TRAUMA RESPONSIVE PRINCIPLES AND INTERVENTIONS IN THE TREATMENT OF COMPLEX TRAUMA IN ADULTS: THE *PRISM META-MODEL*

INTERNATIONAL CHILDHOOD TRAUMA SYMPOSIUM

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TREATING COMPLEX TRAUMA IN ADULTS: THE **PRISM** META-MODEL

- **Agenda**
  - Expanding understanding of complex traumatic stress disorders and effects
  - **Complex PTSD: a diagnosis whose time has come!**
  - Advances in assessment and treatmen

COMPLEX TRAUMA:

EXPANDING DEFINITIONS AND UNDERSTANDING

PRIMARY CHARACTERISTICS OF COMPLEX TRAUMA

- Interpersonal, **intentional;** often involves relational/role **betrayal**
- Often emotional as well as physical traumatization
- Direct attack/exploitation/harm/grooming within relationship
- Repeated, prolonged, pervasive, layered, ongoing (?)
- Entrapping, inescapable, conditions of accessibility/captivity
- Disregard/non-protection and non-intervention
- Victim blame and shame when disclosed/reported/discovered

COMPLEX TRAUMA: THE "I'S" HAVE IT

- ***Interpersonal***
- Intentional
- Inescapable
- Intimate perpetration
- Invasive, intrusive
- Intensive
- Injurious
- Insidious
- Irreparable (?)

- Imminent threat to individual &/or intimates
- Identity assailed and deformed
- Identity dis-integration/ dissociation
- Integrity impacted
- Interpersonal distrust and disruption
- Intervention: DARVO (Freyd, 1997)

COMPLEX TRAUMA IN CHILDHOOD

- Relational and attachment trauma
  - Pre-birth, infancy and early childhood
  - Attachment insecurity and disruptions, loss
  - Parent/child attachment styles
    - Good enough → secure, self and other-reliant
    - Anxious/intrusive → anxious/pre-occupied
    - Non-responsive → avoidant/detached
    - Disorganized/disoriented → disorganized/dissociative/incoherent
- Child abuse—sexual, physical, emotional & abandonment, and neglect
- Domestic violence
- Community violence
- Discrimination/bullying
- Revictimization
- Other….

COMPLEX DEVELOPMENTAL/ DISSOCIATIVE TRAUMA IN CHILDHOOD

- Child is maturationally vulnerable
- Development is severely impacted and compromised
    - bio-psycho-social maturation & development, including attachment capacity/style & other
    - epigenetics
    - neurophysiology
    - psychophysiology
- "survival" vs. "learning brain" *and body*
    - not associated with intelligence
    - somatosensory and implicit impact: right brain

OTHER FORMS OF COMPLEX TRAUMA ACROSS THE LIFESPAN

- Community violence
- Domestic violence and IPV
- Deep and chronic poverty
- Racism, race-based trauma and discrimination
- Combat trauma: warrior or civilian, POW
- Terrorism
- Political trauma: persecution, "ethnic cleansing", displacement, refugee status
- Immigration and resettlement
- Slavery/trafficking: forced servitude and prostitution
- Chronic illness w/ invasive treatment
- Bullying
- Sexual harassment
- Other...pandemic…political atmosphere

- Can cause developmental regressions and posttraumatic disorders

COMPLEX PTSD: ORIGINAL FORMULATION PROPOSED TO *DSM-IV* (HERMAN, 1992)

- Seven primary criteria of alterations in:

- 1. affect regulation
- 2. consciousness (dissociation)
- 3. self-perception
- 4. perception of the perpetrator
- 5. relations with others
- 6. somatosensory impact
- 7. systems of meaning

- Accepted by committee but ***not*** listed when *DSM-IV* published

COMPLEX PTSD DEFINED (ISTSS, 2012)

- Expert consensus survey & treatment guideline developed:

50 experts in PTSD & complex trauma treatment

- Core symptoms of PTSD, *plus*
- Range of disturbances in self-regulatory capacities-- often developmental during childhood:

  - Emotion regulation
  - Attention and consciousness (dissociation)
  - Relational
  - Belief systems
  - Somatic distress or disorganization

26 YEARS AFTER HERMAN'S ORIGINAL PROPOSAL…

- In June 2018 WHO ICD-11 included Complex PTSD and in May 2019 all member states adopted it
- Recognition of diagnosis will
  - allow insurance reimbursement
  - support research funding
  - facilitate better treatment
  - Provide better science in the development of more effective therapies

(Cloitre, 2017)

ICD-11 PTSD AND COMPLEX PTSD

"Gate" Criterion: Traumatic Stressor

PTSD	Complex PTSD
Re-experiencing	Re-experiencing
Avoidance	Avoidance
Sense of Threat	Sense of Threat
	Affect Dysregulation
	Negative Self Concept
	Disturbed Relationships
Functional Impairment	Functional Impairment

World Health Organization

ICD-11 COMPLEX PTSD

- **PTSD**
  - **Re-experiencing** nightmares, flashbacks **in** here-and-now, as if it were happening (vs. rumination)
  - **Avoidance** of thoughts, feelings, places people associated with the trauma
  - **Sense of current threat** manifest by hypervigilance or an enhanced startle reaction
- **DSO (Disturbances in Self-Organization)**
  - **Emotions: Affect Dysregulation** heightened emotional reactivity, anger , recklessness, numbing, and dissociation
  - **Identity: Negative Self-Concept** marked by feeling diminished, defeated and worthless, feelings of shame, guilt, or despair
  - **Relationships: Difficulties Engaging and Maintaining** difficulties in feeling close to others, having little interest in engagement difficulty sustaining them.

CO-MORBID/CO-OCCURRING DISORDERS OF PTSD/CPTSD

Dissociative Disorders

Anxiety Disorders

Depression

Personality Disorders

Sleep disorders

Medical illnesses

Other affective disorders (bipolar, etc.)

PTSD or Complex PTSD

Addictions/Substance Abuse*

Eating Disorders

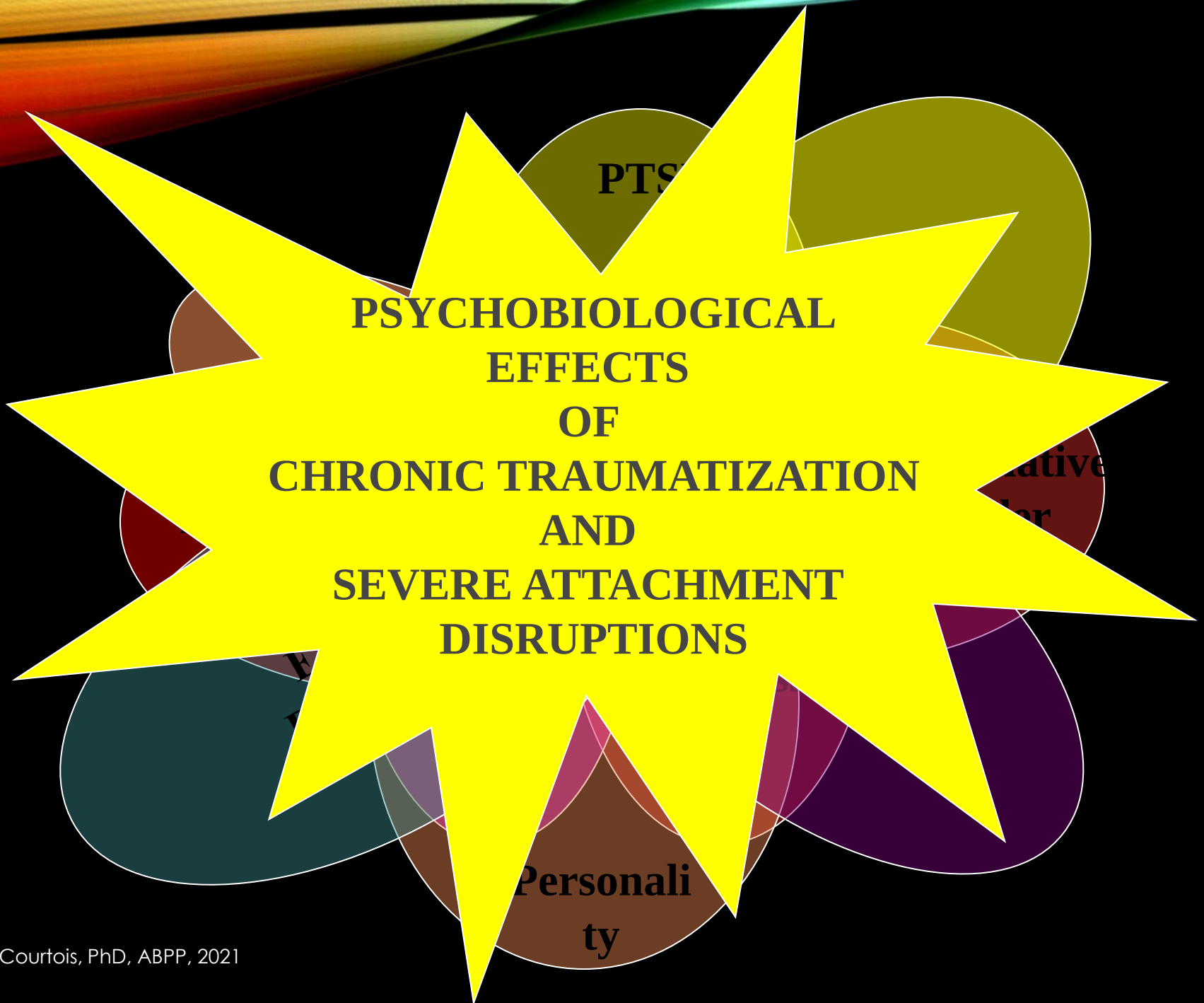
Obsessive-Compulsive Disorder

Brief reactive psychosis

Somatization

Many other reactions & complications

*Many the result of physiological dysregulation/attempts at self-regulation (tension reducing)



PSYCHOBIOLOGICAL EFFECTS OF CHRONIC TRAUMATIZATION AND SEVERE ATTACHMENT DISRUPTIONS

REACTIONS, ADAPTATIONS, SYMPTOMS, AND DIAGNOSES

LAYERING AND INTERTWINING OF REACTIONS OVER TIME

EXPRESSION:

CONTINUOUS
EPISODIC
DELAYED

COMPLEX TRAUMATIC STRESS DISORDERS

MUCH REMAINS TO BE LEARNED ABOUT COMPLEX TRAUMA AND ITS CONSEQUENCES/ADAPTATIONS/SYMPTOMS (I.E., COMPLEXITY THEORY OF TRAUMA EXPOSURE AND ADAPTATION) AND THAT CPTSD AS CURRENTLY DEFINED MAY BE TOO NARROW

TREATMENT OVERVIEW AND STRATEGIES

EVIDENCE-BASED PRACTICE

- Best research evidence
- Clinical expertise
- Patient values, identity, context, preference

American Psychological Association Council of Representatives Statement, August 2005

CPGS FOR "CLASSIC" PTSD

- Treatment outcomes: ***decrease of PTSD symptoms, remission of diagnosis***

- Predominance of Trauma-Focused Treatments (TFTs), those with most research evidence

- Benefits: They work!
  - Ever increasing data
  - Mixed samples of different populations

- Limitations: Not for everyone
  - Usually single vs. combined treatment
  - Dropout rates high; harms/adversity not addressed
  - Generalizability & feasibility

CPG FINDINGS: EFFICACIOUS TREATMENTS FOR CLASSIC PTSD

- Prolonged Exposure (PE)
- Cognitive Processing Therapy (CPT)
- Eye Movement Desensitization and Reprocessing Therapy (EMDR)
- Cognitive (CT) and Cognitive Behavior Therapy (CBT)
- Brief Eclectic Psychotherapy for PTSD (BEPP)
- Interpersonal Psychotherapy (IPT)
- Present-Centered Therapy (PCT)
- Narrative Exposure Therapy (NET)
- STAIR Narrative (STAIR NPT)
- Psych-education & other supportive
- Psychopharmacology: 3 main classes

SOME LIMITATIONS OF PTSD CPGS TO CPTSD

- Developed according to Institute of Medicine Standards
  - Use of RCTs and limited scoping questions in Systematic Review
  - How applicable are these to behavioral/mental health?
- Subject pool limitations
- Little attention to diversity of population
- No inclusion of qualitative studies
- Limited attention relationship variables and information
- Applicability and generalizability in question
- Little information on adverse effects

EVIDENCE- BASED RELATIONAL VARIABLES (EBR) OMITTED

- Despite the fact that there is a large body of RCT evidence
- Attachment and relational approaches undergird whatever techniques are used
- Need to be incorporated
- **Both relationship & technique make up the treatment and the relationship is a technical intervention**

QUESTION OF APPLICABILITY AND GENERALIZABILITY

FROM RESEARCH SETTING TO "REAL WORLD"

AND TO CPTSD/CSDT AND DSO

****

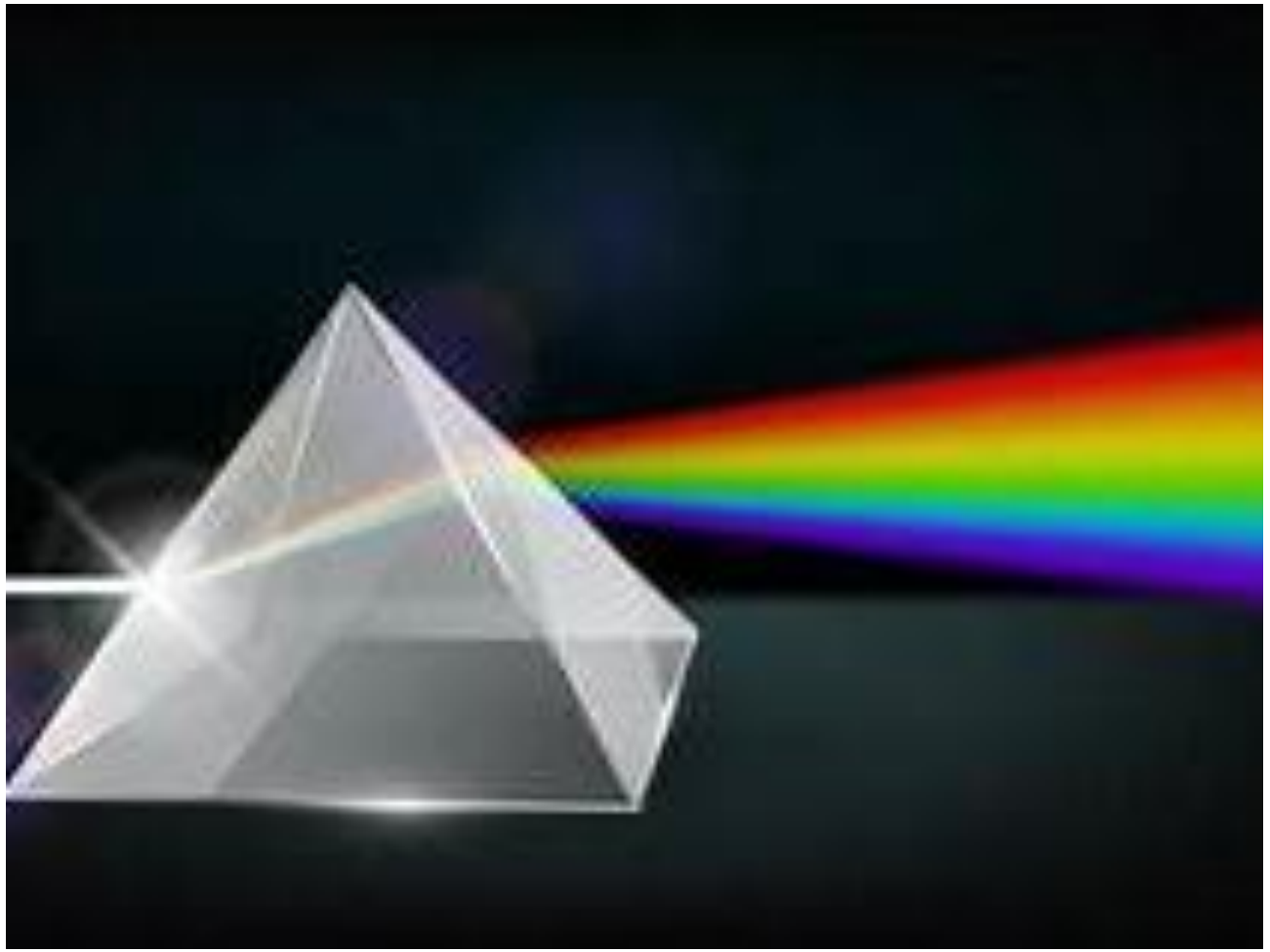
LACK OF DATA DOES NOT MEAN LACK OF EFFICACY

RESEARCH IS UNDERWAY FOR CPTSD TREATMENT

THE *PRISM* META-MODEL OF TREATMENT FOR COMPLEX TRAUMA AND CPTSD

THE *PRISM* META-MODEL

- Personalized
- Relational
- Integrated
- Sequenced
- Multi-modal and multi-component



PRISM

- Personalized/phenomenological
- Person-centered
- Priorities identified
- Psychophysiological approaches
- Preferences of client
- Past and-present-centered but future-oriented
  - Possibilities
- Personalization vs. disowning
- Presentification vs. past-oriented
- Philosophy of treatment
- Principles of treatment
- Preparation and training of therapist
- Professionalism of therapist

PRISM

- Relational
- Respectful
- Resonant
- Reflexive and not reactive
- Resolution of trauma
- Resilience enhancing
- Restore Self and relational capacity
- Recovery-oriented
- Risk management

PRISM

- Integrative
- Individualized
- Identity development
- Intensity titrated
- Intersectionality and context considered
- Impact on the therapist
  - Negative and positive transformation possibilities

PRISM

- Sequenced
- Strategic
- Security of relationship
  - "Safe Haven"
- Safety as priority
- Self-regulation
- Self-identification and development
- Security of attachment "earned"
- Selective
- Somatosensory
- Supervision and consultation

PRISM

- Memory processing as indicated for resolution
- Multi-modal
- Multi-dimensional
- Multi-component
- Modification as need
- Modulation
- Mindfulness and mentalization
- Medication and psychedelics?

PHILOSOPHY OF TREATMENT

- Respect for individual and right to self-determination
- Assumption of natural healing potential
- Strengths-based empowerment
- Therapeutic relationship: secure, attuned, and responsive
- Trauma-informed care: "What happened to you vs. what's wrong with you?"
- Evidence-based and supported treatment strategies
- Professional training and qualifications
  - Specialized training and trauma-competencies: APA and SW
- Ongoing supervision and consultation
- Impact on the therapist
  - Need for emotional health and ongoing self-care
  - Therapist with own trauma history

CONSENSUS TREATMENT PRINCIPLESS

1. Safety is an essential condition for successful treatment and may take time to develop.

2. Relational attachment and safety in the therapeutic relationship and alliance are essential.

3. Treatment must enhance the ability to manage extreme arousal states and tolerate feelings. Somatosensory and affective identification and skill-building in self-regulation are needed.

4. Treatment is strength-based and should enhance the sense of personal control, competency, empowerment, and self-efficacy.

CONSENSUS TREATMENT PRINCIPLES

5. Treatment must enhance the client's ability to approach and master rather than avoid experiences/events that trigger symptoms.

6. Treatment must assist in maintaining an adequate level of functioning consistent with past and current lifestyle.

7. Therapists must be aware of clients' trauma/transference reactions and effectively manage their own countertrauma/countertransference/VT and personal health status. Therapists must be able to be non-reactive

CONSENSUS TREATMENT PRINCIPLES

8. Treatment, like complex trauma, is complex, multimodal and integrative. It must be individualized.

9. Treatment focuses on desensitization of traumatic memories and associated emotions to enhance personal authority over memory and meaning-making rather than memory retrieval. Resolution results in the lessening of trauma-based symptoms and posttraumatic adversity and decline, personal development

10. DO NO *MORE* HARM!!!

RELATIONSHIP

Relationship or technique or both?
Relational healing for relational injury

- Attachment styles of therapist and client
  - Many CT clients have disorganized/dissociative styles
  - Best for therapist to be secure or "earned secure"
  - Striving for "earned secure" in client
- Evidence-based Psychotherapy Relationships (EBRs)
  - A working alliance
  - Quality of relationship is of central concern
  - Responsive, noticing, consistent
  - Demeanor, self-awareness and professionalism

RISK MANAGEMENT

- "Risky business": A high risk population
- Preparation: practical issues and knowledge
- Risk management practices
- Crisis anticipation and management
  - Violence to/from self or others, including therapist
  - Self-harm
  - Risk-taking
  - Suicidality
  - Addictions
  - Other…
- Don't go it alone. Get consultation and help
- Not Ok for you to be victimized by client: may be grounds for termination

TREATMENT

As with PTSD, comprehensive treatment must be:

BIO-SOMATIC

PSYCHO-SOCIAL

SPIRITUAL

&

Culture, Race, Gender and Identity Sensitive

CROSSOVER GUIDELINE: RECOMMENDED TREATMENTS FOR CPTSD (ISTSS COMPLEX TRAUMA TASK FORCE SURVEY RESULTS, JTS, 2011)

- Sequenced or phased

- Customized: interventions tailored to specific symptoms
  - "First line" approaches:
    - Emotional regulation
    - Narration of trauma memory
    - Cognitive re-structuring
    - Anxiety and stress management
    - Interpersonal approach
  - Second line"
    - Meditation/mindfulness

- Course and duration of treatment unclear, but longer than for PTSD sx relief

EFFICACIOUS TREATMENTS FOR CPTSD/CSTD

- PE: (Foa), applied later
- CPT: (Resnick), applied later ??
- EMDR: (Shapiro), applied by stage
- EFT:(Greenberg; Johnson, for couples) Emotionally Focused Treatment
- EFTT: (Paivio & Leone) Emotionally Focused Trauma Treatment
- IPT: (Markowitz) Interpersonal Psychotherapy
- IRRT: (Smucker & Dancu) Imaginal Restructuring and Reprocessing
- NET: (Schauer et al.) Narrative Exposure Therapy
- PCT: (Gold, 2020) Present and Person-Centered Therapy
- SCAN: (Lanius & Frewen) Social Cognitive and Affective Neuroscience
- Some group models

"HYBRID" AND ADAPTED MODELS FOR CPTSD/CSDT

- TARGET (Ford)—multiple chapters
- STAIR-NTP (Cloitre)—revised book
- Contextual Treatment (Gold)—revised book
- Components Model (Hopper et al.)—new book
- EFTT, Narrative (Paivio & Angus)—new book
- Seeking Safety (Najavits): addictions—new book
- DBT & ACT adapted for trauma treatment—new books
- Psychodynamic/psychoanalytic, relational—new books
- Treatments for dissociation—new books
- Other models, topics, and workbooks...

THE QUESTIONS ARE NOW:

WHAT TO USE WHEN?

WHAT IS EFFECTIVE FOR WHOM?

THE NECESSITY OF SEQUENCING?

ONE SIZE DOES NOT FIT ALL

(COURTOIS, 1999; CLOITRE, 2015)

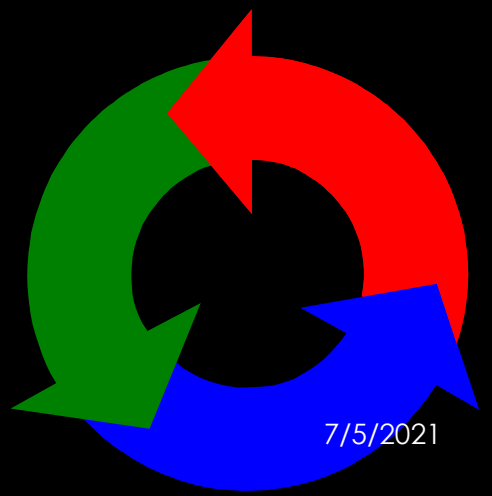
CUSTOMIZATION IS NEEDED

SEQUENCED MODEL IS LINEAR BUT NOT LOCKSTEP/RIGID

IT'S OFTEN LIKE A PUZZLE AND IS DYNAMIC AND EVER-CHANGING

COMPLEX TRAUMA TREATMENT SEQUENCE

- Pre-treatment, assessment, treatment planning
- 1. SAFETY & SECURITY: stabilization, skill-building, education, building of relationship
- 2. Trauma memory processing: gradual and prolonged exposure, putting pieces together, grieving
- 3. Integration to life, meaning making, and self and relational development



DIAGNOSIS AND TREATMENT PLANNING

- Share findings with client
- Diagnose conservatively; may start with provisional dx
  - Client may be confused by a posttraumatic or dissociative diagnosis
- Identify strengths and resilience
- Collaborate on client goals: what is achievable and reasonable?
  - Client preferences
  - Client identity issues: gender, gender orientation, racial and cultural humility

EARLY STAGE: SECURITY AND SAFETY: GETTING TO KNOW EACH OTHER

- Security: Therapeutic alliance and collaboration as essential but take time
- Safety as essential, not to be ignored
  - Safety from self and others
  - Detox and abstinence as possible
  - Life stabilization
  - Safety planning: collaborative problem-solving vs. time-limited contracting
  - Relapse planning
  - Stages of change

EARLY STAGE: DSO

- Emotional regulation
  - Affect identification and modulation

- Identity: Attunement and reflection of individual
  - Somatic and psychological approaches
  - Attachment style/personality and related issues
  - Cognitive errors & distortions

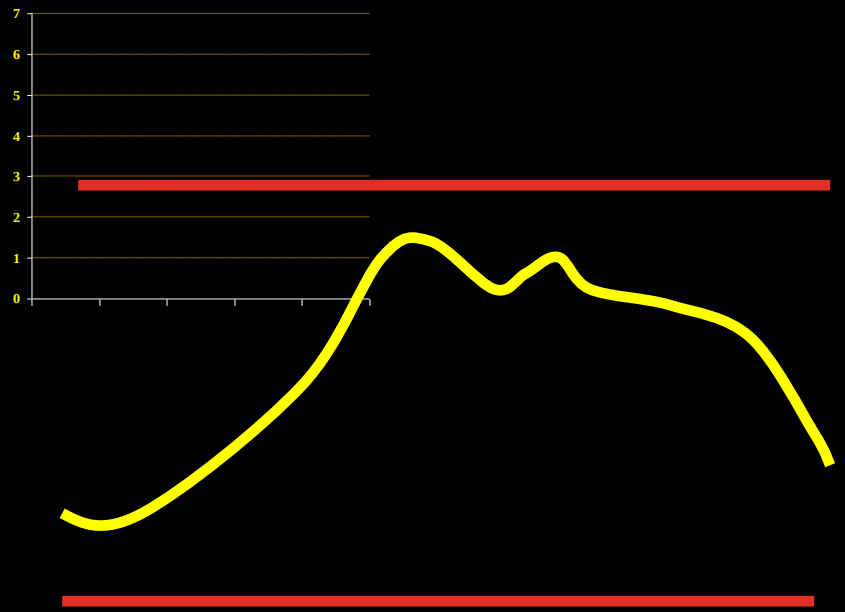
- Relational:
  Security and collaboration
  Transference and countertransference

EARLY STAGE: SKILLS

- Identifying triggers
- Teaching affect regulation
- Grounding and stabilization
- Reducing and managing arousal levels
- Identifying and challenging dissociation & teaching management
- Psych-education
- Life skills
  - assertiveness, problem-solving, decision-making, organization, finances, parenting, relationship, other…

WINDOW OF TOLERANCE: DOMINATE PHYSIOLOGICAL SYSTEMS

arousal



time / exposure

Danger zone: dominance of sympathetic nervous system

Safety zone / window of tolerance: dominance of ventral vagal system

Insufficient level of arousal zone: dominance of dorsal vagal system

Van der Hart, Nijenhuis, & Steele, 2000/ den Boer & Nijenhuis, 2006

MIDDLE STAGE: TRAUMA PROCESSING, DE-CONDITIONING, RESOLUTION

- When to move forward
- What does trauma/emotional processing mean?
  - Counter avoidance
  - Approach vs. avoid to point of resolution of symptoms
- Education of client and preference
- Motivation enhancement
- Titration and support
- Relapse planning

MIDDLE STAGE: TRAUMA PROCESSING, DE-CONDITIONING, RESOLUTION

- Revisiting and reworking the trauma
  - for resolution, not to retraumatize
  - after stabilization skills have been learned--even with careful pacing, work is destabilizing
  - plan for possible relapse
- Prolonged or graduated exposure and de-conditioning
  - processing of traumatic memories and emotions to de-condition them, allow integration
  - work from least to the most painful of the traumas
  - gradual, approach-avoid, controlled uncovering
  - geared to the "therapeutic window"

MIDDLE STAGE: TRAUMA PROCESSING, DE-CONDITIONING, RESOLUTION

- Expression of emotion and resolution of core issues/affect/cognitive distortions/schema
  - guilt, shame, betrayal
  - responsibility, self-blame
  - fear, terror
  - mistrust, ambivalent attachment,/trauma bonding and individuation
  - rage: safe expression and channeling
- Griefwork and mourning
  - past and present issues
  - foster self-compassion and self-forgiveness
- Careful attention to body reactions/responses as part of the processing

MIDDLE STAGE: TRAUMA PROCESSING, DE-CONDITIONING, RESOLUTION OF DSO IMPACT

- Creating a *coherent* narrative over time
  - owning of history
  - increased understanding , meaning, and resolution
- Behavioral changes indicative of resolution
- When processing is complete and memory is de-conditioned, symptoms often cease and anguish fades as trauma is integrated with other aspects of life
  - increased control & authority over memories, self
  - greater affect range and tolerance
  - improved self-esteem and capacity for attachment
  - lessening or cessation of symptoms
  - new meaning/spirituality

MIDDLE STAGE: TRAUMA PROCESSING, DE-CONDITIONING, RESOLUTION

- Application of evidence-based and empirically-supported TFT techniques
  - CT & CBT
  - PE
  - CPT
  - EMDR
  - EFTT
  - Others
  - EFT/couples
  - Special treatment programs and protocols
    - STAIR, TARGET

MIDDLE STAGE: TRAUMA PROCESSING, DE-CONDITIONING, RESOLUTION

- Collateral work?
  - w/ cautions, preparation, training, support
    - with current family/significant others: often desirable at different stages of the treatment process
    - with family of origin/abusive others
      - mediation model: third reality (Barrett)
      - re-connection in some cases
      - alienation in others
      - the issue of forgiveness
        - self
        - others

LATE STAGE: SELF AND RELATIONAL DEVELOPMENT

- Treatment trajectories: not everyone heals the same way and to the same degree
- Development and connection with new sense of self
- Existential crises and spirituality
- Ongoing meaning-making
  - may involve a survivor mission
- Current life stage issues
- Remission of PTSD symptoms and DSO issues

LATE STAGE: SELF AND RELATIONAL DEVELOPMENT

- Career/vocational issues?
- Continued development of connection with others/restitutive relationships
  - Partner/spouse
    - intimacy
    - sexuality
  - children and parenting
  - family of origin: nuclear and extended
  - friends
  - colleagues
- Spirituality/meaning-making

INNOVATIONS AND EMERGING TREATMENTS

- More attention to the body: drawing on the body's wisdom
  - Somatosensory attention and approaches
  - Making the implicit explicit
- More attention to the mind and neuroplasticity
  - Interpersonal neurobiology
- Relational and attachment-based approaches
- Flexible, modular treatment
- Medications and psychedelics?

WHAT'S COMING?

- Modular, multi-component treatment based on assessment
  - Complexity of trauma and symptoms
  - need for tailoring to patient
- Patient-treatment matching models or algorithms
- Hierarchy of problems
- Repeat assessment and adjustment of treatment (Briere & Lanktree)
- Collaboration and session by session feedback & adjustment

A WORD ABOUT TRAINING

- Therapists need training to do this work
  - Often lacking in formal curriculum
- Consider what you need and develop a plan of study
  - Lots of options so check out before you sign up
- Suggestions:
  - Read!
  - Take CE courses on ongoing basis
  - Training in different treatment methods
  - Get certified
- Get consultation and supervision
- Join professional organizations & attend conferences
- Beware applying treatments haphazardly

SUMMARY

- Complex trauma, complex reactions, complex treatment (Courtois & Pearlman)
- Complex trauma increasingly recognized as more common than single-event trauma
- Clinical consensus has developed; treatment evidence base under development
- More to come!

AVAILABLE TREATMENT GUIDELINES FOR PTSD

- ISTSS Guidelines (2020, Bisson et al.; Foa, Friedman, Keane, & Cohen; 2011, Foa, Keane & Friedman, 2000)
- American Psychological Association (2017, under revision)
- Veterans' Administration (US DoD, 2004, 2017)
- Australian (Phoenix) Centre for Posttraumatic Mental Health (2007, 2017)
- National Institute of Clinical Excellence (NICE, UK, 2005)
- American Psychiatric Association (2003)
- Clinical Efficiency Support Team (CREST, Northern Ireland, 2003)
- Journal of Clinical Psychiatry (2000)

TREATMENT RECOMMENDATIONS AND GUIDELINES FOR CPTSD

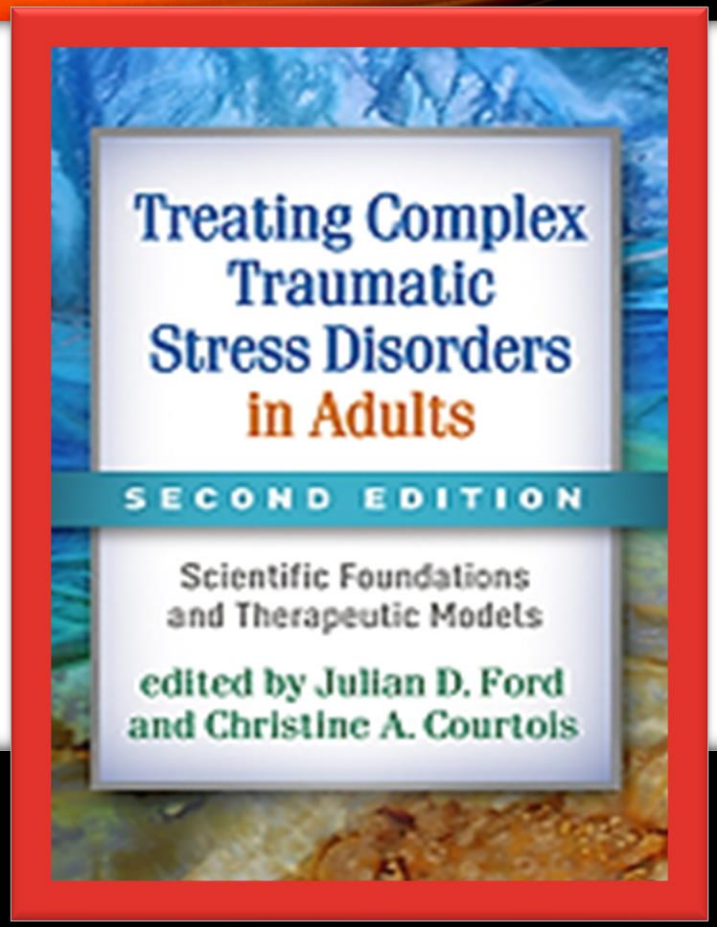
- Courtois, 1999
- CREST, 2003
- Courtois, Ford, & Cloitre, 2009; 2020
- Blue Knot Australia (Keselman & Stavropolous, 2018, 2012)
- ISTSS complex trauma expert consensus survey, Cloitre et al., 2011, *JTS*; Cloitre et al., 2012--available at ISTSS.org)
- UK Psychological Trauma Society (2017)
- Joint Division 56 and ISSTD guidelines (forthcoming)

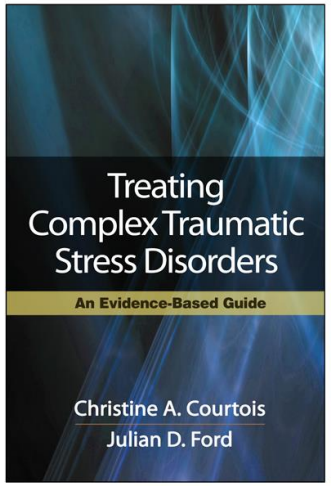
OTHER RELEVANT TREATMENT GUIDELINES

- Dissociative Disorders
  - Adult (ISST-D, 1994, 1997, 2005, 2011, new set under development)
  - Children (ISSD, 2001)
- Delayed memory issues
  - Courtois (1999; Mollon, 2004)

RESOURCES

- Blue Knot.au.org
- ISTSS.org
  - Complex Trauma Special Interest Group
- ISST-D.org
- NCPTSD.va.gov (info and links)
- NCTSN.org (child resources)
- Sidran.org (books and tapes)
- APA Div. 56: Psychological Trauma traumadivision@apa.org
- Child Trauma Academy.org





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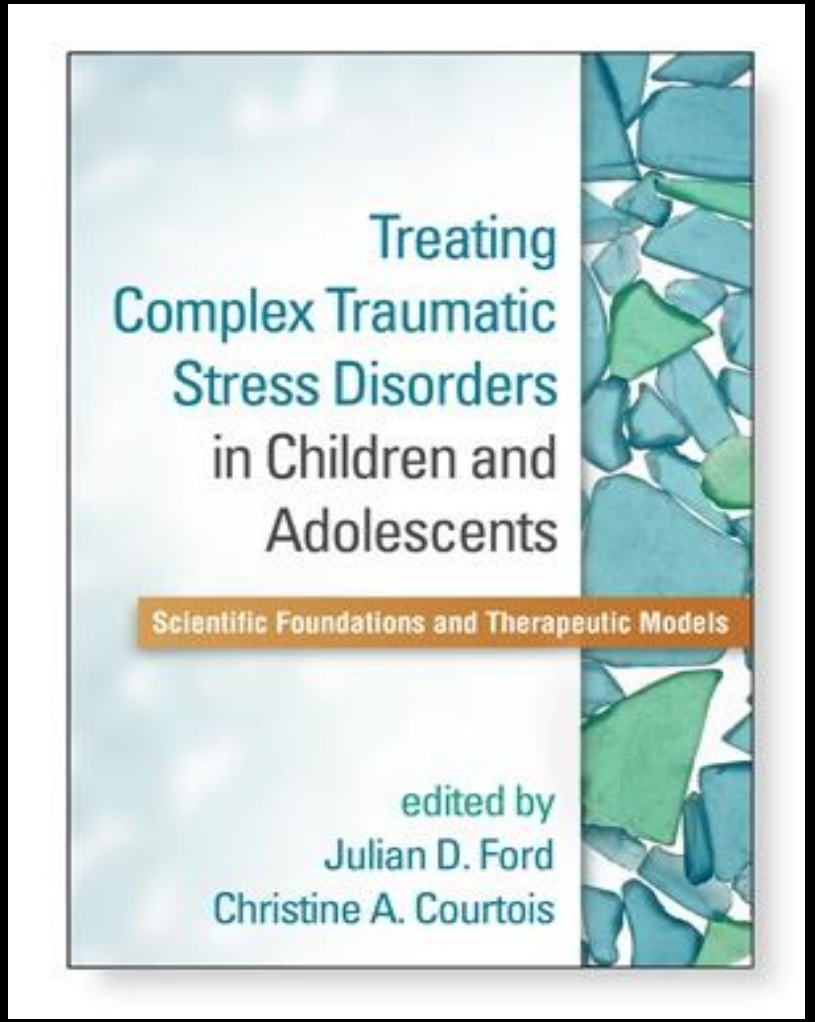
PUBLISHED, 2013, CO-EDITED



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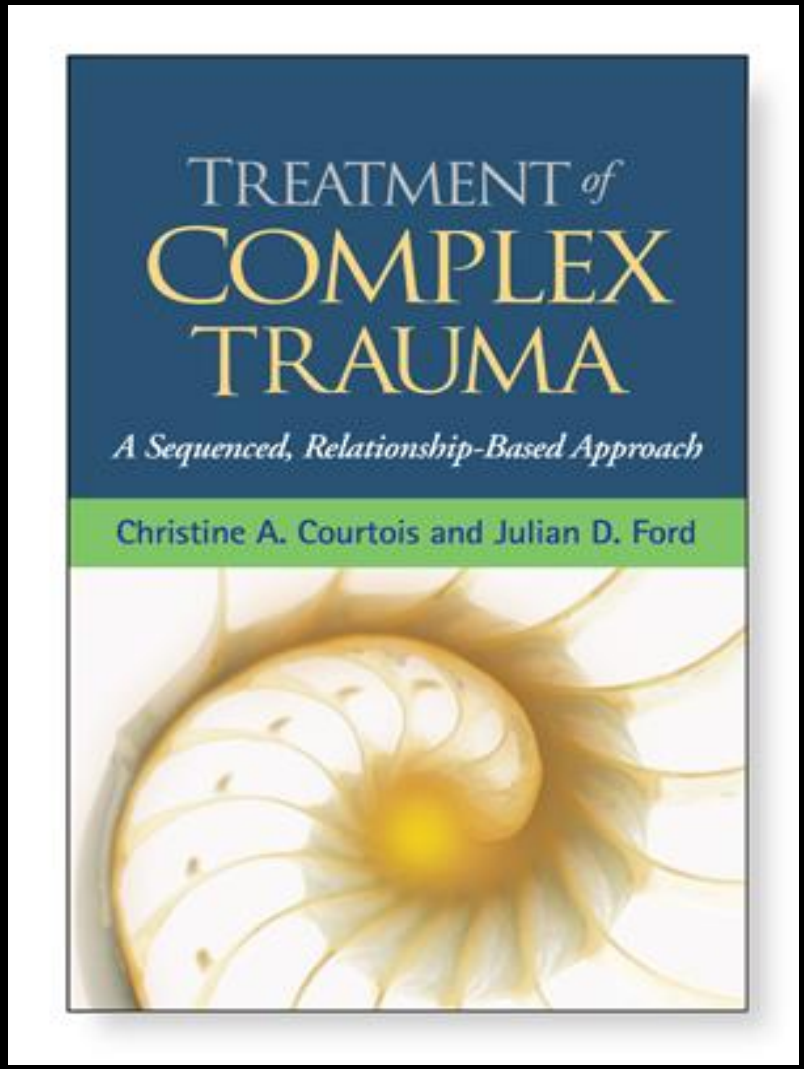
PUBLISHED, 2012, CO-AUTHORED

SOON TO BE REVISED



7/5/2021

PUBLISHED 2014, REISSUED 2020

A trade book for survivor/ consumers and supporters