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Trauma-focused treatment of a client with Complex PTSD and comorbid pathology using EMDR therapy

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Abstract

Objective: Complex post-traumatic stress disorder (CPTSD) is a classification within the International Classification of Diseases, 11th Revision (ICD-11) that, besides the DSM-5 symptom clusters of post-traumatic stress disorder (PTSD), includes the presence of negative self-concept, difficulties in regulating emotions and relationship skills. The purpose of the present study was to provide guidance on how to deliver Eye Movement Desensitization and Reprocessing (EMDR) therapy in the context of CPTSD, based on current clinical knowledge and the latest scientific research findings.

Method: This paper describes the treatment of a 52-year-old woman with CPTSD and borderline personality disorder for which immediate trauma-focused EMDR therapy was used.

Results: First, a description of what EMDR therapy entails and some important treatment strategies that the therapist may employ to assist in trauma-focused treatment of clients with CPTSD using EMDR therapy are outlined.

Conclusion: The treatment results are in line with mounting evidence supporting the notion that EMDR therapy is a safe and potentially effective treatment alternative for individuals with CPTSD or personality problems.
INTRODUCTION

Complex post-traumatic stress disorder (CPTSD) is a relatively new classification included in the most recent edition of the World Health Organization classification system (International Classification of Disease 11th revision, ICD-11, 2023). The symptom clusters of this classification are those that have also been central in the DSM classification of post-traumatic stress disorder (PTSD) for decades (re-experiencing, avoidance, and hyperarousal) but include three additional symptom clusters involving difficulties in regulating emotions, engaging in and maintaining interpersonal relationships, and the presence of negative beliefs about self, others, or the world (Cloitre et al., 2012, 2013; Maercker et al., 2013). In the literature, the latter symptom clusters are collectively referred to as the DSO (Disorders of Self Organization) construct (Hoeboer et al., 2020).

In 2012, a guideline committee of the International Society for Traumatic Stress Studies (ISTSS) recommended that people with early childhood interpersonal trauma and symptoms associated with CPTSD should be treated according to a phase-based treatment model (Cloitre et al., 2012). This approach starts with a preparation phase based on the assumption that people who have experienced interpersonal traumatization in their childhood lack psychological stability to confront their traumatic memories (Cloitre et al., 2011). The behavioral and emotional dysregulation associated with clients with a background of early childhood trauma, the presence of multiple comorbid disorders, therapy-interfering behaviors, and serious functional impairment could lead to negative effects, such as symptom exacerbation, psychological disruption, and suicidality, complicating the implementation of standard trauma-focused treatment protocols (Cloitre et al., 2011). Therefore, a stabilization phase was recommended to prepare for actual trauma processing to help the client establishing a sense of security, a therapeutic relationship, self-control and affect regulation, before the processing of trauma memories (Cloitre et al., 2002; Dorrepaal et al., 2006; Zlotnick et al., 1997).

This phase-based treatment approach is widely used worldwide. However, its empirical basis is lacking (De Jongh et al., 2016, 2019). Recent research using randomized controlled trials showed that adding a stabilization phase to an otherwise trauma-focused treatment for complex PTSD is effective but not necessary (Opren et al., 2021; Raabe et al., 2022; Van Vliet et al., 2021). Thus, to date, there is strong support for the use of immediate trauma-focused therapy for the treatment of CPTSD, in accordance with general PTSD treatment guidelines, as opposed to the need for any preparatory intervention.

The purpose of the present study was to provide guidance on how to deliver Eye Movement Desensitization and Reprocessing (EMDR) therapy in the context of Complex PTSD based on current clinical knowledge and the latest scientific research findings. First, we provide a description of what EMDR therapy entails and discuss some important treatment strategies that the therapist may employ to assist using immediate trauma-focused treatment of clients with CPTSD using EMDR therapy. Next, a case example of a woman with Complex PTSD and comorbid psychopathology is presented to illustrate the application of EMDR therapy for this target group in clinical practice.
Guidelines Committee, 2018a, 2018b), as a recommended treatment for post-traumatic stress disorder (PTSD). EMDR therapy was first described in 1989 under the name Eye Movement Desensitization (EMD; Shapiro, 1989a). In the same year, the results of a study on the effectiveness of Eye Movement Desensitization (EMD) in clients with distressing memories were published (Shapiro, 1989b). In the years following, the procedure was further refined and evolved into a full-fledged therapy. Adaptations to meet the specific characteristics and needs of various client groups, including young children, were also described.

EMDR therapy differs from other psychotherapeutic approaches in several respects. For example, it has traditionally used hand-evoked lateral eye movements (generally referred to as “bilateral stimulation”), but nowadays other modalities are employed, such as tactile stimulation (“taps”), auditory tones, and other working memory-demanding tasks such as making mathematical calculations and the spelling of words (Matthijssen et al., 2021). According to the founder of EMDR therapy, American psychologist Francine Shapiro, the application of lateral eye movements is associated with an increased speed of information processing, referred to as Adaptive Information Processing (AIP; Shapiro, 2018). For EMDR therapy to be effective, strict application of the so-called “Standard Protocol” (Shapiro, 2018) is considered crucial. It comprises a number of fixed steps consisting of a series of standard questions and formulations that are intended as process instructions. The procedure should ensure that the client eventually focuses his or her attention on the trauma memory in a dosed manner, while simultaneously performing another (“dual attention”) task. Through a process in which spontaneous associations occur, the emotional charge of the trauma memory gradually decreases, creating room for new and positive perspectives about the memory (e.g., “I can deal with it”), the environment (“I am safe now”), or about the client as a person (“I am worthy”). Another distinguishing element of EMDR therapy is that relatively few words are spoken. The therapist’s role is primarily to guide and provide process instructions to help the client focus on the internal experiences and thought associations that arise spontaneously. The duration of the session was usually 60–90 min. EMDR therapy can be administered individually or in groups. Although treatment is usually administered in weekly or biweekly sessions, intensive treatment programs (with daily sessions or with multiple sessions per day) have also been shown to be effective (Bongaerts et al., 2017).

2.1 | The treatment of Complex PTSD using EMDR therapy

To support people with CPTSD as best as possible, treatment should mainly focus on desensitizing those memories that are considered crucial to the person to enable rapid and adequate symptom reduction. This means that case conceptualization and treatment planning for people with CPTSD do not need to differ much from the procedure used to treat PTSD (De Jongh et al., 2016), wherein it is helpful to focus on therapeutic interventions primarily on clients’ most disruptive symptoms. For a large number of clients, these involve intrusive experiences of traumatic events, in which traumatic memories are regarded as causal factors.

2.1.1 | Dealing with fear

Perhaps the most striking feature of people with CPTSD is that they are likely to fear being confronted with memories from the past and the emotions they evoke. Many individuals who have been exposed to (childhood) abuse display a natural tendency to more or less completely close themselves off from their past, and therefore, also from trauma-focused treatment. They may be experiencing impulses to flee or to avoid, for instance, by distracting the therapist from the content of their trauma and trauma history. This was also reflected in their tendency to dissociate. Although research shows that, generally, dissociation does not affect the outcome of trauma-focused therapy (Hoeboer et al., 2020), it may limit access to traumatic memories during the sessions in some patients. In clinical practice, a client’s tendency to dissociate usually manifests itself in the fact that they are unable to recall the trauma image, do not experience any tension, and may state that they are “unable to access the memory.” Furthermore, it is likely that
the subjective unit of distress (SUD) does not decrease or was minimal during the session. The most plausible explanation in these cases is that the client is afraid of being overwhelmed by his or her memories and the emotions attached to them, and therefore only partially activates the memory (in a weakened form) or does not place the memory in the working memory at all. When this happens, there is obviously little opportunity for the desired processing of the trauma memory. Accordingly, the core of dealing with this type of dissociation is for the therapist to normalize it. Furthermore, it makes sense to first motivate the client by using a psycho-educational and motivational approach and explaining the working memory theory to the client. This can help them understand that by constantly overloading the working memory, the memories cannot become overpowering, as is feared. To this end, in the context of EMDR 2.0, a new approach for the application of EMDR therapy, it is recommended to motivate the client to take up the challenge and to keep the memory in the working memory as much, and for as long, as possible, while the therapist tries to load the working memory to the maximum (Matthijssen et al., 2021). In fact, a consistently high working memory load is a simple and effective way to keep clients within the so-called “window of tolerance.” Another useful procedure by which clients tend to suppress their memories for fear of being overwhelmed by the same memories is to apply the flashforward technique (Logie & De Jongh, 2014). This technique is specifically used for the treatment of (phobic) fear of objects or situations by focusing on desensitizing the patient’s disaster fantasy, in this case, the fear of the therapy itself. To this end, much experience has been gained in recent years with this type of case conceptualization in intensive PTSD treatment programs for PTSD (Bongaerts et al., 2017).

2.1.2 | Dealing with shame

Another important factor that can limit or block the successful treatment of patients diagnosed with CPTSD is shame. This is especially true in the case of repetitive sexual trauma, and even more specifically, regarding the incest. Clients often hesitate to share such memories with therapists. Differing from imaginary exposure, where the client tells the story in detail, EMDR therapy offers the possibility to perform the treatment completely “Blind to the therapist.” The Blind to therapist procedure is for the therapist to reassure the patient that the trauma story does not need to be shared, but that it is enough to “just think strongly about it.” This procedure has been found to be effective and yielded no negative consequences for the implementation and effect of EMDR therapy (Hafkemeijer et al., 2020).

3 | CASE ILLUSTRATION

3.1 | Presenting problem and client description

Sabine is a 52-year-old mother of a daughter who participated in a multicenter randomized controlled trial investigating the effectiveness of EMDR therapy in clients with a personality disorder (Hofman et al., 2022). Sabine presented with recurring suicidal thoughts and flashbacks of multiple traumatic events that had occurred in her life, meeting Criterion A of the PTSD classification. This involves a series of events related to physical and sexual violence. Therefore, Sabine was assessed to determine whether she fulfilled the diagnostic criteria of PTSD according to DSM-5 (American Psychiatric Association, 2013), and to determine treatment progress by measuring changes in severity of PTSD symptoms using the Clinician-administered PTSD Scale for DSM-5 past month version (Weathers et al., 2017). The International Trauma Questionnaire (ITQ) was used to establish a Complex PTSD (CPTSD) diagnosis based on the ICD-11, the International Trauma Questionnaire (ITQ) was used (Cloitre et al., 2018). Sabine fulfilled the diagnostic criteria for CPTSD and borderline personality disorder (SCID-5-P; First et al., 2016).

From the history, it appeared that Sabine’s father had many psychological complaints. Because her family of origin suffered from the effects of neglect and emotional abuse, Sabine lacked the support and security of her parents. Her
parents had intense relationship problems, and father often fled the house. The mother regularly had other partners and was often absent. At school, Sabine was bullied by other children. As a child, she received assertiveness training several times, and often felt alone. When the patient was 19-year-old, she left home along with her older sister. When her sister emigrated after meeting a man with whom she fell in love, Sabine felt abandoned.

Sabine developed a relationship with a man who had physically and verbally abused her. This was followed by multiple relationships with men who abused both verbally and physically. After her last relationship, she experienced serious financial problems. Her daughter was removed from her home and Sabine was no longer allowed to contact her. A few years ago, Sabine had lost her job because she had many conflicts at work. She worked as an administrative assistant in a small office and ended up on long sick leave. Sabine was worried intensively and did not know what to do with her feelings. As a result, she had trouble regulating her emotions, engaged in regular binge eating, often felt isolated, and had very low self-esteem. She also experienced many problems in relationships with other people and quickly felt abandoned. As she was very suspicious of other people, she was often in intense contact with others and had frequent conflicts. As a result, she was unable to build trusting relationships or a supportive network. She often felt that she could not handle life, and tended to isolate herself.

Sabine regularly had painful memories of the past. She then felt that herself had become very small and went into the survival mode. Sometimes, she flew her house to get peace of mind. Since childhood, she has reported having unpleasant dreams about things that she never spoke about. Sabine indicated that she had always gone on but had never processed her past. As a result, she experienced herself almost continuously as tense and restless, and experienced serious concentration problems. Therefore, Sabine’s main treatment goal was to gain more peace of mind, no longer suffer from intrusive memories, and make a healthy partner choice.

### 3.2 Case formulation

As with all psychotherapeutic treatments, thorough case conceptualization is the fundamental starting point for the treatment of PTSD and other trauma-related problems. In case conceptualization, the connection between symptomatology and the crucial memories that drive pathology should be explained. The assumption is that desensitizing these memories will lead to a significant reduction in complaints and, by extension, to a maximum improvement in the patient's quality of life. This is in line with Shapiro’s Adaptive Information Processing (AIP) model, which describes how to view case histories in a trauma-sensitive manner, where the therapy focuses on desensitizing the meaningful memories underlying the patient's presented complaints, with the aim of influencing this symptomatology. To this end, and in terms of case conceptualization, the Tempo study in which Sabine participated used a fixed sequence of memories that are supposed to be processed to influence the patient's existing complaints at the core (Hofman et al., 2022; see Box 1). This structure is based on the practice of (intensive) treatment of Complex PTSD (Bongaerts et al., 2017; Voorendonk et al., 2020) which has shown that it is especially useful to first hierarchically order the intrusive memories of A-criterion-worthy events, that is, exposure to physical and sexual violence, and other

**BOX 1** Case conceptualization. Structure of types of memories that were targeted

1. Intrusive memories of A-criteria worthy events
2. Nonintrusive memories of A-criteria worthy events
3. Intrusive Memories of non-A-criteria worthy events
4. Memories that are thought to have given rise to, or still “fuel” or “feed” the client’s most prominent symptom cluster (e.g., emotion regulation problems or a negative self-image)
confrontations with (threatening) death, based on the severity or intrusiveness of these memories. The same procedure was used for nonintrusive memories of A-worthv events and intrusive memories of non-A-worthv events. To this end, the therapist asks clients about specific memories that bother them most in daily life, during the day, as if they were re-experiencing the trauma, and at night when they dream. Based on this information, a list of memories of adverse events is drawn up, starting with the memory that most directly and strongly fuels clients' PTSD symptoms (see Box 2 for a text example that can be used for this purpose). The next step is to map out the symptoms that are most prominent for the client, such as emotion-regulation problems or a negative self-image. The memories that gave rise to or worsened these symptoms were then identified. In the last step, all memories are placed in a hierarchy based on subjective units of disturbance (SUD). This strategy was based on the experience and findings of previous studies aimed at treating personality problems using EMDR therapy (De Jongh et al., 2020; Hafkemeijer et al., 2020).

Hence, before starting therapy, the therapist and Sabine carefully prepared a case conceptualization for the treatment, during which the main goal of the treatment was formulated as the processing of Sabine's memories of traumatic (i.e., sexual and physical violence) and adverse events (i.e., emotional violence and neglect) that proved to have a direct effect on her key symptoms (i.e., PTSD symptoms, difficulties in emotion regulation and interpersonal relationships, and self-esteem problems associated with her borderline personality disorder. See Table 1 for the list of memories in the suggested order of treatment.

Within this case conceptualization, regarding these four clusters, the SUD (0-10) determines the order of the memories. All memories are placed in a hierarchy based upon the subjective units of disturbance (SUD) and will be treated from high to low SUD-scores. Memories within the same cluster with an equal SUD are ordered by age (i.e., memories at a younger age are targeted first).

### 3.3 Course of treatment

Sabine was administered 10 EMDR therapy sessions for 5 weeks. At the beginning of each session, she was asked to recall a memory, focusing on the most disturbing images, thoughts, emotions, and bodily sensations, and to combine this with a focus on the therapist's moving hand. In addition to eye movements, hand tapping, counting, and word spelling have been used as working memory tasks (EMDR 2.0; Matthijssen et al., 2021).

During the first session, Sabine felt overwhelmed by feelings of helplessness. She experienced the intense emotions of fear, hatred, and sadness. In addition, she felt very tired because she slept little because of nightmares. It turned out that Sabine experienced anticipatory anxiety about the therapy itself, so initially no reduction in SUD occurred. The therapists first tried to convince Sabine that trauma-focused therapy is safe. She indicated that she was afraid to memorize her working memory because this would lead to flooding and decompensation. The therapist applied the flashforward technique (Logie & De Jongh, 2014). In this case, the therapist asked Sabine exactly what she was afraid of if she would allow herself to bring up the memory. She indicated that she was expected to be overwhelmed by her traumatic memories. Next, EMDR therapy targeted this mental representation
of Sabine’s worst-case scenario. This could be completely desensitized, with the result that Sabine felt less afraid of the treatment afterwards, and that the trauma memories became sufficiently accessible for subsequent desensitization. After this intervention, Sabine gradually started to recall certain aspects of memories that she thought she had forgotten. For example, she remembered her rapist’s clothes, gray shirts, and white shoes. She found that her memories were clearing again without being overwhelmed by them.

During therapy, Sabine frequently indicated that she considered herself worthless. This negative self-image appeared to be strongly driven by the memory of being beaten by her ex-partner while holding her child (Memory #3). This memory was for Sabine, the strongest proof that she was worthless. During the processing of this memory, there was “loops.” This term refers to a stalled information processing process. Despite the continuous stimulation of information processing through the working memory load of the therapist’s moving fingers, no shift from dysfunctional to functional occurred, which meant that Sabine was still convinced that she deserved this beating. Furthermore, processing was blocked because of the feeling of being in danger during the session, which was driven by the thought that he might come in at any moment. To enable Sabine to allow the processing process to take a different, more functional direction, the therapist used so-called “cognitive interweaves” (Shapiro, 2018). This is a short, preferably open, question, or suggestion from the therapist that provokes a stream of thought, action, or imagination in the client, with the aim of enabling the process by making functional information accessible or by inserting new functional information. To break the feeling that Sabine would be in danger, the therapist asked her (the cognitive interweave): “Where is your ex-husband now?” The answer “He is in prison”, immediately followed by a set of eye movements led to a more sense of safety in the present. Another type of interweave that the therapist used has been developed in the context of imagery rescripting and is aimed at strengthening the inner connection between the (adult) client in the present and the victim (often themselves as a child) in the past (Smucker et al., 1995). When Sabine’s compassion for herself as the victim has become tangible, the therapist asked her what she would like to say to the victim now, with that feeling of compassion, and was then encouraged to imagine and enact it in fantasy. The latter type of interweave the therapist applied was intended to alleviate feelings of powerlessness in relation to her perpetrator. Sabine was explicitly given the opportunity

<table>
<thead>
<tr>
<th>Order</th>
<th>Trauma memory</th>
<th>Initial SUD-score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Physical violence ex-husband</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>Rape by ex-husband</td>
<td>9</td>
</tr>
<tr>
<td>3</td>
<td>Physical violence with child in arms</td>
<td>9</td>
</tr>
<tr>
<td>4</td>
<td>Locked up in a barn</td>
<td>9</td>
</tr>
<tr>
<td>5</td>
<td>Threat with gun by ex-partner</td>
<td>8</td>
</tr>
<tr>
<td>6</td>
<td>Rape at the street</td>
<td>8</td>
</tr>
<tr>
<td>7</td>
<td>Ex-husband throws hot coffee in her face</td>
<td>8</td>
</tr>
<tr>
<td>8</td>
<td>Judge’s ruling that she is no longer allowed to see her daughter</td>
<td>5</td>
</tr>
<tr>
<td>9</td>
<td>Ex-husband scolds her and shouts that she is only good for sex</td>
<td>5</td>
</tr>
<tr>
<td>10</td>
<td>Jacket catches fire during a fight</td>
<td>2</td>
</tr>
<tr>
<td>11</td>
<td>Confrontation with ex-partner’s mistress</td>
<td>10</td>
</tr>
<tr>
<td>11</td>
<td>Not allowed to be present when people visited Sabine’s home; she was locked up</td>
<td>8</td>
</tr>
<tr>
<td>12</td>
<td>Not allowed to buy clothes, contrary to her brother</td>
<td>10</td>
</tr>
<tr>
<td>13</td>
<td>Evaluation interview at work with a negative assessment</td>
<td>8</td>
</tr>
</tbody>
</table>

Abbreviation: SUD, subjective unit of distress.

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>Sabine’s list of disturbing events that were addressed.</th>
</tr>
</thead>
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to imagine, in fantasy, what they would like to deal with the situation now as a more experienced adult. Sabine was asked whether she would want to express what she now thinks of her ex-husband, imagine physically harming the perpetrator, or both. Therefore, the therapists emphasized that it was about fantasy. Sabine immediately reacted as she felt and said, “You have to keep your hands off me, you filthy bastard that you are.” By giving herself explicit consent to express herself in this way, Sabine felt liberated from moral reins and enabled her to “let go.” The series of interweaves had a positive effect on the processing process, and Sabine felt that a huge burden had been lifted off her shoulders. It also helped her understand that she was not a weak or worthless person but that she experienced very bad events that had severely affected her self-image. She realized that she is now a brave and independent woman, and that the terrible events she had endured were over. She viewed herself as a strong woman, and her violent ex-husband as a small man.

When the therapist arrived at the memory of the street rape (memory #6), the treatment process stalled. Sabine felt unable to describe and share the memory with the therapist, which was likely to stem from self-disgust or self-hate, especially because she was accused of having contributed to the sexual assault. It was clear that she felt embarrassed about what had happened and was afraid to talk about it. Because “Blind to therapist” is a procedure to desensitize a memory without the patient having to share the event with the therapist, the therapist assured Sabine that the trauma story did not need to be shared, but that it was enough to “just think about it.” The therapist was convinced that Sabine was sufficiently motivated to take memory into working memory and use the standard cognition “I am powerless.” After each set, Sabine was indicated nonverbally, or with a catchword, what had come up, and whether anything came up at all, so that the therapist could estimate when to go back to the target. The latter was also performed blindly: “Please retrieve the image we started with sabine. As it is now stored in your head and concentrates on the most disturbing detail, please.”

Over the course of the sessions, the SUD scores of the processed memories began to decline at an accelerated rate. Often, the sessions ended with the thought that she had survived, and she was happy that she could now make good choices for her. After memories from the hierarchy were dealt with, Sabine reported her worst fear: a confrontation with her ex-husband. This fear was addressed by targeting this fear with EMDR therapy incorporating the flashforward procedure, after which she indicated that she was no longer afraid of him.

### 3.4 Outcome and prognosis

After 10 biweekly sessions, all selected memories from the case conceptualization were successfully processed. Sabine no longer met the criteria for Complex PTSD and no longer suffered from intrusive memory. She gradually stopped avoiding situations and lost her alert state. At the end of treatment, her total CAPS score was 0 and her PTSD Check List (PCL-5) total score was 17. Figure 1 shows the course of Sabine’s total CAPS-scores.

![CAPS Scores](image)

**FIGURE 1** Sabine’s CAPS-5 scores at pre- and post-treatment.
Sabine no longer met the diagnostic criteria for borderline personality disorder (SCID-5-P total score was 11 and the score on borderline personality was 2), and she reported better regulation of her emotions and significant behavioral changes. She had peace of mind and was doing pleasant things again. Sabine also took the risk of making contact with other people again without becoming very anxious. She felt that she was better able to make her own choices. This realization boosted her confidence and led her to take up new hobbies, including paintings.

4 | CLINICAL PRACTICES AND SUMMARY

There is growing evidence that trauma-focused treatments, including EMDR therapy, are effective not only for the treatment of PTSD but also for the treatment of clients with a history of interpersonal trauma in early childhood, who suffer from symptoms characteristic of CPTSD. The efficacy of these treatments does not appear to be significantly influenced by the fact that the traumatic event is an interpersonal trauma in early childhood or by the person suffering from dissociations or other characteristic symptoms of CPTSD (Ehring et al., 2014; Hoeboer et al., 2020; De Jongh et al., 2016; Van Minnen et al., 2016; Wagenmans et al., 2018; Van Woudenberg et al., 2018; Zoet et al., 2018, 2021). This notion is further illustrated by the case study presented here, which describes the treatment of a woman with Complex PTSD and borderline personality disorder. There has been a long-standing debate over whether CPTSD and borderline personality disorder differ substantially enough to warrant separate diagnostic classification. In a recent study in a clinical sample of 330 polytraumatized individuals using network analysis, it was found that the symptoms of ICD-11 PTSD and the DSO cluster and borderline personality disorder differ (Owczarek et al., 2023). In our opinion, this justifies the decision to make both diagnoses in this patient.

The results of the treatment during which a variety of interventions were used, including the “Flashforward technique,” cognitive interweaves and the “Blind to therapist method” are in line with the underlying model of EMDR therapy, the AIP model. This predicts that if the therapy focuses on desensitizing meaningful memories or other mental representations that are believed to underlie the patient’s presented complaints, it will affect their presenting symptoms and comorbid psychopathology, a process commonly referred to as “processing.” We would like to argue in favor of approaching the treatment of CPTSD in the same way as treating “regular” PTSD (De Jongh et al., 2016).

This may need to be supplemented with the use of various strategies to identify and address memories that are at the core of the client’s pathology and the application of a wide array of evidence-based interventions. In this respect, it is important to note that this reasoning applies not only to complaints that arose directly after one or more major events that met the A criterion (confrontation with death or sexual violence), but to almost all types of memories. This is well reflected in the results of a series of studies testing the efficacy of EMDR therapy, in which significant improvements in personal functioning were found after only a few sessions of EMDR therapy, both in patients with PTSD and symptoms characteristic of a (borderline) personality disorder (De Jongh et al., 2020; Kolthof et al., 2022) as well as in people diagnosed with a personality disorder without PTSD (Hafkemeijer et al., 2020). In the latter study, approximately half of the 49 participants had been exposed to emotional neglect, 23% to emotional abuse, and 27% to some other type of event. Interestingly, no significant differences in symptom reduction associated with the application of EMDR therapy among memories involving these three different types of adverse events were revealed. To this end, these results support the notion that EMDR therapy is not only an effective therapy for memories related to A-criteria-worthy events but is also a valuable treatment for the consequences of interpersonal trauma in childhood in clients suffering from a personality disorder. Thus, when these memories are processed, the severity of symptoms decreases (Hafkemeijer et al., 2021).

It is important to note that treatment for CPTSD will not always proceed that smoothly, as in the case described above. In this paper, we have tried to offer a number of recommendations for difficult cases, but it is impossible to describe the treatment of all potential problems, complications, and possible solutions. In addition, many situations require experience and specific expertise, such as working with comorbid addiction, drug dependence, intellectual disabilities, psychosis, or treating refugees, where language and cultural differences play a role. To this end, it is also
important to note that EMDR therapy is not only aimed at remission of symptoms, but also focuses on addressing problems in the patient’s attachment and repairing the concomitant injuries inflicted, so that there can be personal growth, which is “often described as healing as well as transformative, not just because of the memory reprocessing but also because of the relationship between the therapist and client, and the shared experience or going through it together” (Laliotis et al., 2021).

In conclusion, the treatment results support the utility of trauma-focused treatment of Complex PTSD and the notion that EMDR therapy is a safe and potentially effective treatment alternative for this mental health condition. However, although the results are promising, it is clear that future research on the treatment of CPTSD is still urgently needed, especially studies involving individuals with a long history of psychiatric (inpatient) treatment. It seems likely that better designed research will become available in the coming years to clarify how EMDR therapy and other trauma-focused treatments in clients with CPTSD can be applied in the safest, most efficient, and cost-effective way.

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CONFLICT OF INTEREST STATEMENT
Ad de Jongh receives income from published books on EMDR therapy and from training postdoctoral professionals in this method.

DATA AVAILABILITY STATEMENT
The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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PEER REVIEW
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