6th International Trauma Informed Care in Practice online conference, Nov 2025
"Overcoming dilemmas & challenges to maximise outcomes in complex trauma"

TREATMENT AS USUAL FOR CPTSD IN NHS SERVICES IN SCOTLAND

CONSIDERING THE PERSONAL, TREATMENT & SERVICE FACTORS

DR EDEL MC GLANAGHY

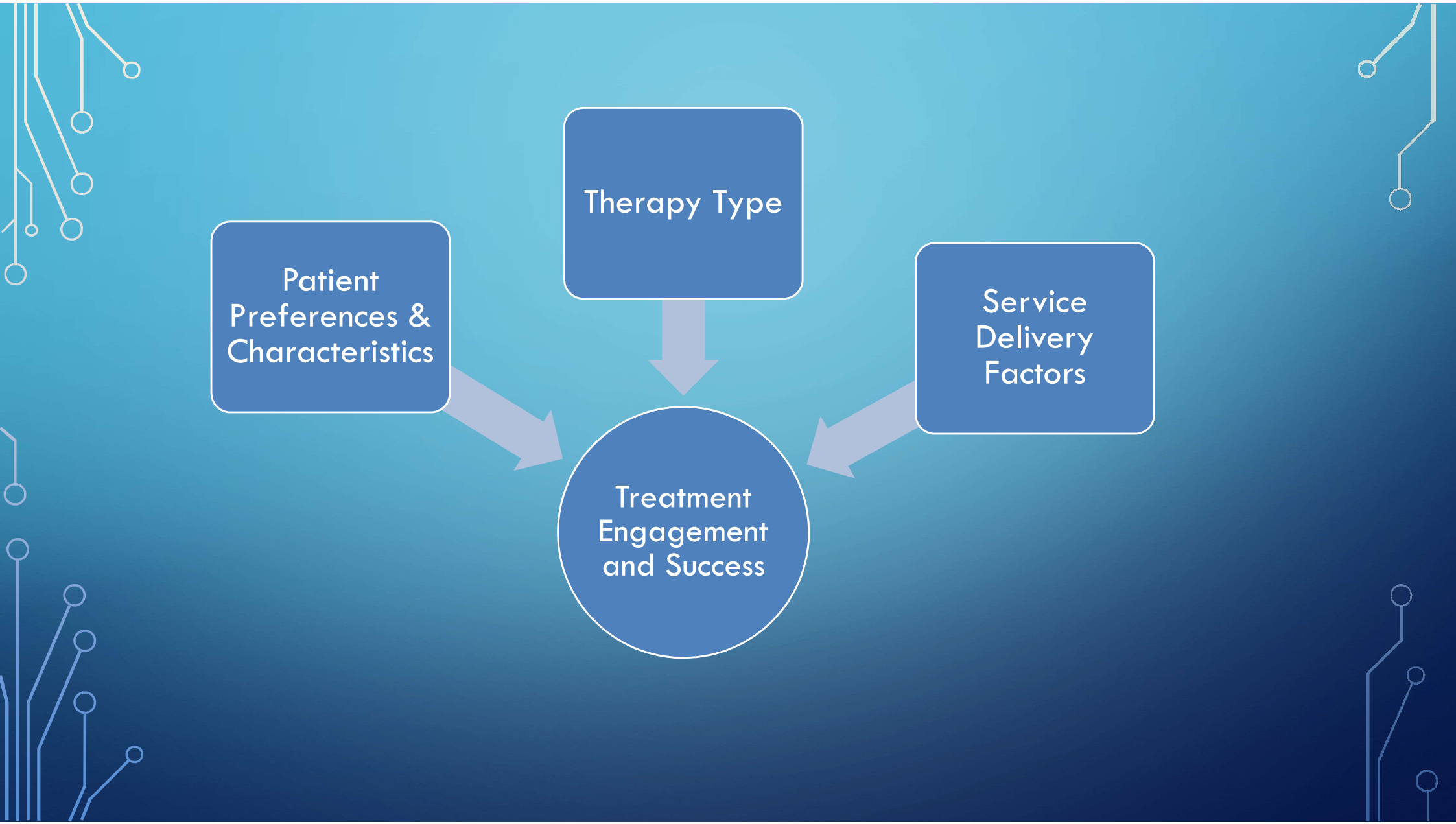
CLINICAL PSYCHOLOGIST & NRS CAREER RESEARCH FELLOW

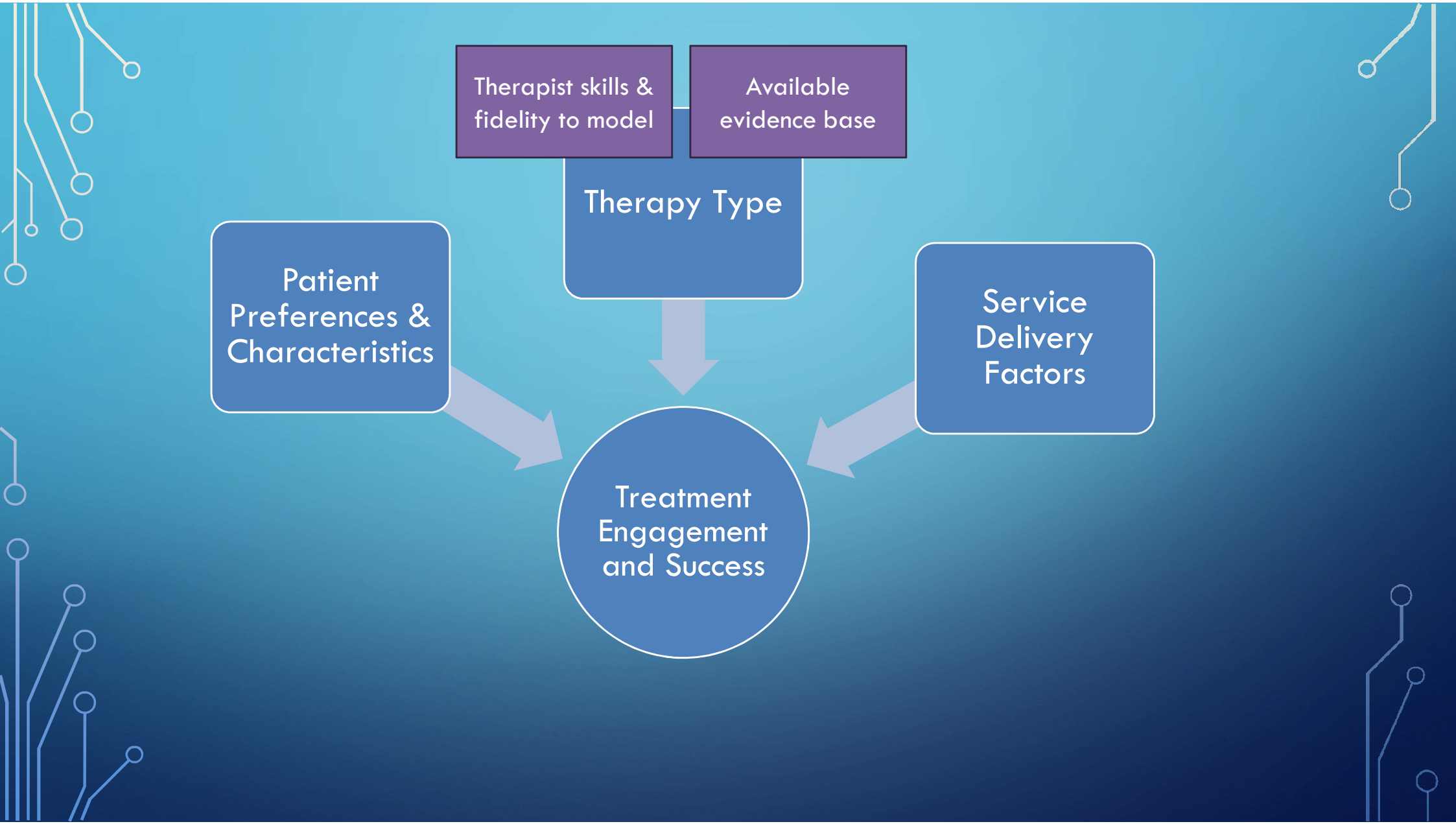
CONTEXT FOR MY RESEARCH

- Clinical Psychologist delivering psychological therapy in NHS services for people with CPTSD
- Team Lead and Supervisor supporting teams to also deliver psychological therapy
- Regional Trauma Informed lead (TPTIC)
- NRS Research Fellowship investigating;
  - Trauma Informed understandings of why people with complex trauma histories dropout from NHS psychological therapy

RESEARCH PORTFOLIO SHARED TODAY

- 1. Brief summary of drop out/engagement rates in current services
- 2. Factors influencing patient Journey through services
- 3. Peer research into reasons for drop out
- 4. …and current Treatment as Usual for CPTSD


Therapy Type
Patient Preferences & Characteristics
Service Delivery Factors
Treatment Engagement and Success


Therapist skills & fidelity to model
Available evidence base
Therapy Type
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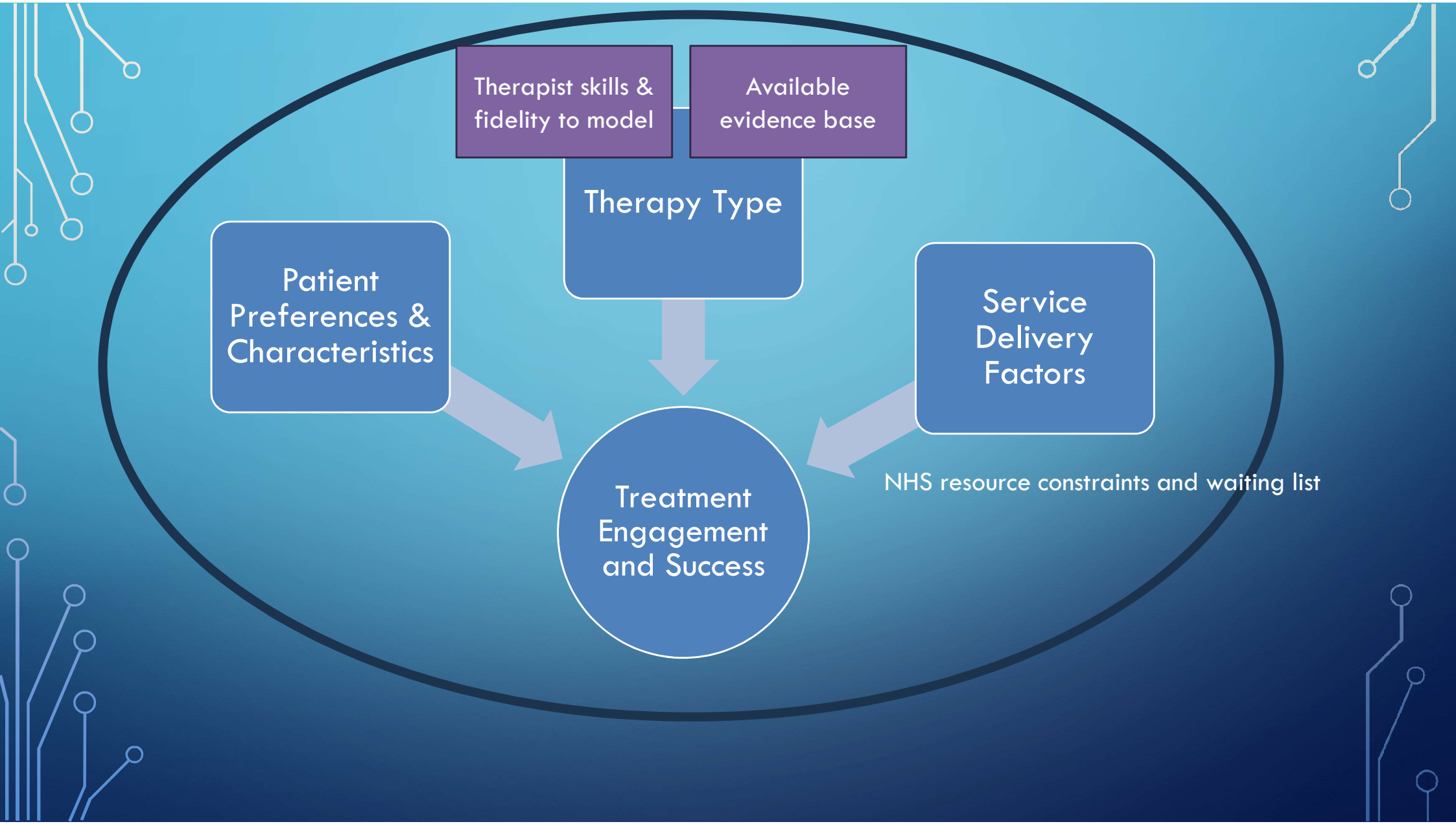

Therapist skills & fidelity to model
Available evidence base
Therapy Type
Patient Preferences & Characteristics
Service Delivery Factors
NHS resource constraints and waiting list
Treatment Engagement and Success

Review > Eur J Psychotraumatol. 2020 Mar 9;11(1):1709709.

doi: 10.1080/20008198.2019.1709709. eCollection 2020.

Dropout from psychological therapies for post-traumatic stress disorder (PTSD) in adults: systematic review and meta-analysis

Catrin Lewis [1], Neil P Roberts [1 2 3], Samuel Gibson [1], Jonathan I Bisson [1]

Pooled rate of dropout from RCTs of psychological therapies for PTSD was 16% (95% CI 14-18%).

Dropout from guideline-recommended psychological treatments for posttraumatic stress disorder: A systematic review and meta-analysis

Tracey Varker [a], Kimberley A. Jones [a], Hussain-Abdulah Arjmand [a], Mark Hinton [a], Sarah A. Hiles [b], Isabella Freijah [a], David Forbes [a], Dzenana Kartal [a], Andrea Phelps [a], Richard A. Bryant [c], Alexander McFarlane [d], Malcolm Hopwood [e], Meaghan O'Donnell [a]

2021 The dropout rate for guideline recommended psychological PTSD treatments is 20.9%.

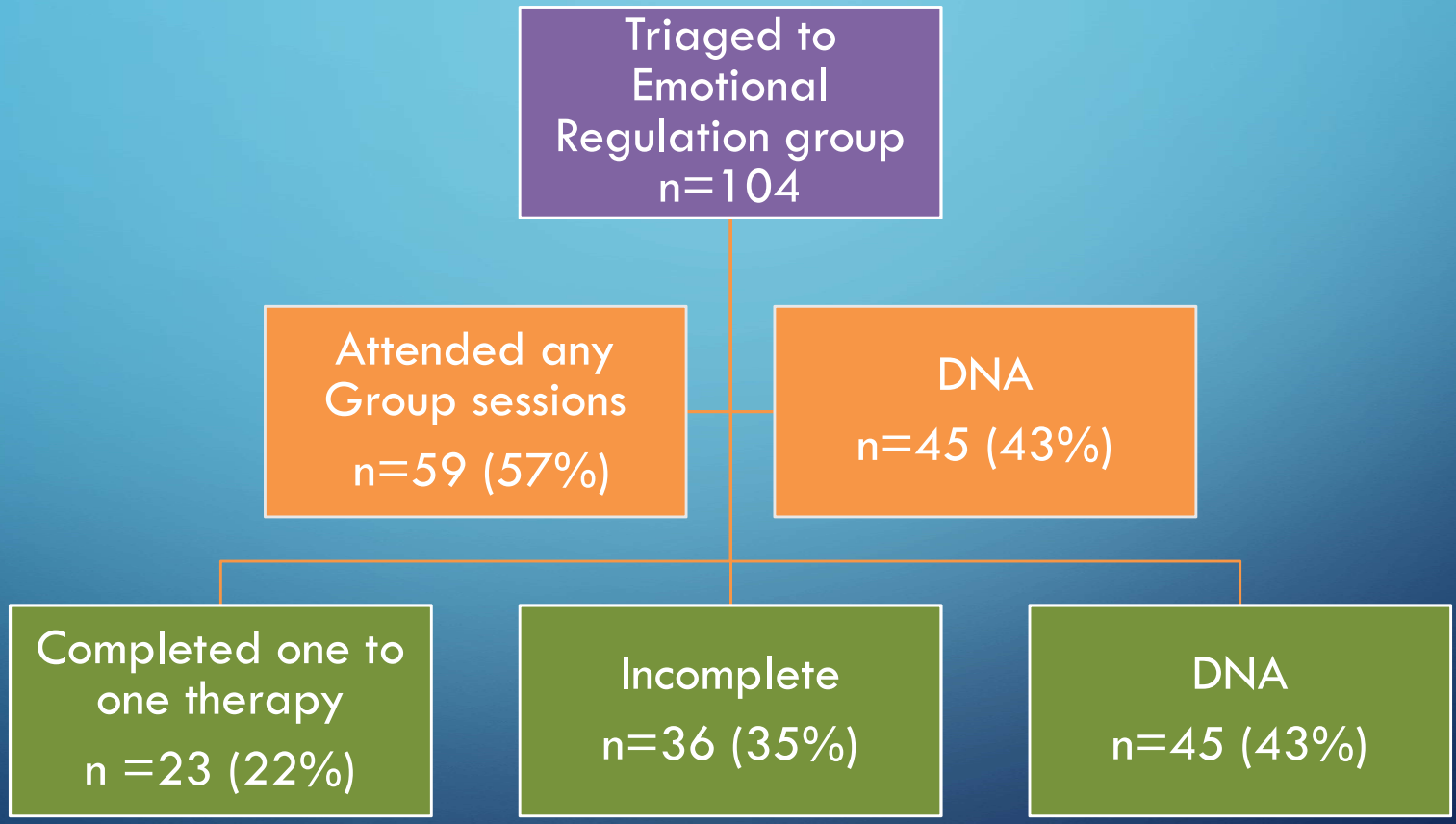
Dropout by military and veteran populations was higher than for civilians.

Predictors of study dropout in cognitive-behavioural therapy with a trauma focus for post-traumatic stress disorder in adults: An individual participant data meta-analysis

Author affiliations • Simonne Wright [1 2], Eirini Karyotaki [2], Pim Cuijpers [2 3], Jonathan Bisson [4], Davide Papola [5 6], Anke B Witteveen [7], Sudie E Back [8], ... 40 Show all authors

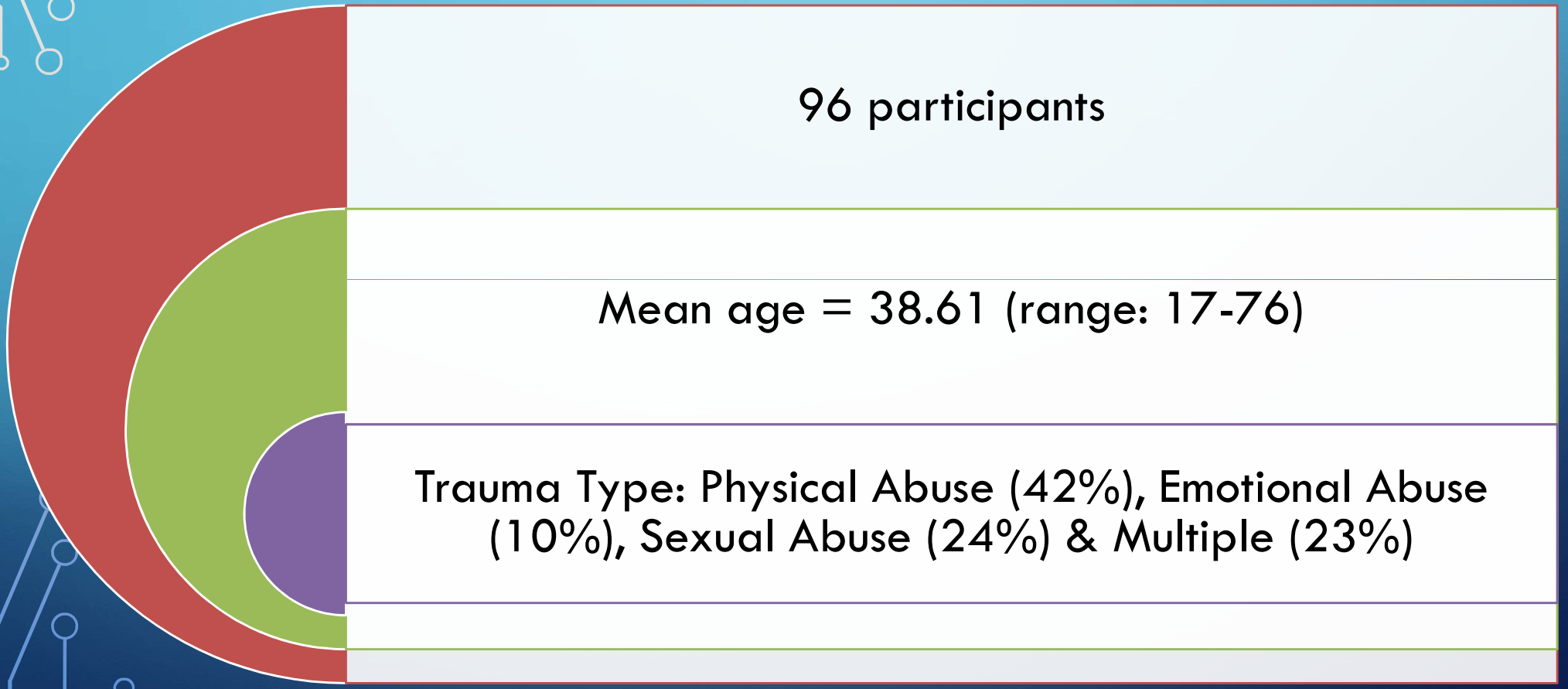
2024. 23% civilian drop out, 42% of veterans. Chance of drop out decreased with advancing age.

1. ENGAGEMENT WITH TRAUMA PATHWAY 2019-2024



With thanks to Laura Brosnan

2. PERSONAL AND SERVICE FACTORS- SAME SAMPLE



• With thanks to Stefanie Marsh

RESULTS

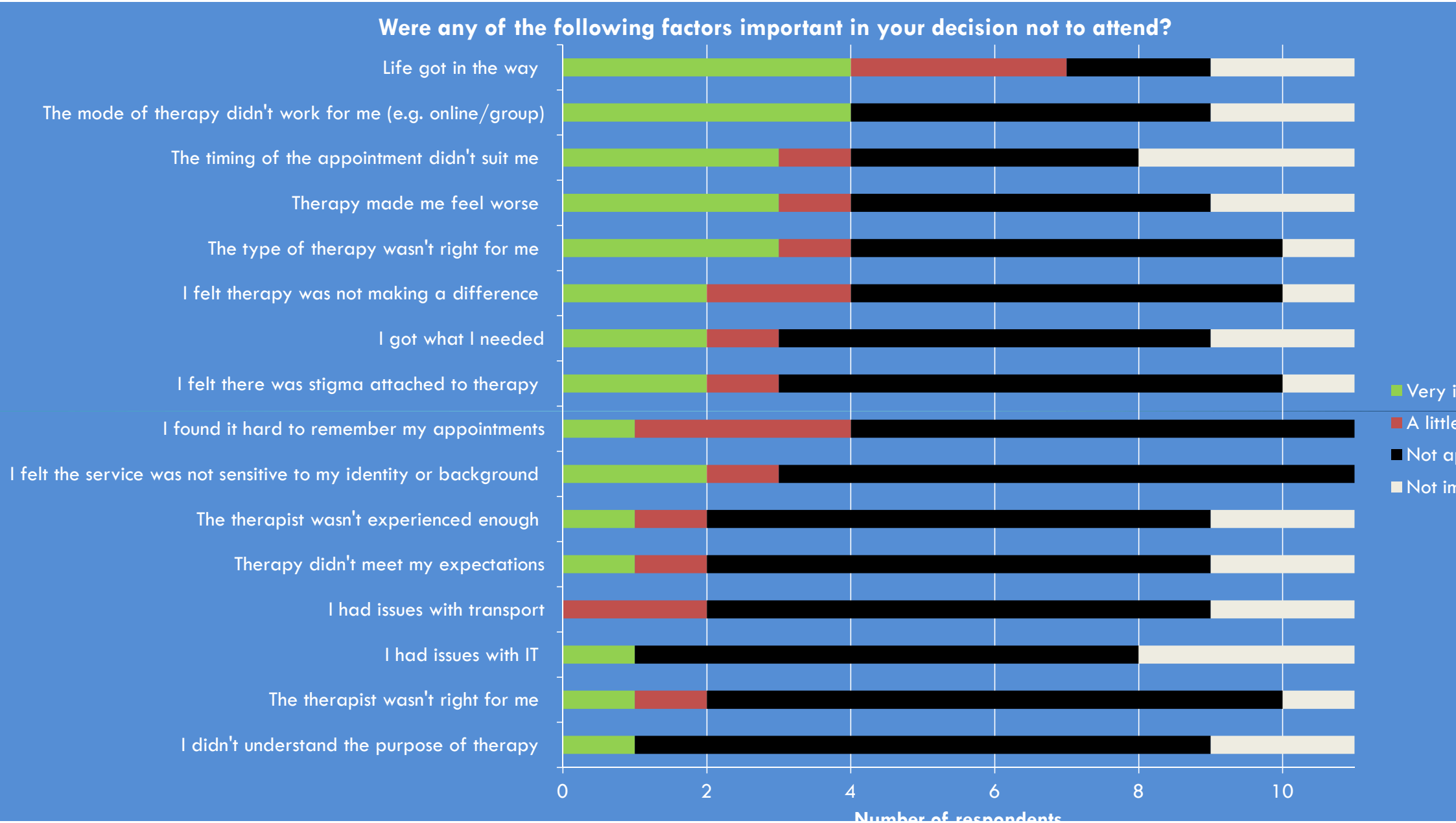
- Female patients were more likely to engage
- No influence of age on engagement
- No influence of type of trauma
- No relationship of therapy type on outcome
- Therapist Qualification had significant effect on missed appointments (NP = 12.20 vs QP = 6.58).

3. PEER LED PROJECT



1. Identify people eligible to participate	2. Invite them to complete a survey	3. Invite those who complete survey to interview
60 eligible	12 responses (20%)	3 interviews

With thanks to Sophie Lawson


Were any of the following factors important in your decision not to attend?
Life got in the way
The mode of therapy didn't work for me (e.g. online/group)
The timing of the appointment didn't suit me
Therapy made me feel worse
The type of therapy wasn't right for me
I felt therapy was not making a difference
I got what I needed
I felt there was stigma attached to therapy
I found it hard to remember my appointments
I felt the service was not sensitive to my identity or background
The therapist wasn't experienced enough
Therapy didn't meet my expectations
I had issues with transport
I had issues with IT
The therapist wasn't right for me
I didn't understand the purpose of therapy
0
2
4
6
8
10
Number of respondents
Very i
A little
Not a
Not im

WHY DIDN'T YOU ATTEND: INTERVIEWS

Three main themes identified:

1. System rigidity
2. Therapy didn't help in the way it should've
3. Nevertheless, we persisted

WHAT COULD HAVE HELPED?

Clearer expectations	Understanding
Better communication	Easier access
More support	Peer-support
More flexibility	Choice of mode
Change in policy	

4. WHAT ARE PEOPLE DROPPING OUT FROM: TREATMENT AS USUAL FOR CPTSD

- Historical context of treatment prior to introduction of CPTSD diagnosis
- National guidance working group for CPTSD in Scotland *The Matrix
- Designing RCT for CPTSD and wondered how to characterize TAU
- Service delivery- considering how to translate newest innovation into practice
- All researchers- a bit nosey!

INTRODUCTION

- NICE (2018) for PTSD- TFCBT and EMDR being adapted and evaluated with specific populations, such as people with experiences of childhood sexual abuse and veterans with combat trauma (Karatzias, Murphy et al, 2019)
- Strong culture of 'phased based' approaches
- Emerging evidence about not delaying processing (Sele et al, 2023; van Vilet et al, 2021)

METHOD

Setting and participants: Practicing therapists, NHS psychological therapies services Scotland

Data collection : Anonymous survey on Microsoft forms emailed via management networks Feb to April 2024.

- Clinician characteristics, reported therapeutic approach to CPTSD, latest 3 cases for CPTSD and the outcome.

Data Analysis: Descriptive statistics and content analysis

Ethical approval: Caldicott approval locally. National Public Benefit and Privacy Panel for Health and Social Care was consulted and approved the study.

SAMPLE

- 47 clinicians reported 139 patient cases.
- Most were clinical psychologists (64%), then counselling psychologists (15%), nurse psychotherapists (11%) and other psychological therapists (10%).
- Working in Adult Psychological therapy services (40%), secondary care psychology (32%) and older adult services (9%), with others in other specialties such as Learning disability, clinical health Eating Disorders, Prison

CLINICIAN OFFER FOR CPTSD

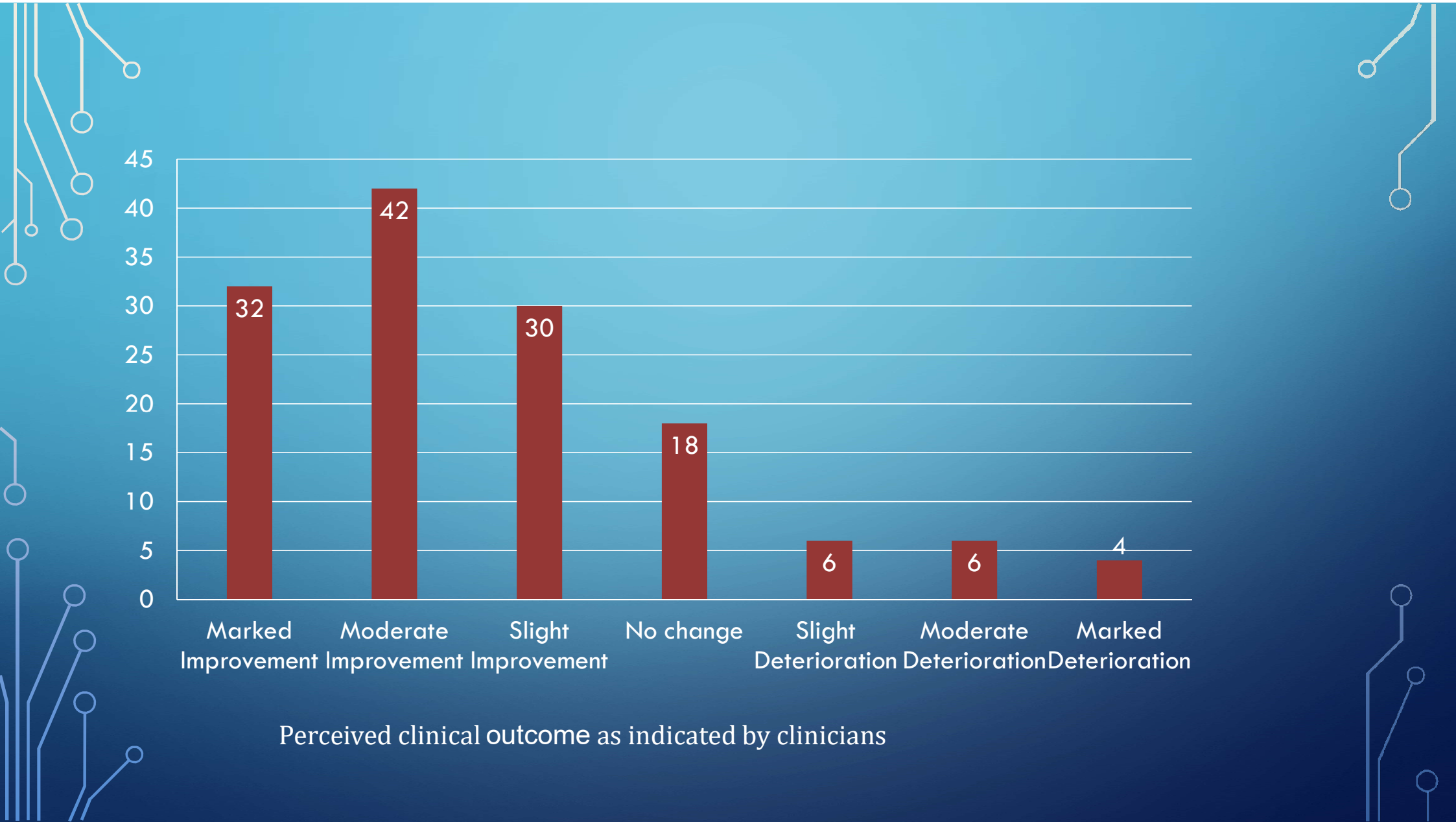
- Twenty (43%) specifically referred to using formulation to determine intervention.
- Eleven (23%) described using multiple models in a blended/integrative fashion
- Nine (19%) described applying interventions in a modular fashion.
- Session length: 50/60 minutes, (3 x30-minute sessions). Twenty-five (53%) clarified also offer 90 minutes for trauma memory reprocessing.

Therapeutic Approach	Mentioned in text response	
CBT with a Trauma focus/TFCBT	39	83%
Phase based Safety & Stabilisation	30	64%
Emotional regulation skills development	24	51%
EMDR	24	51%
Compassion Focused Therapy	16	34%
Schema therapy	8	17%
Prolonged Exposure	7	15%
Acceptance & Commitment Therapy (ACT)	6	13%
Dialectical Behavioural Therapy	3	6%
Narrative exposure therapy	2	4%
Interpersonal Therapy (IPT)	2	4%
Cognitive Analytic Therapy (CAT)	2	4%
Assertiveness skills	2	4%
Mindfulness	0	0%
Supportive Counselling	0	0%
Mentalization based therapy	0	0%
Other: Imagery Rescripting	3	6%

Most (89%) described using a trauma memory reprocessing therapy in their responses

Therapeutic Approach	Mentioned in text response		Chosen from list	
CBT with a Trauma focus/TFCBT	39	83%	38	81%
Phase based Safety & Stabilisation	30	64%	38	81%
Emotional regulation skills development	24	51%	37	79%
EMDR	24	51%	26	55%
Compassion Focused Therapy	16	34%	31	66%
Schema therapy	8	17%	11	23%
Prolonged Exposure	7	15%	17	36%
Acceptance & Commitment Therapy (ACT)	6	13%	14	30%
Dialectical Behavioural Therapy	3	6%	14	30%
Narrative exposure therapy	2	4%	14	30%
Interpersonal Therapy (IPT)	2	4%	8	17%
Cognitive Analytic Therapy (CAT)	2	4%	2	4%
Assertiveness skills	2	4%	17	36%
Mindfulness	0	0%	21	45%
Supportive Counselling	0	0%	6	13%
Mentalization based therapy	0	0%	5	11%
Other: Imagery Rescripting	3	6%	0	0%

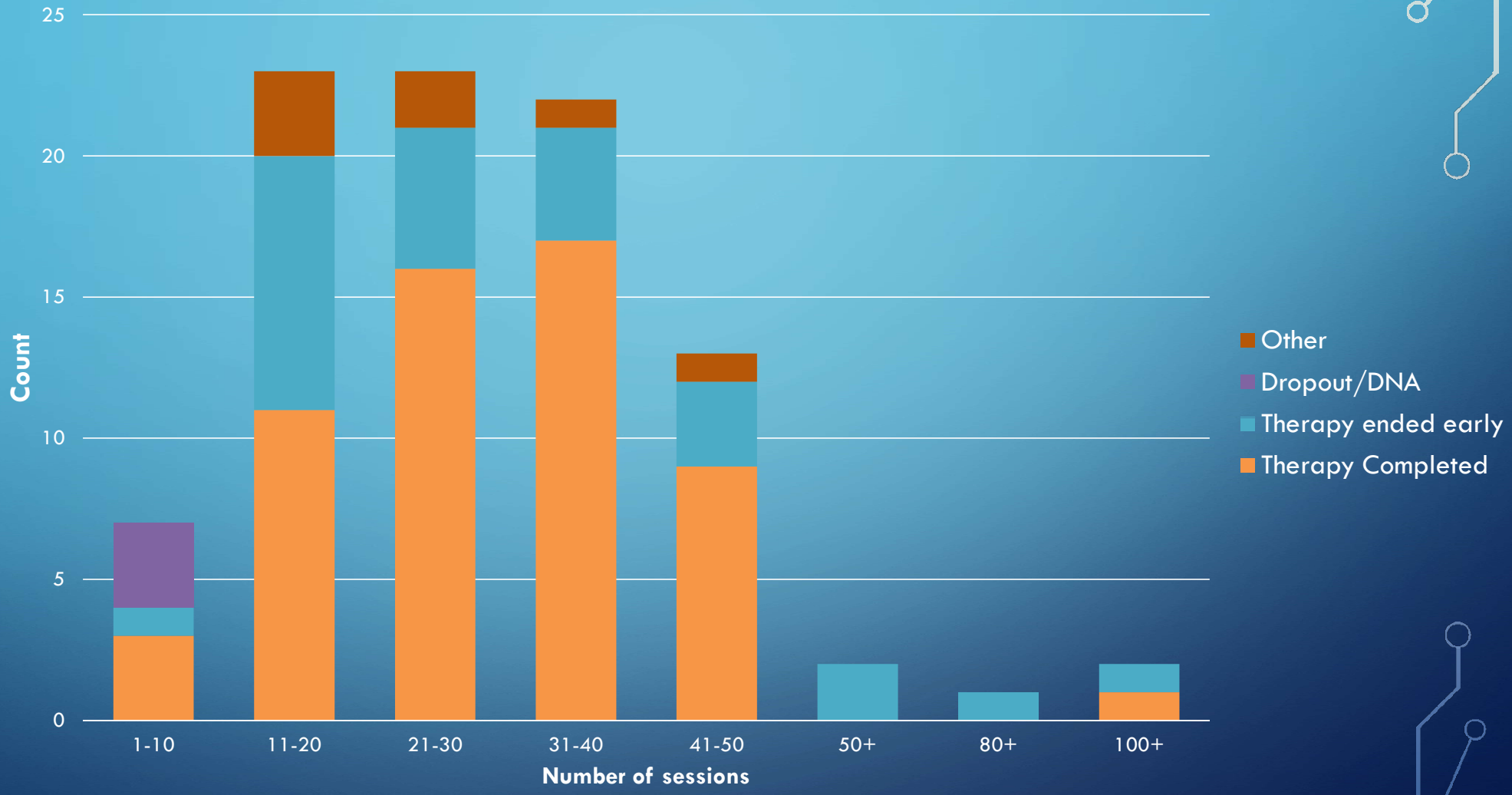
PATIENT OUTCOMES



Perceived clinical outcome as indicated by clinicians

Table 2: How therapy ended and clinician described outcome

	Completed	Incomplete	DNA/ Dropout	Other
	n= 79	**n = 39**	**n= 10**	**n=11**
Improved (n=104)	68 (86%) 49% of total	24 (62%)	2 (20%)	10
No change (n=18)	1 (1%)	11 (28%)	6 (60%)	0
Deteriorated (n=16)	9 (11%)	4 (10%)	2 (20%)	1



Number of sessions and perceived clinician rated patient outcome

CONCLUSIONS

- Huge variance in approach, session numbers and clinician reported outcomes
- Phased based, Trauma memory reprocessing and TFCBT dominate
- This makes predictability and governance difficult
- Modular and manualised approaches the cover both skills and trauma memory reprocessing, such as ESTAIR, may offer a service compatible solution

PEER SUGGESTIONS & FUTURE DIRECTIONS

Let people know what's happening and what to expect	Improve service communication and clearer policies
Offer more support when people don't attend	Considering trial of peer waiting list coordinator
Offer more choice and flexibility	Offer choice between Past focused, Present focused and skills-based treatments
Consider alternatives to the group	Use of modular approaches offering consistency and choice
Let people share in their own time	

THANK YOU

- To everyone who contributed, especially the ERG cohort whose information has been used.
- Stef Marsh and Laura Brosnan and all the assistants who contributed to this work, especially Rhiannon Gil
- Management and colleagues for supporting these projects
- Prof Thanos Karatzias for post doctoral support
- Endowments & CSO funding
- To Sophie.