and to practice with the therapist the process of reflecting on her mental states, that is, her feelings, thoughts, and urges that accompanied her suicidal ideation and self-injurious behaviors. This allowed Sharon to identify events that gave rise to her difficulties and to better understand her "weekend distress." Additionally, the consistent validation provided by the therapist enabled Sharon to decrease her judgmental attitude toward herself, to self-validate, and to develop a growing feeling of trust in her therapist. Sharon came to realize that her suicidal thoughts and self-injurious behaviors did not appear "out of the blue," but rather reflected her maladaptive efforts to regulate feelings of sadness and loneliness that she found unbearable. To enable Sharon to better cope with her emotional distress, several DBT strategies (e.g., self-soothing, improving the moment) were taught during therapy. After 14 months, Sharon was stabilized, and the frequency and intensity of her suicidal ideation and self-injurious behaviors were low, although she still suffered from distress during weekends, and her feelings of loneliness even intensified.

At this phase of treatment, the therapist began to notice that Sharon was describing her difficulties in an increasingly detached and dissociated manner, as if they have happened to someone else, and not herself. At that point, the therapist felt as if another therapeutic chapter had opened, this time focusing on dissociation (i.e., disintegration of mental processes) and its various manifestations in Sharon's world. This went hand in hand with the therapist's emotional experience (i.e., her countertransference reaction), characterized by feelings of detachment and sometimes even indifference toward Sharon's "weekend distress," sometimes viewing her complaints as self-indulgent, fake, or surreal. While reflecting on her emotions, the therapist began to understand them as mirroring Sharon's own experience and was thus able to utilize them in therapy.

Subsequently, the therapist found ways to share parts of this experience with Sharon. She shared with her an Interpretation according to which her (the therapist's) reaction reflected Sharon's difficulty in integrating two dissociated self-states, as well as the way in which Sharon's mother used to invalidate, ridicule, and even blame Sharon for her needs and feelings. Sharon reacted to the therapist's words with great relief. She felt that the therapist's honesty enabled her to deepen her trust, and to bring to the forefront other parts, which were not part of therapy up to that point. These included the emotional abuse that she experienced during her childhood, and her

self-state that adopted her mother's view of herself as worthless and blameworthy. Sharon began to share her painful feeling during the weekends and, for the first time, her craving for a relationship.

At this point, it was interesting for the therapist to see how the combination of interventions yielded a window for the appearance of traumatic memories, which were mostly undisclosed before. For example, during one of the therapy sessions, Sharon shared a particularly painful memory from elementary school: 1 day, she came back home from school, feeling very upset after having a fight with her best friend. While sitting around the dinner table, next to her younger sister and her mother, she started crying. Her mother looked at her with contempt: "You are a whiny baby, a whiny spoiled baby! You will do anything to get attention!," she shouted at Sharon. Sharon tried to stop but failed to do so. While continuing to cry, she remembered hearing her mother yelling and her sister imitating her and laughing. At these moments, Sharon felt tremendous shame, and thought to herself that her mother was right—she is weak and manipulative; she does not deserve to feel loved. While describing this memory to the therapist, Sharon started crying, saying "I am crying not only over the shame and insult that she (mother) inflicted on me, but over the shame that I have inflicted on myself as well…I believed her!."

It was around that time, after almost 2 years, that Sharon started dating Or, a fellow student from the college. He was very different from other men that she used to date, as he was, in her words, "kind, stable, and warm." Or courted Sharon for more than a year and established a close friendship with her before they started dating. For the first time, Sharon was hopeful about the possibility that she would be part of a healthy and long-lasting relationship. Two months into their dating period, a dramatic change occurred. Sharon came to therapy feeling very distressed, saying that she cannot be with Or anymore, nor can she ever date other men. When the therapist asked her about what had happened, Sharon said that she does not really know, but can only say that she was disgusted of Or the last time they met and cannot bring herself to meet him. Although feelings of disgust were familiar to Sharon from previous interactions with men, she could not further explain them or describe associated emotions or thoughts. Her disgust was "in her body" and felt like "Something suffocating and heavy in the throat that makes you want to vomit."

In the subsequent period, Sharon began to avoid Or and reduce her level of contact with him. However, in light of what was discussed and processed in therapy, she decided to wait and not break up with him until the experience of disgust became clearer. Meanwhile, self-validation and distress tolerance DBT strategies were used to better cope with her feelings of disgust. During several sessions, the therapist invited Sharon to observe her experience of disgust, to try and connect it to something that happened with Or, or to come up with any other explanation. However, this attempt was mostly futile. It seemed that Sharon's experience of disgust, which caused great distress, was coded in a primary sensory-bodily language and served as a voice for a difficult, disconnected, inaccessible, and unprocessed experience. At this stage, the therapist suggested processing the experience of disgust using EMDR. Sharon described an image that represented for her the first time she experienced a similar feeling of disgust: *her mother forcibly kisses her, not because she really loves her, but because they are at a family event, and it is necessary to show that everything is fine. Mother's empty mouth rejects Sharon, she feels the suffocation in her throat and the need to vomit*. In therapy, her level of distress related to the image was high (SUD = 7 out of 10), and the negative self-belief attached to it was "I am weak."

With repeated bilateral stimulation, Sharon's bodily reactions intensified. Now she felt that she had no air, and that her hands were heavy. She free-associated about a doll lying motionless. Then, a thought arose: could she refuse her mother's kiss? was it her fault that she did nothing about it? The image of mother was slowly replaced by other events in which Sharon felt she had no control: moments at the dentist's, who opened her mouth using force; a fight with her sister during which she laid Sharon on her back; and, finally, a "too close" image of her cousin's face as he leaned over her. This last image recurred and accompanied the EMDR sessions from then on, with Sharon's distress intensifying. Now her disgust was replaced by fear and helplessness, and she described a feeling of paralysis in her hands, as well as being cold. The therapist soothed Sharon and encouraged her to continue the bilateral stimulation.

Gradually, the threatening picture changed. It became blurry, and Sharon watched it from afar, from the perspective of her adult self. She could feel empathy for herself in the picture, and a positive self-belief arose—"I can choose whom I want to be close to. I am free." Next, the memory of the triggering situation with Or arose (he leaned up in surprise in the morning and kissed her), but now Sharon interpreted it differently, as a moment of intimacy rather than of threat. At the end of the EMDR sessions Sharon reported low distress (SUD = 1; "I do not want to not feel distress at all. This level helps me acknowledge what had happened to me") and felt hopeful regarding her ability to reconnect with Or. It was this final aspect of therapy—getting in touch with her body and senses—that added a much-needed relief.

3.5 | Outcome and prognosis

After 18 months of therapy, Sharon presented a remission in "disturbances in self-organization" symptoms (Cloitre, 2021). These symptoms refer to a wide range of emotional and cognitive symptoms, that together represent the patient's instability. Thus, Sharon was now much more stabilized, and her ability to reflect on her feelings and to express them verbally, as well as her emotion regulation capacities, improved. She also no longer presented fluctuations in mood and functioning, nor did she report any suicidal thoughts or self-injurious behaviors. Sharon exhibited a growing level of identity integration. Self-states, which were previously disconnected (i.e., viewing herself as competent and high achieving vs. weird, rejected, and unlovable), have become more integrated, and Sharon could emotionally connect with and validate her painful traumatic past. The strong therapeutic alliance formed with the therapist alongside reprocessing of Sharon's traumatic experiences, have led to enhancement in her interpersonal abilities. Now, Sharon did not relive her past abusive interactions within her current relationships, and could form a healthy intimate connection with Or.

4 | CLINICAL PRACTICES AND SUMMARY

Sharon's case illustrates the inherent complexity of CPTSD therapy. In what she brought to therapy, one may find the major components of complex trauma: problems in inter-personal relationships and severed object relations, dissociation, difficulties in identity integration, and unique bodily and sensory experiences. Considering this wide and dynamic clinical presentation, therapists are often in need of a particularly large and flexible toolbox. Focusing on only one line of treatment may simply be insufficient in such cases, and may significantly limit the therapist's ability to accurately respond to the changing needs and symptomatic manifestations of the patient.

It was Wilford Bion (1967) who, several decades ago, spoke of a particular kind of therapeutic attention, which is sensitive to the natural development of therapy. In his words: "*…The evolving session is unmistakable, and the intuiting of it does not deteriorate. If given a chance, it starts early and decays late.*" While these famous words are often taken to represent psychoanalytic thinking, we would like to argue that they are relevant to any mode of therapy related to complex psychopathology. Trauma therapy has developed in such a way that it now offers us a myriad of techniques, representing vastly different domains. The integration of these techniques in a thoughtful, clinically valid way, poses a considerable challenge to CPTSD therapists. The combination of distinct modes of therapy is by no means an easy task (Safran & Messer, 1997). If not conducted wisely, it may arguably compromise the coherence and effectiveness of therapy. Further risks may include the patient's confusion over the aims of therapy, as well as insufficient work on certain important aspects of distress. Nonetheless, as we hope could be seen in Sharon's case, the advantages of integration in CPTSD therapy may outweigh the risks, given a sensitive, professional, and theory-driven approach. We hereby call for the development of further integrative treatment approaches, which would take into account the intricate psycho-physiological aspects of CPTSD.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no datasets were generated or analyzed during the current study.

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ENDNOTE

[1] This illustration is based on a mix of several cases. Many details were changed to maintain the patients' privacy.

PEER REVIEW

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