

# Treating Complex Trauma Among Veterans: Three Stage-Based Treatment Models

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This article addresses the issue of complex trauma in veterans and treatments for symptom presentations resulting from complex trauma exposure. While various definitions have been proposed for complex trauma, the clinical issues related to it are relevant for veterans as they are at risk for cumulative trauma exposures such as multiple combat deployments and military sexual trauma. Several treatments were either developed to address and/or implemented with complex trauma. This article discusses three of these treatments that share a stage-based approach, focusing on the present (e.g., skills training and psychoeducation), which can then be followed, if needed, with a past-focused (e.g., exposure-based) treatment: Dialectical Behavior Therapy (Linehan, 1993), Seeking Safety (Najavits, 2002), Skills Training in Affective and Interpersonal Regulation (STAIR) Narrative Therapy (Cloitre, Cohen, & Koenen, 2006). This article also discusses what is currently being done to address symptom presentations resulting from complex trauma exposure and challenges and possible solutions to implementing this care. © 2013 Wiley Periodicals, Inc. *J. Clin. Psychol.* 69:523–533, 2013.

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Traumatic events are defined as events that involve actual or threatened death, serious injury, or threat to the physical integrity of self or others. Complex trauma has been defined as exposure to multiple or prolonged traumatic events.

Typically, complex trauma exposure involves the simultaneous or sequential occurrence of maltreatment—including psychological maltreatment, neglect, physical and sexual abuse, and domestic violence . . . . Exposure to these initial traumatic experiences—and the resulting emotional dysregulation and the loss of safety, direction, and the ability to detect or respond to danger cues—often sets off a chain of events leading to subsequent or repeated trauma exposure in adolescence and adulthood. (Cook, Blaustein, Spinazzola, & Van der Kolk, 2003, p. 5)

Some definitions also focus on age at the time of trauma, such as childhood trauma (e.g., child abuse or neglect), that occurs at developmentally vulnerable times. Under definitions that include young age, chronic trauma in adulthood, such as multiple combat deployments or repeated domestic violence, is not classified as complex trauma. However, broader, accepted definitions used in the field typically include any repeated, chronic trauma exposure that results in substantial trauma-related symptoms (Department of Veterans Affairs/Department of Defense, 2004).

Complex trauma is important to consider because the clinical presentation of clients with complex trauma exposure may be distinct from those with acute stress and posttraumatic stress disorders as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Individuals who have experienced complex trauma may report a variety of difficulties, including but not limited to the defining symptoms of PTSD (re-experiencing, avoidance/numbing, and

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hyperarousal), emotion dysregulation, and interpersonal problems. Difficulties such as these are present in individuals with diagnoses of Complex PTSD and Borderline Personality Disorder (BPD).

Complex posttraumatic stress disorder (PTSD) is a term used to describe the constellation of symptoms seen in those with complex trauma exposure. Symptoms associated with Complex PTSD include PTSD symptoms and a range of self-dysregulation symptoms that are formally represented in the DSM-IV-TR (2000) under the associated features of PTSD; the definition used by the International Society for Traumatic Stress Studies (ISTSS) Expert Treatment Guidelines for Complex PTSD in Adults (Cloitre et al., 2012) groups the self-dysregulation symptoms into five broad domains: (a) emotion regulation difficulties, (b) disturbances in relational capacities, (c) alterations in attention and consciousness (e.g., dissociation), (d) adversely affected belief systems, and (e) somatic distress or disorganization.

### *Complex Trauma and Personality Disorders*

Childhood trauma has been correlated with the presence of personality disorders in adulthood. As described by Johnson and colleagues (1999), in retrospective studies, personality disorders were more prevalent in those who reported child abuse than in matched controls (Pribor & Dinwiddie, 1992; Silverman, Reinherz, & Giaconia, 1996). In a community-based longitudinal study, Johnson and colleagues found that individuals with documented abuse and neglect were more than four times as likely as those without to have a personality disorder in early adulthood.

One personality disorder, BPD, shares some symptom presentation with Complex PTSD. BPD is defined in the DSM-IV-TR (2000) as a “pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts” (p. 710). Individuals must demonstrate at least five of the following criteria: (a) frantic efforts to avoid real or imagined abandonment, (b) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation, (c) identity disturbance: markedly and persistently unstable self-image or sense of self, (d) impulsivity in at least two areas that are potentially self damaging (e.g., spending, sex, reckless driving), (e) recurrent suicidal behavior or self-mutilating behavior, (f) affective instability due to a marked reactivity in mood, (g) chronic feelings of emptiness, (h) inappropriate, intense anger or difficulty controlling anger, (i) transient, stress-related paranoid ideation or severe dissociative symptoms.

### *Co-Occurrence of PTSD and BPD*

There is a significant association between BPD and anxiety disorders (Zanarini et al., 1998). Zanarini and colleagues (1998) found that PTSD is a common comorbid disorder among those with BPD and is more common with BPD than with other personality disorders. In a sample of 504 inpatients with personality disorders, 56% of those with BPD had PTSD versus 22% of those with other Axis II diagnoses. They reported that these results are consistent with previous work demonstrating that those with BPD often report childhood trauma.

Golier and colleagues (2003) examined the relationship between BPD, PTSD, and trauma in male and female outpatients with a personality disorder. They found that early trauma was not unique to BPD and those without BPD (and with other personality disorders) had higher rates of childhood/adolescent physical abuse and were two times as likely to develop PTSD than those with BPD. They concluded that these results do not support “the idea that BPD should be singled out from the other personality disorders as a trauma-spectrum disorder or variant of PTSD” (Golier et al., 2003, p. 2023).

Given that the comorbidity rates of BPD and PTSD are less than 100% and not all those with BPD report traumatic childhood experiences, it is unlikely that BPD is better defined as Complex PTSD. Zanarini and colleagues (1998) highlight this and how it may mean that BPD has different etiologies in different groups of individuals.

One theory regarding the etiology of BPD is Linehan’s (1993) biosocial theory, a transactional model in which the interaction of an invalidating environment and biological disposition towards

emotional sensitivity result in the behaviors seen in BPD. The characteristics of a biological predisposition to emotional sensitivity are (a) increased sensitivity, (b) increased reactivity, and (c) a slow return to baseline. The characteristics of an invalidating environment include (a) pervasive invalidation of private experience, (b) punishment of expressions of emotion, with intermittent reinforcement of larger emotional expression, and (c) oversimplification of problem solving. An invalidating environment could include instances of neglect and abuse. Based on the biosocial theory, the development of BPD is in part determined by the goodness of fit between the individual's emotional sensitivity and the environment. For example, an extremely emotionally sensitive individual may find a seemingly "normal" family environment to be invalidating. Another example is an individual who is not very emotionally sensitive in an extremely invalidating family environment. With the biosocial theory, then, not all individuals who meet criteria for BPD have experienced trauma or complex trauma.

### *Understanding the Relationship Between Complex Trauma and Axis I and II Disorders*

Looking at PTSD, Complex PTSD, and BPD, it appears that complex trauma exposure can lead to both Axis I and Axis II diagnoses. It may be that the timing of complex trauma exposure (e.g., when a person experiences complex trauma) is a primary determinant of the types of difficulty that will manifest. For example, those with complex trauma in early childhood and during developmentally crucial periods may be more likely to have more pervasive difficulties, such as BPD. Those with complex trauma exposure in adulthood (e.g., multiple combat trauma exposure) that does not occur during important developmental periods may have less severe difficulties and have PTSD or Complex PTSD.

It is appropriate to mention that the manual for psychiatric diagnosis, the DSM, is based on a categorical model. Numerous arguments have been made that a dimensional model would be more clinically useful (e.g., Trull & Durett, 2005; Widiger & Coker, 2003). "A dimensional system classifies clinical presentations based on quantification of attributes rather than the assignment to categories and works best in describing phenomena that are distributed continuously and that do not have clear boundaries" (Kraemer, Noda, & O'Hara, 2004, p. 17). A dimensional model may account for the overlapping symptoms between these disorders.

### **Complex Trauma Among Veterans**

Here, we review the literature on traumatic events among veterans that fit current definitions of complex trauma exposure.

#### *Combat*

The number of combat deployments among Operation Enduring Freedom (OEF) in Afghanistan, Operation Iraqi Freedom (OIF), and/or Operation New Dawn (OND) in Iraq era veterans continues to rise. One study found that approximately 37% of OEF/OIF service members had been deployed at least twice (Litz & Schlenger, 2009). Kuhn, Hoffman, and Ruzek (2012) summarize that as the number of deployments increases, possible exposure to combat trauma increases, which leads to the increased likelihood of negative psychological outcomes. Multiple deployments increase the likelihood of developing PTSD (Maguen, Ren, Bosch, Marmar, & Seal, 2010) and those with prior deployments had more PTSD, depressive, and somatic symptoms in one study (Polusny et al., 2009).

Previously, women deployed to combat zones experienced less combat exposure than their male counterparts (Tolin & Foa, 2006). However, trends in combat exposure among military personnel are changing as women assume a greater number and variety of roles in combat (Street, Vogt, & Dutra, 2009). Approximately three quarters of women deployed to Iraq experienced at least one or more combat experiences (Dutra et al., 2011), which is comparable with studies conducted with primarily male samples (Miliken, Auchterlonie, & Hoge, 2007). Like their male counterparts, women may encounter traumatic stressors not traditionally viewed as "combat stressors," such as exposure to the aftermath of combat (e.g., handling remains, caring for

wounded; Hoge, Clark, & Castro, 2007; Maguen, Luxton, Skopp, & Madden, 2012). Findings from a large sample of active duty men and women deployed to Iraq suggest that men are more likely than women to report being in firefights (47% vs. 36%) or directing fire at the enemy (15% vs. 7%). Conversely, 38% of women reported being involved in handling human remains compared with 29% of men, which may be a result of the higher proportion of women serving in medical roles (Hoge et al., 2007).

### *Military Sexual Trauma*

Military sexual trauma (MST) is a term used to refer to sexual assault or repeated, unsolicited, threatening acts of sexual harassment that occur during active duty or active duty for training. Exposure to MST may place military personnel and veterans at higher risk for developing PTSD and other negative mental health outcomes. Female gender confers a much higher risk of exposure to these types of traumas during military service (Street et al., 2009; Vogt, Pless, King, & King, 2005). When screening Department of Veterans Affairs (VA) outpatient users from all eras of service, rates were higher for female veterans (19.5% of women and 1.2% of men; Kimerling, Street, Gima, & Smith, 2008).

Evidence suggests that exposure to sexual assault while in the military poses a greater risk for negative mental health outcomes compared with nonsexual trauma in the military or sexual trauma as a civilian. One study found that among a sample of Gulf War veterans, sexual assault during deployment was a stronger predictor of PTSD than combat exposure alone (Kang, Dalager, Mahan, & Ishii, 2005). A study of 196 female veterans recruited from an urban VA medical center examined whether the presence of MST was a stronger predictor for PTSD than other trauma (e.g., physical and sexual assault, combat trauma, witnessing violence, illness, accidents, traumatic deaths, natural disasters) using self-report measures and a structured clinical interview to identify the number of criterion A events and whether these events occurred before, during, or after participants' military experience (Yeager, Himmelfarb, Cammack, & Mintz, 2006). Women who reported experiencing MST (alone or with other traumas) had higher rates of PTSD (60%) versus women who did not experience MST (43%). To further examine whether trauma prior to the military might contribute to high rates of PTSD among women who experienced MST, researchers controlled for presence of trauma prior to the military and found that while MST was a significant predictor of PTSD, prior trauma was not. Additional research has found that veterans who report experiencing MST are more likely to endorse positive screening measures for anxiety, depression, and substance use disorders (SUDs) than those who do not (Hankin et al., 1999; Kimerling, Gima, Smith, Street, & Frayne, 2007; Maguen et al., 2012).

### *Childhood Abuse*

Veterans tend to report higher levels of childhood abuse than the general population. In a large retrospective study on adverse childhood experiences, 30.1% endorsed physical abuse, 19.9% sexual abuse, and 12.5% witnessed their mothers being physically abused (Felitti et al., 1998). Nearly half of female veterans endorsed childhood physical or sexual abuse (Zinzow, Grubaugh, Monnier, Suffoletta-Maierle, & Frueh, 2007), and 45% of male Vietnam veterans reported severe childhood physical abuse (Zaidi & Foy, 1994). These high rates of childhood abuse among both male and female veterans may increase the likelihood of complex trauma exposure and symptom presentations among veterans seeking VA care.

### *Intimate Partner Violence and Abuse*

Intimate partner violence (IPV) is another type of chronic trauma exposure that can occur in adulthood. Male veterans seeking mental health treatment tend to report overall higher rates of physical and psychological aggression (as perpetrators and victims) in their relationships compared to the general population (Sayers, Farrow, Ross, & Oslin, 2009). Among returning veterans, nearly 60% reported experiencing abuse in their current intimate relationship (Sayers et al., 2009),

where intimate partner abuse was assessed with questions about experiencing the following: (a) shouting, pushing, and shoving; (b) anyone getting hurt during disagreements/arguments; (c) feeling afraid of your partner; (d) children being hurt or threatened during an argument; (e) partner feeling afraid of you; and (f) partner from a previous relationship who is making you feel unsafe now. Female veterans are at increased risk for incurring IPV versus perpetrating it (Campbell, Greeson, Bybee, & Sheela, 2008), where IPV was assessed by asking whether respondents had experienced five different acts of physical violence: (a) being grabbed/pushed/shoved, (b) being punched/kicked, (c) hit with objects/tried to hit with object, (d) being physically restrained, (e) threatened with a weapon.

### Treatment

There are various therapies that have evidence for reducing symptoms of PTSD. However, there is limited empirical evidence for the use of treatments with the specific clinical presentations of complex trauma exposure described earlier. A recent expert clinician survey indicated that the majority (84%) endorse a phase-based approach for treating Complex PTSD (Cloitre et al., 2011). In addition, the ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults summarizes nine published randomized controlled trials (RCTs) examining phase-based treatment models for symptoms of complex PTSD in adults and highlights one (Cloitre et al., 2010) that found a phase-based approach was superior to an exposure-focused treatment approach (the skills-only condition fell in the middle).

These studies examined only individuals with complex trauma occurring in childhood, not those experiencing complex trauma in adulthood as described above (e.g., combat exposure). In this section we present three treatments that were designed to address the clinical presentations associated with complex trauma and that, in line with the phase-based approach, initially focus treatment on skills to help regulate emotions and behaviors, followed by more direct processing of traumatic experiences: Dialectical Behavior Therapy (DBT; Linehan, 1993), Seeking Safety (SS; Najavits, 2002), and Skills Training in Affective and Interpersonal Regulation (STAIR) Narrative Therapy (Cloitre, Cohen, & Koenen, 2006). How they are offered as part of a comprehensive treatment plan is up to the individual clinician. Providers may find that by offering these treatments, they will also be addressing behaviors that are thought to interfere with successful engagement and use of other psychological treatments.

#### *Dialectical Behavior Therapy*

DBT (Linehan 1993) is a manualized cognitive behavioral individual plus group treatment for suicidal individuals with BPD, which for some may result from complex trauma exposure, especially in childhood. It has been adapted for the treatment of individuals with BPD and other presenting problems (e.g., SUD). As summarized in Landes and Linehan (2012), there have been 11 published RCTs and five controlled trials. DBT has been shown to be helpful at reducing suicide attempts, non-suicidal self-injury (NSSI), drug use, symptoms of eating disorders, and improving psychosocial adjustment and treatment retention in studies primarily with individuals with BPD. In an RCT, Koons and colleagues (2001) found that DBT was helpful for female veterans with BPD; treatment lasted 6 months, in contrast to other trials where DBT lasts 1 year. While they did not report comorbid disorders such as PTSD, they reported types of past trauma, and “60% reported sexual abuse before 13 years of age, 65% reported being battered by a partner, and 85% reported being raped as an adult, 46% while on active military duty” (Koons et al., 2001, p. 375).

In an outpatient treatment setting, DBT includes (a) group skills training, (b) individual therapy, (c) phone coaching, and (d) a therapist consultation team. Completion of DBT takes approximately one year (approximately 182 hours of group and individual treatment). As described above, abbreviated courses of DBT (6 months vs. 1 year) have been shown to be helpful with female veterans with BPD; replication of this briefer version is needed. A 6-month course of DBT would include approximately 84 hours of group and individual treatment. DBT was not developed to address trauma symptoms (Harned et al., 2008), but rather to address severe

emotional and behavioral dysregulation that may have resulted from complex trauma exposure. Linehan described four stages of treatment and DBT is used to address stage 1 problems (behavioral dyscontrol).

Stage 2 addresses traumatic experiencing of emotions, and trauma work usually occurs during this phase; treatments such as prolonged exposure (PE) that target symptoms of trauma are encouraged at this time. Therefore, one can consider DBT as a means to stabilize clients and teach them skills prior to doing trauma work. The effectiveness of DBT in treating behavioral dyscontrol provides support for this premise; however, the use of DBT followed by treatment for trauma has not been examined, except with the combined protocol described next.

Given that PTSD treatment guidelines recommend addressing suicidality before treating PTSD (e.g., Foa, Keane, Friedman, & Cohen, 2008) and that PTSD can exacerbate or maintain behaviors common in BPD such as suicidal and NSSI (Harned, in press), Harned and Linehan (2008) developed a protocol for concurrent use of DBT and a modified version of PE (Foa & Rothbaum, 1998). The protocol includes DBT (individual therapy, skills group, phone consultation, and therapist consultation team) and a modified version of PE—the DBT PE Protocol—and is implemented once clients achieve control over higher priority targets, such as NSSI and suicide attempts for 2 months (in an initial presentation of three cases, the DBT PE Protocol was implemented after 6 months of DBT; Harned & Linehan, 2008). Once implemented, clients receive either one combined individual therapy session per week (90 minutes of the DBT PE Protocol and 30 minutes of DBT) or two individual therapy sessions per week (90 minutes of the DBT PE Protocol and 60 minutes of DBT). They continue to receive weekly DBT skills group and as needed phone consultation. In a preliminary evaluation, the majority completed the DBT PE Protocol in between six and 19 sessions (mean [ $M$ ] = 13, standard deviation [ $SD$ ] = 1.6; Harned, Korslund, Foa, & Linehan, 2012).

For an individual completing the DBT PE Protocol in the mean of 13 sessions, this concurrent approach would involve between 195 and 202 hours of group and individual treatment. While this increases the amount of treatment hours, concurrent implementation would result in a treatment length that is approximately 3 months shorter than consecutive implementation of DBT and PE. Although this treatment is lengthy compared with those described next, the treatment course is in line with expert consensus treatment guidelines for Complex PTSD in adults (Cloitre, et al. 2012), which recommends a treatment duration of approximately 9–12 months for Complex PTSD and notes that for more impaired individuals, treatment may need to last longer than 12 months.

In a preliminary evaluation using an open trial design with women ( $N = 13$ ) with BPD, PTSD, and NSSI, participants reported an average of 14 types of lifetime trauma beginning before 6 years of age. Implementation of the treatment was feasible; 10 clients (76.9%) completed one year of DBT and three (23.1%) dropped out. All 10 started the DBT PE Protocol and, of those, seven completed it. Harned et al. (2012) found reductions in PTSD; the majority (71.4% of treatment completers) no longer met criteria at posttreatment. While a minority (27.3%) engaged in NSSI during the study, Harned and colleagues reported that the DBT PE Protocol did not appear to exacerbate NSSI and this was lower than what is normally reported in DBT studies (Harned et al., 2012).

### *Seeking Safety*

SS (Najavits, 2002) is a cognitive-behavioral therapy for individuals with PTSD and/or SUD, designed for group or individual modality. Comorbidity of PTSD and SUD among veterans is well established (Ruzek, 2003). Research suggests that veterans with SUD and PTSD have more severe substance use and trauma histories, more problems associated with each disorder, and worse treatment outcomes than veterans with SUD-only or PTSD-only (Ouimette, Wolfe, & Chestman, 1996). SS has been tested extensively with complex trauma clients in various populations, including criminal justice, homeless, and community care, with positive overall outcomes (See Najavits, this issue).

SS emphasizes present-focused coping skills and psychoeducation and was designed for flexible use (i.e., group or individual format, open or closed groups, treatment topics can be conducted in any order). SS offers 25 topics (25 hours, when done in a 60-minute sessions) divided among cognitive, behavioral, interpersonal, and case management domains; each topic addresses a coping skill relevant to both trauma and substance abuse.

SS has been shown to have positive outcomes among male and female veterans. In a large, multisite study with homeless female veterans in residential VA treatment for substance use, those who received SS reported significantly better outcomes over one year in employment, social support, general symptoms of psychiatric distress, and symptoms of PTSD than those receiving treatment as usual (e.g., residential treatment services including case management, substance abuse counseling; Desai, Harpaz-Rotem, Najavits, & Rosenheck, 2008, 2009).

Similarly, in an outpatient substance use clinic, male veterans receiving SS demonstrated greater drug use outcomes (e.g., fewer days of use), greater improvement in coping skills, and higher treatment satisfaction and attendance than those receiving treatment as usual (Boden et al., 2012). Smaller pilot studies showed positive results in symptom reduction among veterans (Cook, Walser, Kane, Ruzek, & Woody, 2006), even when the model was tested in partial-dose format (less than half the model) to fit program structure/requirements (Norman, Wilkins, Tapert, Lang, & Najavits, 2010). For a review of other studies on SS in nonveteran samples, see Najavits and Hien (this issue).

In light of the stage-based approach that is the focus of this article, one additional study on SS deserves mention. Najavits and colleagues (Najavits, Schmitz, Gotthardt, & Weiss, 2005) conducted a preliminary trial of SS combined with what was called exposure therapy revised (ETR), the latter a precursor to the “creating change” (CC) model (Najavits, in press). The combination evidenced positive outcomes among men with complex PTSD/SUD (i.e., both disorders current, severe, and chronic, and the PTSD childhood-based). This pilot comprised 30 sessions in 5 months, with flexible dosing of the SS and exposure components such that client and clinician decided at each session whether to do SS or ETR at that visit (with the data showing an average of 21 SS and nine ETR sessions). Results showed improvements in drug use, PTSD symptoms, anxiety, dissociation, hostility, family/social relationships, overall functioning, and thoughts related to safety.

The promising results of the pilot led to the development of CC, a new past-focused model for PTSD and/or SUD (Najavits, in press). CC is identical to SS in key features (e.g., format, flexibility, theme-based focus, individual or group modality), but with a focus on the past rather than, as in SS, the present. CC can be combined with SS, sequentially, concurrently, or interwoven, or can be used without SS. CC has shown positive results in a pilot study with complex trauma clients (Najavits & Johnson, under review).

### *STAIR Narrative Therapy*

STAIR Narrative Therapy (Cloitre, Cohen, & Koenen, 2006) is a phase-based manualized cognitive-behavioral therapy originally developed for PTSD related to childhood abuse, in which skills training precedes trauma narration. It can be implemented in individual or group modality. The rationale for the development of the treatment was to resolve PTSD symptoms by engaging in traditional trauma memory processing but also to address the various problems observed among PTSD clients with early life trauma in two particular domains of disturbances, namely, emotion regulation problems and interpersonal disturbances. The selection of these two domains was based on the clinical observation of these domains as salient areas of difficulty in PTSD clients with early life trauma (Cloitre, Cohen, & Koenen, 2006). It was further supported by the developmental theory that identified emotion regulation and relational capacities as key developmental tasks of early life and an empirical literature that demonstrated the disruptive effect of trauma on these capacities. The treatment sequence was organized with skills first to immediately address difficulties in day-to-day functioning and to provide the client with skills that would allow the more effective use of exposure therapy.

The therapy is a hybrid of DBT techniques (Linehan, 1993) and PE (Foa & Rothbaum, 1998), organized in a phase-based fashion for individual one-on-one therapy. STAIR Narrative

Therapy comprises a total of 16 60-minute individual sessions (16 hours of treatment). The first phase of treatment comprises eight sessions of training in emotion regulation and interpersonal skills. The second phase comprises eight sessions of continued skills training with the addition of a modified version of prolonged imaginal exposure for trauma.

To date there have been four treatment studies of STAIR Narrative Therapy. Two RCTs with women with PTSD related to childhood abuse (Cloitre, Koenen, Cohen, & Han, 2002; Cloitre et al., 2010) indicated that the treatment was helpful in reducing PTSD, as well as improving emotion regulation and interpersonal functioning. Specific improvements in emotion regulation included greater overall emotion regulation, more effective anger expression, reduced depression, and reduced dissociation. The studies also found improvement in a range of interpersonal behaviors, social support (Cloitre et al., 2002, 2010), and overall functional status (Cloitre et al., 2002). STAIR Narrative Therapy has been shown to facilitate use of trauma memory processing during stage 2 (Cloitre et al., 2002) and found to be more helpful in improving all three symptom domains (PTSD, emotion regulation, and interpersonal disturbances) than either skills training or exposure work alone.

STAIR Narrative Therapy was also tested among both men and women with PTSD symptoms related to the 9/11 World Trade Center attacks in an effectiveness study that evaluated flexible application of the treatment (Levitt, Malta, Martin, Davis, & Cloitre, 2007). Results indicated that the flexible application was just as helpful for PTSD symptoms as the use of strict adherence to the manual. In addition, there was significant improvement in use of social support and decreased use of alcohol and drugs, particularly among the men.

A fourth study compared STAIR alone (without exposure) in a group format with inpatient men and women with PTSD symptoms and a range of comorbid schizoaffective disorders (Trappler & Neville, 2007). Compared with group treatment as usual, STAIR provided greater reduction in PTSD symptoms, agitation/tension, emotional bluntness, and unusual thought content. These results suggest the value of the treatment using skills training alone.

### Implementing Treatment for Veterans With Complex Trauma

When deciding which treatments to implement and how to do so, it is worth considering several practical topics.

#### *Service Organization Challenges*

One challenge to implementing these treatments in some settings is the organization of care. In medical or academic settings, where specialists and specialty care may be readily available, there may also be a consequential separation of clinics along diagnostic lines such as PTSD, mood disorders, and SUDs. Individuals who have experienced complex trauma will likely have a number of these diagnoses, so it may not be immediately clear where these individuals go for treatment. Further, this organization of services results in no clear home for treatments such as DBT, SS, or STAIR Narrative Therapy, making it potentially more difficult for clients to access these therapies. For example, a veteran with a complex trauma history, recent combat exposure, and emotion regulation problems may be initially referred to a PTSD or anxiety disorders clinic. If the above treatments are not offered there, then he or she may not receive that treatment.

One potential solution to this problem is to organize services according to the treatment being offered. A number of clinic administrators and clinicians have implemented this solution and have created DBT teams in their settings. The Minneapolis VA is an example of this; their DBT team is not housed within a specific specialty clinic, but rather is staffed by interested and trained clinicians from various mental health specialty clinics (Landes & Meyers, 2012; Spooon, Sayer, Thuras, Erbes, & Winston, 2003). These clinicians see their individual clients in the clinic space in which they work. This approach removes concern about where clients enter treatment, as clients from any clinic can be referred to and receive DBT. Similarly, SS has become a central focus in various agencies, such that any client (regardless of diagnosis) can enter SS and focus on coping skills broadly.



Another possible solution to the barrier of services organized for specific diagnoses is to offer integration of treatment. An example within VA medical centers and clinics is coordinated treatment of SUD and other co-occurring conditions, such as PTSD (Department of Veterans Affairs, 2008). The need for this stemmed in part out of the recognition that there was a high rate of comorbidity of PTSD and substance use among veterans (Kulka et al., 1990; Seal et al., 2011). These clients were recognized as more complex, and the VA funded SUD/PTSD specialists to help coordinate treatment planning and service delivery for this population. Specialists in providing care to these particular comorbid conditions may offer a logical place to refer and treat complex trauma clients.

This approach is one example of pathways that support the implementation of treatments like SS for comorbid PTSD and SUD, by creating a clear home within a system of care. SS, however, has been used in the VA since the late 1990s, and as of 2010 data, has in fact been implemented in a majority of VAs (112 of the 153 VA hospitals; Tracey & Kivlahan, personal communication, October 19, 2011, reporting on 2010 data).

Increasing gender-sensitivity within mental health services may also offer a solution. This can be achieved by increasing awareness of the differences in traumatic event exposure by gender, implementing clinical practices for the assessment of gender-related risk factors, assessing a range of symptoms versus diagnosis, as well as gender-related issues that may affect accessing care (e.g., significant interpersonal difficulties, stigma). These practices could more easily allow for the recognition and treatment of symptom presentations resulting from complex trauma.

In addition, implementing systematic assessments of a wider set of trauma-related symptoms helps identify and meet more complex needs. An example is the Women's Prevention, Outreach, and Education Center in the VA Palo Alto Health Care System. Recognizing the high rates of childhood and adult trauma exposure among women veterans seeking mental health care, this clinic adapted a trauma-informed care model (Harris & Fallot, 2001) that includes actively considering the role of violence and trauma in women's lives, establishing collaborative and empowering working relationships, and designing services to avoid retraumatization.

Practical considerations in implementing these treatments should also be considered, as the models differ in various aspects.

### *Dialectical Behavior Therapy*

For DBT, time can be quite a practical challenge. The treatment is time-intensive and may exceed available resources, for both the client and the providers. For clients, the amount of treatment involved in DBT may be too large of a time commitment to make. It may also be more than treatment than is covered by insurance or more than the client can afford. Reimbursement can also be a challenge for providers. A number of private practice clinics have addressed this challenge by obtaining increased reimbursement by presenting clinic outcome data when requesting additional coverage from insurance companies and/or by requesting additional outpatient coverage by converting inpatient coverage benefits to outpatient benefits (as DBT decreases hospitalization).

In DBT, skills training groups are designed to be 2.5 hours (150 minutes) long. This length of time is not always feasible for providers, depending on the treatment setting in which they work. There can be administrative barriers to this, such as billing practices, as well as limits on time for providers who have large caseloads. Some clinicians have attempted to address such barriers by shortening the groups, while still covering the same material in less depth. Changes such as these are current areas of research.

Another component of DBT that can pose a practical difficulty is the coaching phone calls that are designed to occur when a patient needs skills coaching, which includes outside of usual business hours. Some providers have found creative ways of supporting these extra responsibilities (e.g., requesting compensation for time on calls outside of normal hours) or addressing them in other ways (e.g., referring clients to local crisis services, ideally where staff have awareness of DBT skills; training psychiatric inpatient nurses in skills for use both on the floor and to provide phone coaching).

Also, DBT was not designed to be conducted by a solo provider, but rather is expected to be implemented by a team. Finding a DBT team can be a challenge, especially for clinicians in smaller organizations or private practice. Some providers have solved this problem by creating teams spanning multiple settings and/or by meeting using alternative methods (e.g., via phone or video conferencing).

### *Seeking Safety*

SS, as mentioned earlier, was designed for flexible implementation (group or individual modality, open or closed groups, and dosage and timing of sessions can vary). Also, it was designed for complex trauma clients (e.g., comorbid, severe, chronic) and has been implemented with a very wide range of clinicians and also nonclinicians (e.g., case managers, peers, advocates).

### *STAIR Narrative Therapy*

STAIR Narrative Therapy was designed to be adaptable to the unique needs of complex clients. It was originally designed as an individual treatment, where challenges may include the cost of such treatment for clients and for agencies, as individual treatment is more costly than group. STAIR without exposure has been implemented in group settings, which may be a more feasible way to implement the treatment.

### *Training*

Another consideration in deciding which treatments to implement has to do with the training that may be needed of treatment providers. Below, requirements and options for training are described for each model.

**DBT.** Formal training in DBT may not be needed for clinicians who have had prior training and supervision in behavior therapy. For clinicians without this background, training is needed to implement the treatment adherently given the treatment is a principle-based treatment (rather than a protocol-based treatment that may require less training; Linehan, personal communication, January 3, 2013). The gold standard training for DBT is an intensive training course that requires the treatment team to attend training broken into two parts, each of which lasts 5 days. The training is separated by 6 months in which the team does homework and implementation (Landes & Linehan, 2012; see [www.behavioraltech.org/](http://www.behavioraltech.org/)). Additional training opportunities are also available, including other training formats and trainings addressing implementation challenges, such as how to interact with third-party payers to support delivery of evidence based treatment by addressing reimbursement issues (see [www.ticllc.org/](http://www.ticllc.org/)). Available training in DBT includes the manual (Linehan, 1993), web-based training, and workshops.

**SS.** For SS, training is available but not required, because SS has been found to be very safe even without formal training, and because it was designed to have a highly public health-oriented focus with easy accessibility, low cost, and minimal barriers for its use (see [www.seekingsafety.org](http://www.seekingsafety.org), section FAQ). Training is available, however, in various formats, to aid implementation and provide support to those who want it. Available training includes the manual (Najavits, 2002), a series of training videos, workshops, and telephone consultation (either independently or following a training). The SS website also provides training and implementation resources, such as an adherence scale and other materials.

**STAIR Narrative Therapy.** Formal training in STAIR Narrative Therapy is not required (Cloitre, personal communication, January 9, 2013), but is available if desired. Training includes the manual (Cloitre et al., 2006), a webinar, and 2-day workshops given by trained STAIR Narrative Therapy supervisors on an as-requested basis.

### Summary

Complex trauma exposure among veterans is a salient issue, and treatments exist that may be helpful in their care. There are numerous challenges in treating veterans who present with distress related to symptoms resulting from complex trauma exposure. High levels of distress related to difficulties in regulating affect (e.g., suicidal thoughts/behavior, anger) can result in treatment focusing almost exclusively on crisis management. Alterations in perception of self and others, particularly as it relates to safety and trust among veterans with complex trauma symptoms, may impede the process of developing a strong therapeutic alliance, which has been found to be a meaningful factor in successful psychotherapy outcomes (Krupnick et al., 1996). Finally, alterations in attention or consciousness among veterans with complex trauma symptoms can also make engaging in psychotherapy difficult for such individuals given the level of self-regulation often needed to benefit from various interventions.

A common thread among the treatments outlined above (DBT, SS, STAIR Narrative Therapy) is their focus on structured, skills-based interventions that directly address the behaviors creating significant distress in the lives of veterans (e.g., emotion regulation, impulsive behaviors, view of self and others), which are frequently the same behaviors that can interfere with successful engagement and use of psychological treatments (e.g. premature termination, difficulty interacting with treatment staff), followed by a trauma-focused approach. Each model offers unique features yet also has in common the goal of stage 1 work to help stabilize clients amid the wide range of Complex PTSD symptoms.

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