**Common elements and differences among treatment approaches to complex post traumatic stress disorder: A commentary on five case studies**

***Abstract***

Treating people who have experienced deep and prolonged developmental trauma, i.e., Complex Post Traumatic Stress Disorder (cPTSD), can be challenging given the complexity and severity of their presentations. The main features of Complex Post Traumatic Stress Disorder, i.e., affective and behavioral dysregulation, altered self-experience and identity disturbances, relational difficulties, negative self-concepts, and negative pathogenic beliefs, are, at the same time, therapeutic goals and obstacles to treatment. Therefore, clinicians must be aware of these difficulties in order to identify them and be ready to treat them when they arise during therapy with the same client. For this reason, the clinical cases presented in this issue of the Journal of Clinical Psychology: In Session provide a very useful overview of how to deal with these manifestations from the perspective of different models of psychotherapy. This commentary, after briefly reviewing the clinical features and therapeutic difficulties of these clients, offers a critical summary of the commonalities and differences between the various approaches presented by the clinical cases in this special issue. The purpose is to help the reader navigate the key aspects of treating the pathogenetic processes involved in cPTSD and to identify the different therapeutic tools that may be applicable to the different clinical presentations.

***Introduction***

Treating persons who suffered deep and prolonged developmental traumas, that is complex Post Traumatic Stress Disorder (cPTSD) may be challenging, given the complexity and severity of their presentations. Their symptoms and behavioral manifestations range from anxiety, emotion and behavior dysregulation, in the form of self-harm, impulsivity, aggression, eating disorders and so on; some experience dissociative symptoms and have profound interpersonal dysfunctions for examples they can be mistrustful and paranoid when triggered, feel alone and desperate adopting behaviors that are experience by others as clinging or aggressive responses. When their symptoms are linked to hyperarousal, they live in a state of alarm they cannot understand or control finding extreme challenges to self-soothe in adaptive ways; they often resort to maladaptive strategies including drugs, alcohol abuse, overeating and others. Other times hyperarousal leads to freeze or submission. Other clients feel shut down, flat, empty and devitalized. Some clients alternate between both states. Clinicians need to be aware of these difficulties to identify them and be ready to treat them as they manifest themselves during the therapy with the same client. This is why the case history papers in this issue of the Journal of Clinical Psychology: In Session provide a very useful overview of how to approach these manifestations from the angles of different psychotherapy models.

The common elements between the different approaches presented can help the reader understand the key aspects for treating the pathogenetic processes involved in cPTSD and the differences can help the reader to understand and identify diverse therapeutic tools that can be applicable to different clinical presentations. We hope that understanding both common and unique elements can help clinicians form a clearer picture of how to organize the treatment plan for the clients with cPTSD they will meet in their practice.

Although all the cases in this issue include a description of cPTSD, we start with a summary of what cPTSD is and the main therapeutic challenges it poses.

***Complex trauma and difficult patients: the complication of complex PTSD***

The term complex PTSD was coined by Judith Herman (1992) to indicate a variant of PTSD with multiple psychopathological manifestations, that were no due to single or located in a clearly-defined time as in PTSD, but appeared as the sequelae of prolonged and repeated trauma, especially interpersonal trauma in which the victim is forced to depend on the aggressor. The greater symptomatic complexity of cPTSD has thus been associated with an equally greater complexity of the traumatic experiences that cause it and which result in the victim having to *adapt* to conditions of prolonged and extreme threat (van der Kolk et al., 1996). Such pathological adaptation, not only causes the alteration of certain regulatory systems (vegetative, emotional), but also involves the development of problematic ideas about self and others, as well as dysfunctional coping strategies, as the history filled with violence, abuse and serious neglect did not help that person forming healthier ideas and strategies. Altogether these manifestations have been labeled as *Disturbances of self-organization* (DSO) and consist of (1) affect dysregulation, (2) negative self-concept, and (3) disturbances in relationships (Maercker et al., 2013). Unlike the symptoms of simple PTSD, the triad of DSO appears to emerge from profound personality pathological modifications (Herman, 1992). Indeed, there is ample evidence that complex trauma interferes with and disrupts the healthy physical and psychological development of the victim, especially when it happens early during development, so it can be understood also as early relational trauma or attachment trauma (Ford et al., 2022; Farina & Schimmenti, 2022; Luyten et al., 2020).

Going in to greater details DSO symptoms are characterized by: (1) *affective dysregulation* that includes loss of control of emotions and impulses, difficulty in recognizing emotions; (2) *self-dysregulation* that includes painful states of self-fragmentation, feelings of emptiness, detachment reactions (derealization, depersonalization, and emotional numbing), dissociative multiplicity of self-states, identity alterations, negative self-concepts and pathogenic believes (self-loathing and consequent pervasive shame, viewing oneself as irreparably damaged, helplessness, hopelessness, mistrust in oneself, feeling responsible for the harm of others especially caregivers and consequent pervasive guilt, conviction that they deserved the abuse and neglect they suffered); (3) *relational dysregulation* that includes intensely conflictual, enmeshed, detached, or chaotic relationships, distrust of others, fear of closeness and attachment relationships, dependence (Farina & Imperatori, 2023; Ford & Courtois, 2020; Luyten et al., 2020).

In addition to this symptomatic triad, recently some scholars have noted that these patients present alterations and deficits in both metacognitive functions and epistemic trust (Fonagy et al., 2022). Most of these psychopathological manifestations intertwine and reinforce each other.

It is important to emphasize that all the psychopathological elements of DSO on the one hand constitute therapeutic goals, as we will not when commenting the case reports in this issue. On the other hand, they are factor leading to poor response to treatment if left unaddressed, regardless of the therapeutic approach one prefers. Relational difficulties, pathogenic beliefs, and difficulties in regulating emotions, poor capacity to describe to the clinician what one feels and the reasons for one’s symptoms and behaviors, lack of capacity to trust the information provided by the psychotherapist, negatively affect the therapeutic relationship, hamper the alliance, and the possibility of effectively carrying out psychotherapeutic strategies and techniques. We anticipate that such a problem was evident in the paper by Popolo and colleagues (2024) in which the application of exposure-based techniques resulted in arousal dysregulation that, combined with the patient's pathogenic beliefs and poor capacity to understand mental states and reason about them, caused a momentary therapeutic alliance rupture that needed repairing before therapy could continue.

Another important element that distinguishes cPTSD and other complex trauma-related disorders from PTSD, is how traumatic memories are encoded. While in the case of “simple” PTSD, traumatic memories are almost always explicit episodic autobiographical memories, with evident somatic correlates, in cPTSD and other disorders highly related to traumatic history such as borderline personality disorder (BPD), traumatic memories of disrupting relational events may be implicit, decoded only as patterns of reactions, emotions, arousal fluctuations and actions. When asked about their history, these patients often resort to overgeneralized memories and can have serious difficulties telling specific details about what happened, and when and where bad things happened. These implicit traumatic memories correspond to the non-verbal part of what has been named Internal Working Models (IWMs) of early attachment (Herman, 2020; Luyten et al., 2020; Liotti, 2004). This distinction has important therapeutic implications because when traumatic memories are encoded in different formats, e.g. using detailed verbal accounts of specific autobiographical episodes, vs. implicit patterns of sensations, arousal and symptoms, they require different techniques and interventions.

Before digging into the details of the single cases included in this issue, the issue of differential diagnosis requires attention. The definition and the conceptual borders of cPTSD are still debated since this diagnostic category has broad symptomatic and etiological overlaps non only with PTSD, but also with other disorders which in their etiology include prolonged interpersonal trauma-related such as BPD (Ford & Courtois, 2020). However, research data seem to indicate that cPTSD is distinct from PTSD and BPD even though there is extensive comorbidity between them (Ford & Courtois, 2021).

***Are there shared treatment principles for cPTSD?***

As evidenced by the clinical cases presented in this issue of the JCP: In Session, there are several therapeutic approaches adapted to cPTSD, but empirical evidence is still few and insufficient to definitively establish their effectiveness. In part, this is due to the recent inclusion of this disorder in ICD-11 (WHO, 2019-2021) and its absence in DSM-5 (APA, 2013) that does not help the implementation of controlled outcome studies. Furthermore, the differences in presentation among patients and the widespread comorbidity with other psychiatric disorders, such as BPD and dissociative disorders, certainly makes standardization of treatment difficult (Ford & Courtois, 2021). Nevertheless, since its initial definition by Herman (1992), guidelines for best practice treatment of cPTSD have been suggested. The International Society for Traumatic Stress Studies (ISTSS) formed a Complex Trauma Task Force to implement best practices guidelines for the treatment of cPTSD. The ISTSS task force provided a summary of the results of an expert opinion survey (Cloitre et al., 2012) where the 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.” (Cloitre et al., 2012, pg 615).

As is evident from reading the cases described in this issue, many clinicians support the principles outlined in these guidelines even though phase-oriented therapy is much debated. In a nutshell, the phase-oriented model prescribes that treatment should follow 3 temporal and logical steps. Phase 1 should be devoted to the patient's relational and environmental safety, the stabilization of emotional and vegetative dysregulations, affect regulation skills, reducing symptoms, the building of a good therapeutic relationship and a firm therapeutic alliance. Only when first phase has been successfully completed one proceed to phase 2 in which the patients' traumatic memories can be dealt with, and finally, in phase 3 one must translate the knowledge and skills acquired in earlier phases into day-to-day life (Cloitre et al., 2012; Ford & Courtois, 2020; De Jongh and Hafkemeijer 2024). The phase-oriented model is considered a strategy to avoid that recalling too early traumatic memories in cPTSD patients, especially those with more severe emotional and vegetative dysregulation and relational problems with an history of attachment trauma, may lead to symptom exacerbation, affective dysregulation and negatively affect the therapeutic alliance (Ford & Courtois, 2020). De Jongh and Hafkemeijer (2024) in this issue argue that there is no evidence supporting the phase-based protocol and that cPTSD would benefit of the usual trauma-focused treatment developed for PTSD, skipping the phase of stabilization. De Jongh and Hafkemejier view is supported by evidence that the initial stabilization phase before delivering EMDR did not bring any additional benefits in terms of safety and outcomes in patients with history of childhood abuse, compared to delivering EMDR early on (van Vliet et al., 2021) and that overall adverse events for exposure based therapies for any kind of trauma, included early developmental ones, a defining feature of cPTSD, are rare (Hoppen et al., 2022). In this perspective, delaying the application of active techniques would just have the effect that patients would have to live with their symptoms and suffering for more time. De Jongh and Hafkemeijer point out, the lack of sufficient data to demonstrate the usefulness of phase-oriented treatment prompted the ISTSS to change indications in the guidelines for cPTSD and convert phase-oriented treatment prescribing for all patients to a more personalized approach where recommendation speak: “the identification of symptoms that are clinically significant (e.g., are severe or associate with functional impairment) to a particular patient, and tailoring interventions or a series of interventions to address these problems” (ISTSS, 2018, p 3).”. In other words, the variety among patients with cPTSD dictates individualized treatments and strategies using certain therapeutic tools, such as those outlined below, and we hope to provide the readers with a comprehensive view which will ultimately suggests that an optimal strategy would involve adjusting treatments to the different presentations of this heterogenous group of patients instead of adopting a general one-size-fits-all treatment protocol.

We add that many patients with cPTSD come to therapy without an explicit request to treat trauma, as they do not recall episodic autobiographical traumatic memories and they are unaware these are one of the causes of their current suffering. In these cases, it makes sense to treat traumatic memories if and when they emerge during treatment, as Horesh and Lahav's case nicely describes (Horesh & Lahav, 2024). Moreover, if treating episodic autobiographical trauma memories is not part of the patients' requests, they obviously cannot be treated from the beginning of therapy or before they are ready to realize the link between symptoms and memories.

Beyond the discussion about the phase-oriented treatment, the other commonly accepted elements that emerged in the ISTSS expert clinicians survey are: superiority of combined treatments, utility of tailoring interventions to specific symptoms (i.e. emotion regulation interventions, treatment of dissociative or somatic symptoms), centrality of work within therapeutic relationship (Cloitre et al., 2012). All the cases illustrated in this issue follow these shared principles.

Since cPTSD is associated with interpersonal trauma, particularly but not exclusively occurring in early life, Karatzias and colleagues (2018), after having investigated the association between negative trauma-related cognitions, emotional regulation strategies, and attachment style in 171 patients by a cross-sectional design study, concluded that effective therapeutic approach to cPTSD should include targeting negative thoughts and attachment representations while promoting skills acquisition in emotional regulation. The conclusions of Karatzias and colleagues in our opinion make a lot of sense because one of the forms by which complex developmental trauma emerges is the surfacing in the therapeutic relationship of traumatic interpersonal patterns shaped during development. As we noted earlier, these patterns are often implicit, so patients are unaware of thinking about themselves and the others in specific ways. In simple words, they just enact the pattern and, for example see the therapist as a savior, a persecutor and a victim in a rapid and unpredictable cycle (Liotti, 2004).

In conclusion there are some general principles widely shared among experts: a) given how multifaceted is cPTSD presentation, any treatment must include and combine different tools (Karatzias et al., 2018; Popolo et al., 2024, this issue), for example, somatic techniques, exposure-based practices where patients can relive traumatic episodes or part of the episode until arousal mounts, e.g. EMDR ( ) r guided imagery and rescripting (Dimaggio et al., 2020; Kip et al., 2023); b) therapeutic flexibility (Horesh & Lahav, 2024 in this issue; ISTSS, 2018): patients with cPTSD require individualized treatments since their developmental histories and manifestations of suffering are different; c) giving centrality to the regulation of therapeutic relationship in order to warrant treatment adherence and prevent dropouts, and also for help patients forming more benevolent ideas about self and others, starting from their relationship with their therapist.

***Common elements and differences of the cPTSD approaches in this issue.***

As we have pointed out, the treatment of cPTSD requires some common elements. Were they present in the cases in this issue, or were they not? Or are there others as well? Almost all of the approaches presented in this issue, while coming from different modalities, have several therapeutic elements in common: 1) the regulation of emotions and arousal; 2) the ongoing monitoring of the therapeutic alliance and its repair in case of impasse; 3) work on negative pathogenic beliefs about self and others, along with the negative emotions associated with them; 4) awareness of how well the patient is able to put into words his or her inner experience and reason about it, i.e., the level of metacognition, and work to increase that capacity; and 5) work on traumatic memories. Each different therapeutic approach focuses, albeit differently, on these goals, as we will show later; 6) the importance of working on traumatic shame. It is also worth mentioning that, apart from De Jongh and Hafkemeijer the other Authors agree on the importance of building a safe therapeutic relationship that has the possibility of constituting a corrective relational experience. What are the differences instead? Before going and list them, we now describe succinctly the papers in the issue, highlighting some of their central aspects and beginning to note how they resemble/differ from each other. After this description will be summarize the key elements of actual similarities and differences.

**Five stories of cPTSD in treatment: core elements of therapeutic change.**

The story described by Cloitre and colleagues (2024) describes the use of Skills Training in Affective and Interpersonal Regulation (STAIR) in the context of Narrative Therapy (NT), a flexible phase-based intervention developed for PTSD symptoms related to childhood abuse. Although this method has received empirical support from RCT studies with PTSD, only one pilot study so far has demonstrated its usefulness in patients with cPTSD. In this case STAIR plus NT (SNT) has been applied with a 55-year-old man who was HIV, with depression, a history of child maltreatment, and traumatic bereavement, and was social rejected because of his sexual orientation. Therapy was delivered into 2 modules, the first lasted 10 sessions (STAIR) during which the patient underwent skills training to develop emotional awareness, which is the element of promoting mental state understanding common to the 5 cases, and interpersonal resources that were compromised by his traumatic history. During the second module (SNT), the patient was treated with 6 sessions of exposure to traumatic memories and cognitive restructuring of pathogenic beliefs. The initial stages of treatment were devoted to building a therapeutic relationship to create a secure basis for reflecting on trauma-related dynamics. At the beginning of the treatment, the patient had been reluctant and uncomfortable in dealing with the themes and emotions of his traumatic childhood experiences and had reacted with detached and critical responses towards the therapist when the latter tried to address these themes. However, the therapist's understood these interpersonal dynamics were at play and was able to circumvent them so to preserve the alliance up to a point where it has been possible to pass to module 2, with a focus on themes of abandonment and rejection. These were selected because they were at the root of patient’s anger and interpersonal problems such as social isolation, distrust in others, and fear to be abandoned again. The treatment was successful in both reducing symptoms and restoring the patient's social skills. They used at first *Emotion Surfing*, a metacognitive strategy that allows one to maintain awareness of the intensity, ebb and flow of one's emotions without being overwhelmed. In addition, it was possible to modify pathogenic beliefs and maladaptive interpersonal patterns through their joint exploration with the therapist. Once a better stabilisation of the emotional regulation and the main pathogenic beliefs was achieved, the main traumatic memories were treated through narration reframes. Therapy outcomes were impressive for such a short-term treatment (16 sessions overall). One possible reason for such good outcomes was the absence of personality disorders comorbidity and, we believe, preserved basic regulation of the autonomous nervous system.

Horesh and Lahav presented their case with the purpose of showing the importance of integrating methods and techniques in cPTSD treatment. They emphasize that the psychopathological outcomes of traumas stemming from childhood maltreatment experiences requires multiple and flexible responses. Their treatment had a psychodynamic background to which they added methods and techniques drawn from Dialectical Behaviour Therapy and EMDR. The patient described by Horesh and Lahav was somewhat similar to the patient described by Frankel (2024) which we describe next, while differing from the ones described in the other papers. In fact, the patient did not seek treatment from problems she considered trauma-related, but because of difficulties in forming intimate relationships, mood instability, distressing feeling of alienation, loneliness and unworthiness. These common problems were later in therapy discovered to stem from the patient's history of childhood ongoing maltreatment in the family, in the form of emotional abuse, neglect and later sexual harassment by a cousin. Horesh and Lahav did not rely on the specific cPTSD diagnosis, but rather connected patient's current and past suffering to her history of developmental trauma. Although based on the aforementioned phase-oriented model, they did not follow a structured procedure but rather focused on the patients’ need as they appeared in different moments with a combination of techniques from several psychotherapy approaches (STAIRS, EMDR, DBT). The treatment plan included a first phase whose goal was to reduce suicidal thoughts and self-injurious behaviors as well as depressive episodes and emotional difficulties using various elements of dialectical behavior therapy. Through careful work on the therapeutic relationship in this first phase, the therapist set a second goal: to reduce the effects of maladaptive interpersonal patterns, negative beliefs and dissociative tendencies that could have hindered or prevented treatment. Only after many months of therapy, and after achieved the goals of the first phase, and in a context of a solid therapeutic alliance, the therapist was able to work with EMDR on the traumatic memories that emerged in coincidence with the onset of a new romantic relationship. Horesh and Lahav concluded underscoring how integrating techniques and attitudes coming from different approaches is both necessary and difficult, in order to respond flexibly to the changing needs and symptomatic manifestations of the patient. What is lacking though, are specific suggestion for how to deliver this integration consistently, in a way that can be generalized to other cases.

Frankel (2024) did not follow a protocol, in a vein similar to Horesh and Lahav, and did not even relied on cPTSD as a diagnostic category, but rather on the clinical management of aspects of DSO. Frankel tries to provide a guide for managing the therapeutic relationship with patients who have experienced attachment trauma. Although the author has a psychodynamic approach, the suggestions can be useful for psychotherapists of any orientation. He first remarks how therapists would need to be with the patient, in other words their interpersonal attitude that would help make the therapeutic relationship a potential corrective emotional experience that can lead to changing pathogenic beliefs about interpersonal interactions formed as a consequence of trauma. Frankel reasons that since emotional abandonment stems from having internalized unstable, insensitive, and unresponsive caregiver, therapists would better try and be sensitive and responsive during all stages of therapy and pay attention to exploring memories related to emotional abandonment. Frankel warns readers that even the best therapist is inevitably exposed to retraumatizing the patient due to even minimal empathic failures. It is also the therapist's job to be aware of these failures and to be able to use even these as corrective emotional experiences. We hasten to say that therapists should note place on themselves the burden of preventing ruptures, lack of understanding and triggers: this ranges to impossible. Ruptures in the relationship can become great learning opportunities for both. Therapists need to be aware that sooner or later ruptures will happen and when they do it´s important to identify them and then jointly reflect with them about what is happening in the therapy room until the alliance is repaired. Another element Frankel focuses on in his clinical case and one of the guiding points for the treatment of cPTSD is patient’s shame. Deep-seated shame, caused by a sense of unworthiness and unlovability, is one of the most hallmarks of cPTSD. Shame, in addition to being a source of distress and relational problems, is also difficult to be addressed in treatment Shame, besides being a source of suffering and relational problems, is also difficult to deal with in treatment for different reasons. A first reason is that traumatic shame is often a trait that is not adequately recognized by the sufferer; a second reason is that some patients are ashamed of shame and do not bring it up in therapeutic dialogue (Lopez-Castro et al., 2019). Coherently, all the clinical cases in this JCP: In Session issue mention shame as one of the targets of therapy. Another emotion Frankel focused on is survivor's guilt, which is often present in these patients (Fimiani et al., 2021): “I cannot be happy and pursue my goals of independence and well-being if my parents are suffering and depressed”. It is an emotion that can not just hamper the chances to address post-traumatic symptoms, as the person cannot accept recovering, but also sustains other symptoms often present in cPTSD, such as depression or obsessions. Understanding patients like Claire, the one treated by Franke, under the lens of survivor’s guilt, can help therapists find avenues to treat both core post-traumatic symptoms and comorbid ones. The progress achieved by Claire concerned both a decrease in symptoms (tendency to shame, self-doubt, self-criticism, perfectionism, and bouts of self-hatred) and in greater clarity about the meanings of traumatic memories and a lessening of their emotional effect (distancing). Claire progressive become able to understand the reasons for her suffering and learnt not feeling responsible for the negative things happening around her, though it was not clear from Frankel’s report how did he work in order to achieve this goal. Of note, both Horesh and Lahav and Frankel’s cases lasted a few years. Is this due to problems in delivering empirically supported treatments or is it a matter of being realistic and acknowledge that treatment such serious disorders take time? We note that structured protocols for treating any kind of PTSD, including cPTSD are both effective and safe, but largely far from offering the definitive answer to these persons. Many end treatment with significant suffering, in the few outcomes the study considered. Case histories like the ones described in this issue show how these persons suffer from many symptoms and problems which are often not even measured in the course of randomized controlled trial. We advocate for an attituded which stems from empirically supported therapies, but at the same time being aware that treating the whole spectrum of problems these persons present often requires time beyond what was devoted during any studied protocol.

The case described by Popolo and colleagues (2024) is consistent with some of the elements of the cases just described. The authors used Metacognitive Interpersonal Therapy (Dimaggio et a., 2015; 2020), a manualized empirically supported treatment for personality disorders (PD) to deal with both PD related aspects and post-traumatic symptoms (see Dimaggio et al., in press for how to combine symptom and personality-related work in MIT). One of their targets was promoting the patient capacity to make sense of inner states

The case illustrated by Popolo and collaborators is, we said, a clear example of the integration of the therapeutic elements described before. The patient, Maria, was a 38-year-old woman who asked for help because of anxiety and health worries. Again, the reason for asking for therapy was apparently not trauma-related, though she presented with a history of dissociative symptoms e.g. numbness and feeling anesthesized, and intrusive death images. However, soon history of physical and verbale abuse from her father, and of witnessing her mother suicidal attempts emerged. Symptoms of detachment become more prominent in therapy, as well as dizziness and confusion, which went along with interpersonal problems in particular social isolation and mistrust. Popolo and colleague started treating hyperarousal symptoms with body-oriented techniques as the combination of dysregulation and poor awareness of inners states prevented a more cognitive demanding early work. The regulation of arousal and other somatic symptoms was also achieved by urging the patient to engage in regular physical exercise and allowed for focusing on the reasons Maria asked therapy for: reducing health anxiety and her hypersensitivity to threat. During this first therapy moments, thanks in part to the building of a good therapeutic relationship, it was also possible to understand how she was dominated by a problematic interpersonal pattern: she needed protection and safety but she predicted that others would threaten and neglect her. This pattern, as it will become clearer later in therapy, was at the root of serious alliance ruptures.

During one session, the patient had reacted with manifestations of emotional detachment, stiffening, and relational withdrawal as a reaction to therapist’ attempt to make her process a traumatic episode with imagery rescripting. She felt re-experiencing the episode as overwhelming and the withdrew without telling the therapist about her negative experience. The therapist noted the alliance rupture and successfully worked until it was repaired. In MIT, as well as in other approaches illustrated in this issue, the therapeutic relationship is not just about addressing alliance strains, it is also used to build a “prototype” for secure and trustworthy relationships, ones that would disconfirm pathogenic beliefs such as being unlovable, wrong, defective and helpless and that the others do harm or abandon, all ideas that were are the roots of Maria’s social isolation and chronic mistrust.

In short, thanks to this work it was possible to help Maria become more aware of her inner functioning, and drop the foundations for healthier interpersonal patterns and, moreover, create the conditions for working safely through trauma-related symptoms.

Finally, De Jongh and Hafkemeijer (2024), dealt with episodic autobiographical traumatic memories in a patient with cPTSD, depression and borderline personality disorder through EMDR. This case report is quite different from the previous four in both treatment method and therapy duration, the authors describe only 10 sessions were done in 5 weeks, and in type of problem addressed. De Jongh and Hafkemeijer, unlike Cloitre and colleagues (2024) argue against the need for the stabilization phase recommended by the phase-based model, and instead note that “the case conceptualization, and treatment planning for people with CPTSD do not need to differ much from the procedure used to treat 'normal' (severe) PTSD” (De Jongh & Hafkemeijer, 2024, p. ). They report the therapy process of a 52-year-old woman with recurring suicidal thoughts, flashbacks of multiple traumatic events that had occurred in her life, repeated binge eating episodes, difficulties in regulating her emotions, problems in relationships with fear of abandoning, social isolation, and very low self-esteem. Consistently with their standing that stabilization is not necessary, they treated their patient beginning by constructing a list of potentially relevant memories to intervene on with EMDR and devised as series o strategies to overcome some specific complications that therapists may encounter during trauma-focused treatment of a person with cPTSD. Complications include: avoidance and, patient’s blocks because of embarrassment, process’s blocks due to “looping”, a dysfunctional way of information processing that leads to a stalemate (loop) in the ability to change beliefs. They suggest that to overcome lack of access to traumatic memories dissociation “The patient must be convinced that dissociation is not dangerous at all, and has no negative influence on the outcome of the therapy” (2024, p. 9). This can be easy to understand in cases with enough exceptions in their life to be able to distinguish past from present, and with patients that have Adaptive Information to link with. EMDR Therapy is based on the Adaptive Information Model, the authors do not mention this model in the article. According to Francine Shapiro´s model, even very complex cases can benefit from standard procedures if there is enough adaptive information. This means that either the patient has enough positive, healthy adaptive interactions to pull from or that in their adult life they have learned how healthy interactions take place (or the possibility that previous therapies helped with that – meaning patients have done preparation previously and this is why it´s not needed. To avoid problems with the shame associated with memories of sexual abuse or other scabrous events “the therapist instructs the patient to keep the memory in mind, not to say anything about it”. To overcome looping they used the technique of cognitive interweave, that is “a short, preferably open question or suggestion from the therapist that provokes a stream of thought, action or imagination in the patient, with the aim of enabling the process by making functional information accessible, or by inserting new functional information” (2024, p. 11) which can work when Adaptive Information is available, being more limited in cases where the adaptive is missing. After the 10 biweekly sessions, the patient no longer met criteria for cPTSD and no longer suffered from intrusive memories, she no longer had BPD, had better emotion regulation and displayed significant behavioral changes. She also improved her social problems and her mood improved as she engaged in new relationships and recreational activities. It is difficult to comment on such a brilliantly treated case in which, in a severe patient with suicidal thoughts and DBP diagnoses, even the personality disorder seems to no longer cause serious problems in only ten sessions. We do not question this is very successful case! But we, as clinicians used to deal with this combination of severe forms of PTSD and personality disorders, that such quick good outcomes cases are rare, and usually therapies, are complex, difficult and time-consuming (van der Hart et al., 2006). In this sense it might be interesting to think if we are describing similar presentations with a different underlying structure, with more capacities for adaptive information processing and less avoidance. Of note, neither of us indulges in the stabilization phase, unless patients display clear signs of alliance ruptures (as in Popolo et a., 2024) when directly treating traumas.

**Common elements and differences among treatments in a nutshell**

The first difference is treatment duration. Psychotherapists ranged from a few weeks (De Jongh & Hafkemeijer, 2024), to a few (Cloitre et al., 2024), to some years (Horesh & Lahav, 2024; Frankel, 2024). Not surprisingly, shortest therapies belonged to the CBT family, while longer ones were of psychodynamic orientation. It seems clear that these differences can also be attributed to therapeutic goals and patient characteristics. In fact, as we have already mentioned in previous sections, some patients do not ask help to deal with their episodic traumatic memories but may come to therapy because of problems in relationships or for other purposes: this delays the possibility of working consensually on the traumatic memories and therefore results in longer therapy times. In addition, some patients with cPTSD present greater problems in regulating arousal, greater problems in understanding mental states and more relational difficulties, all elements that make it more difficult to build a good therapeutic alliance and prevent premature dropout. Complex PTSD cases often do better with a good therapeutic alliance, where safety and trust is developed to feel the capacity to do the trauma work.

***Some critical points and limits of clinical reports in this issue***

As noted, the cases reported in this issue are valuable examples for the difficult treatment of cPTSD. However, in the cases presented, except for that of Popolo and colleagues, no major treatment impasses, temporary breaks in therapeutic alliance, or other severe difficulties typical with these patients seem to emerge, though that may depend on the authors’ choice to focus their paper on overcoming ruptures, which might actually have been present also in the other cases described here. Future work requires understanding and analyizing cases with major ruptures, deterioration and dropout, so to figure out avenues to address these extremely negative therapeutic situations.

A second limitation that appears to emerge in the cases presented is that none of them refers to co-therapies or multi-setting integrated therapies (MSIT). As indicated by much scientific literature (Bateman and Fonagy, 2004; Liotti and Farina, 2016). As is mentioned in several clinical cases featured in this issue, patients with cPTSD require the flexible use of different psychotherapeutic tools; these can be provided by the same psychotherapist but would sometimes be better provided by different therapists who constantly communicate with each other cooperatively. Integrating different therapeutic settings but involving two or more clinicians (e.g., a trauma-focused principal psychotherapy and pharmacotherapy, or EMDR, or sensorimotor group therapy) can help prevent or overcome the typical difficulties generated by traumatic attachment in the therapeutic relationship and alliance of cPTSD. The second source of help available in the second therapeutic relationship can mitigate the activation of implicit relational traumatic memories (IWMs) within the first therapeutic relationship. Or the second therapeutic relationship can replace the first one in case of prolonged absence or in case of alliance ruptures with the main therapist by preventing drop out. Furthermore, while the strong activation of the attachment system may hinder the patient's ability to mentalize during the clinical dialogue with the primary therapist, the usually lesser involvement of attachment dynamics in the relationship with the second therapist may allow for better perspective taking, so that in the second setting patients may be able to reflect constructively on, for example, the primary therapist's beliefs and intentions that they have evaluated negatively. Reevaluating the same interpersonal episode from simultaneously different perspectives enhances the capacity for self-reflection and thus promotes the integration of dissociated internal representations of self and others. In addition, the constant cooperative exchange between different therapists may become an implicit model for fostering the patient's ability to cooperate with therapists and enhance the therapeutic alliance and represent a relational experience that is potentially corrective to the tendency to split the representation of others and the self into exaggeratedly positive and negative images (Liotti et al., 2008).

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