

What we really know about PTSD and trauma focused therapies

Omar Sattaur is shaken out of his comfort zone on attending Ad de Jongh's stimulating take on the treatment of Complex PTSD

Attending Ad de Jongh's workshop in Strasbourg - entitled Making complex trauma simple again - was invigorating and thought provoking. It shook up many assumptions - and at least one axiom - that I had somehow acquired regarding EMDR therapy. De Jongh, who is Professor of Anxiety and Behaviour Disorders at the University of Amsterdam and Honorary Professor in Psychology at the Institute of Health and Society at the University of Worcester, seemed to enjoy this process. Some may think of what he had to say as controversial, but the thoroughness, vigour and enthusiasm with which he presented evidence to back up his claims was infectious and convincing. I came away feeling emboldened to try some of what he advocated and felt confident that I would resume my work with renewed enthusiasm.

p15

► Several pieces of conventional wisdom came under fire:

- Clients with Complex PTSD (CPTSD) should be offered stabilisation prior to any trauma-focused therapy such as EMDR;

- CPTSD clients may well include the dissociative subtype (DS) and this group is unlikely to benefit from trauma-focused therapies;

- Treating CPTSD without prior stabilisation may expose clients to risk of self-harm;

- In the absence of the sense of safety offered by stabilisation, many clients are likely to drop out of therapy;

- Even if safety and compliance are not at issue, adults with CPTSD are

likely to profit more from their therapy if they have had prior stabilisation;

- Clients build trust in their therapists, so it is better that they have the same therapist throughout.

It makes sense perhaps to start with the axiom, which holds that the more severe the trauma, the more the need for stabilisation prior to trauma-focused therapy. De Jongh cited his 2016 paper offering a critical analysis of current treatment guidelines for CPTSD – a review of the existing published evidence and found no support for three of the above contentions: that such clients need stabilisation first; that to do otherwise might present unacceptable risks and that adult CPTSD clients would benefit more from therapy if they have experienced a period of stabilisation.

In a spate of papers all published this year, the Dutch

research group led by De Jongh, brought the remaining three of the above contentions under question, finding no evidence to support them. One of these studies, published online this February (*European Journal of*

Psychotraumatology, 9:1, 1430962, DOI:10.1080/20008198.2018.1430962), compared outcomes of intensive trauma-focused therapy among clients with a history of sexual abuse, either in childhood, adolescence or adulthood. The study, which treated a total of 165 clients, found significant reduction in PTSD symptoms across the board. Importantly, it failed to find any evidence to support the hypothesis that a history of CSA would have a detrimental effect on treatment outcome. Indeed, the clients, who had presented with severe PTSD and a wide range of comorbidities (and so would be categorised as having CPTSD) benefited from the intensive therapy without a stabilisation phase.

Stabilisation unnecessary?

Another study published online in May in the same journal

(*European Journal of Psychotraumatology*, 9:1, 1468707, DOI:10.1080/20008198.2018.1468707).

The research was carried out at the Psychotrauma Expertise Centre (PSYTREC) at Bilthoven in the Netherlands, the HQ of this Dutch research group. The treatment methods employed there are probably as controversial as they are ground-breaking. The Centre runs an intensive eight-day programme for its inpatients beginning each day at 7.30 am and ending at 9.30 pm. Clients attend for two sets of four days within a two-week period. Ninety-minute EMDR or exposure therapy sessions are interspersed with 45-minute-sports sessions and each day ends with a two-hour psychoeducation session. Clients continually see new therapists and, surprising at least to me, they report that they prefer this to having the same therapists



Sport is a big feature of the eight-day programme at PSYTREC

▶ throughout. Dropout is minimal, PTSD symptoms plummet – more than half have lost their diagnosis of PTSD by the end of the week.

Much of the thinking behind this radical approach to treatment of CPTSD seems to rest on the Dutch researchers' allegiance to the working memory model for EMDR efficacy (see

<https://www.youtube.com/watch?v=TlJXYN9bPOg> for a lucid animation explaining this model).

De Jongh says we need three things for efficacy: first, an emotionally charged image; secondly, the client must be within the window of tolerance and thirdly the working memory of the client should be sufficiently taxed.

The limitations of working memory make it difficult to perform more than one task at a time. But clients vary enormously in their capacity to hold material in the working memory and some may need much more than eye movements to compete with their attention to traumatic memory. De Jongh thinks nothing of asking clients to perform a complex tapping pattern, following his fingers and counting all at the same time, if he believes that one task is too 'simple' for them. If the SUDs do not decrease, ensure that the client is in touch with their feelings, at least when the traumatic material is summoned up. If not, they may be avoidant of

affect and the flashforward technique may be most helpful here. Ask what is their worst fear concerning being in touch with the emotions pertinent to the trauma. Then ask the client to construct an imaginary scenario of the most scary fantasy involving the fear, and process as normal. If embarrassment is the block, then the blind to therapist protocol may be helpful.

EMDR models, including the working memory model, came in for some criticism during the conference by another presenter – Jonathan Lee, who has made a career of the study of memory – since it seems to explain only some of what we know EMDR achieves clinically. Whatever its inadequacies, the model has given rise to a research trajectory that is yielding not just plenty of stimulating results but making us question our understanding and practice of this extraordinary therapy.