THE *PRISM* PRINCIPLES AND ATTACHMENT BASED STRATEGIES IN THE TREATMENT OF COMPLEX TRAUMA

HIGHER THOUGHT INSTITUTE

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Christine A. Courtois, PhD, ABPP, Licensed Psychologist

Consultant/Trainer & Author, Trauma Psychology and Treatment, Bethany Beach, DE

CACourtoisPhD@aol.com www.drchriscourtois.com

- **Agenda**

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

TREATING COMPLEX TRAUMA IN ADULTS: THE **PRISM** PRINCIPLES AND ATTACHMENT BASED STRATEGIES

COMPLEX TRAUMA:

EXPANDING DEFINITIONS AND UNDERSTANDING

PRIMARY CHARACTERISTICS OF COMPLEX TRAUMA

- Interpersonal, **intentional;** often involves relational/role **betrayal**
- Direct attack/exploitation/harm/grooming/gaslighting/threat within the relationship and using the relationship for access and repetition
- Repeated, prolonged, pervasive, layered, insidious, ongoing (?)—may be individual or collective
- Often emotional as well as physical traumatization

PRIMARY CHARACTERISTICS OF COMPLEX TRAUMA

- Entrapping, inescapable, conditions of accessibility/ captivity/power and status differential
- Individual and collective
- Cumulative
- Often met with denial/disregard/non-intervention and non-protection, while the perpetrator is believed and protected
  - Issues of credibility and bias
- Victim blame and shame when disclosed/reported/ discovered: second injuries by individuals and institutions

COMPLEX TRAUMA: THE "I'S" HAVE IT

- ***Interpersonal***
- Intentional
- Inescapable
- Intimate perpetration
- Individual and groups 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)

OTHER FORMS OF COMPLEX TRAUMA ACROSS THE LIFESPAN

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

- Can cause developmental regressions and posttraumatic disorders

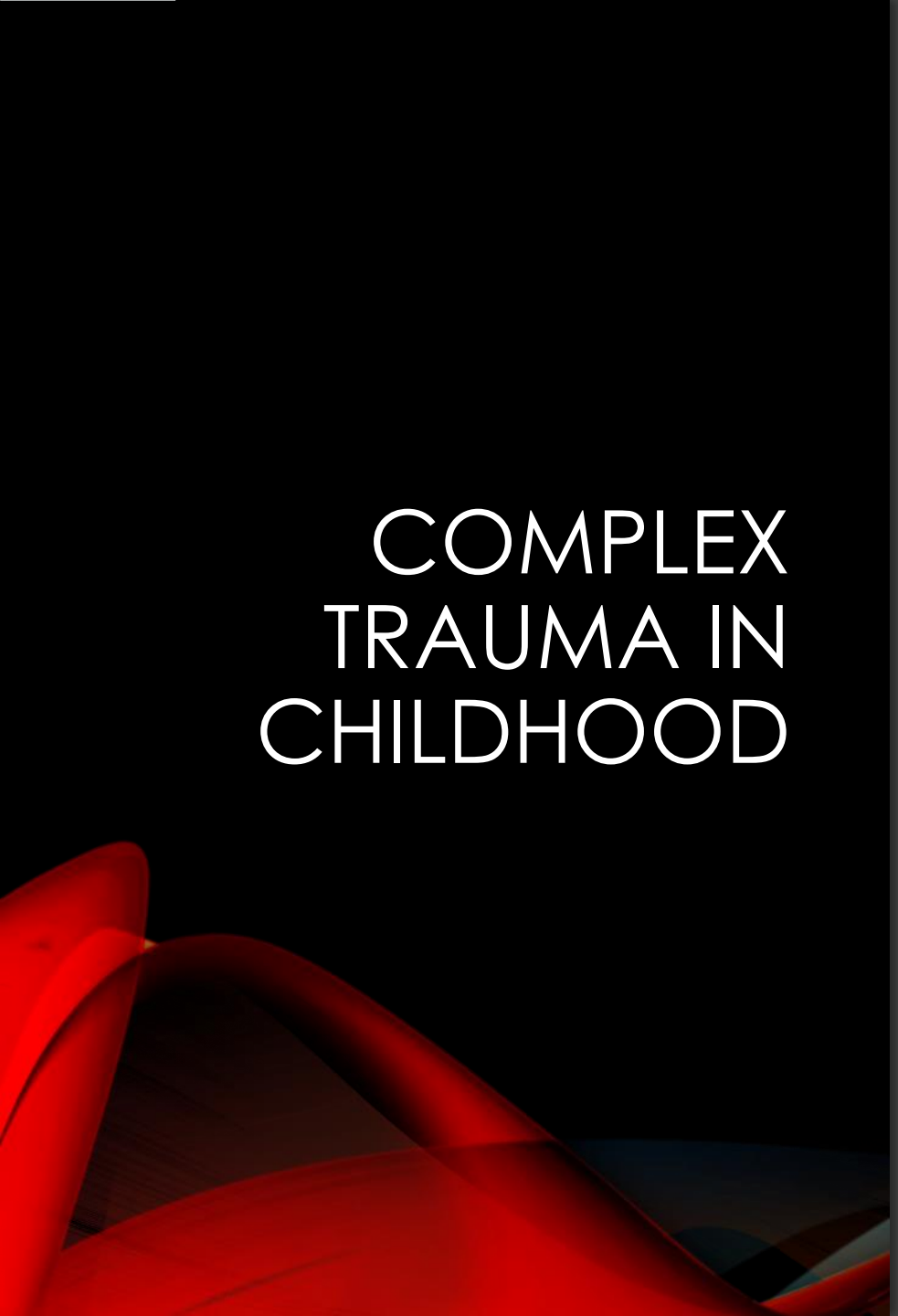
COMPLEX TRAUMA AS MORE COMMON THAN IMPERSONAL FORMS OF TRAUMA

Many more forms have been identified and there is increased recognition that many aspects of today's culture are traumagenic and create potentially traumati events and exposures (PTEs)

CHILDHOOD COMPLEX TRAUMA FREQUENTLY RESULTS IN REVICTIMIZATION AND MAY BE

LAYERED AND INTERTWINED

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

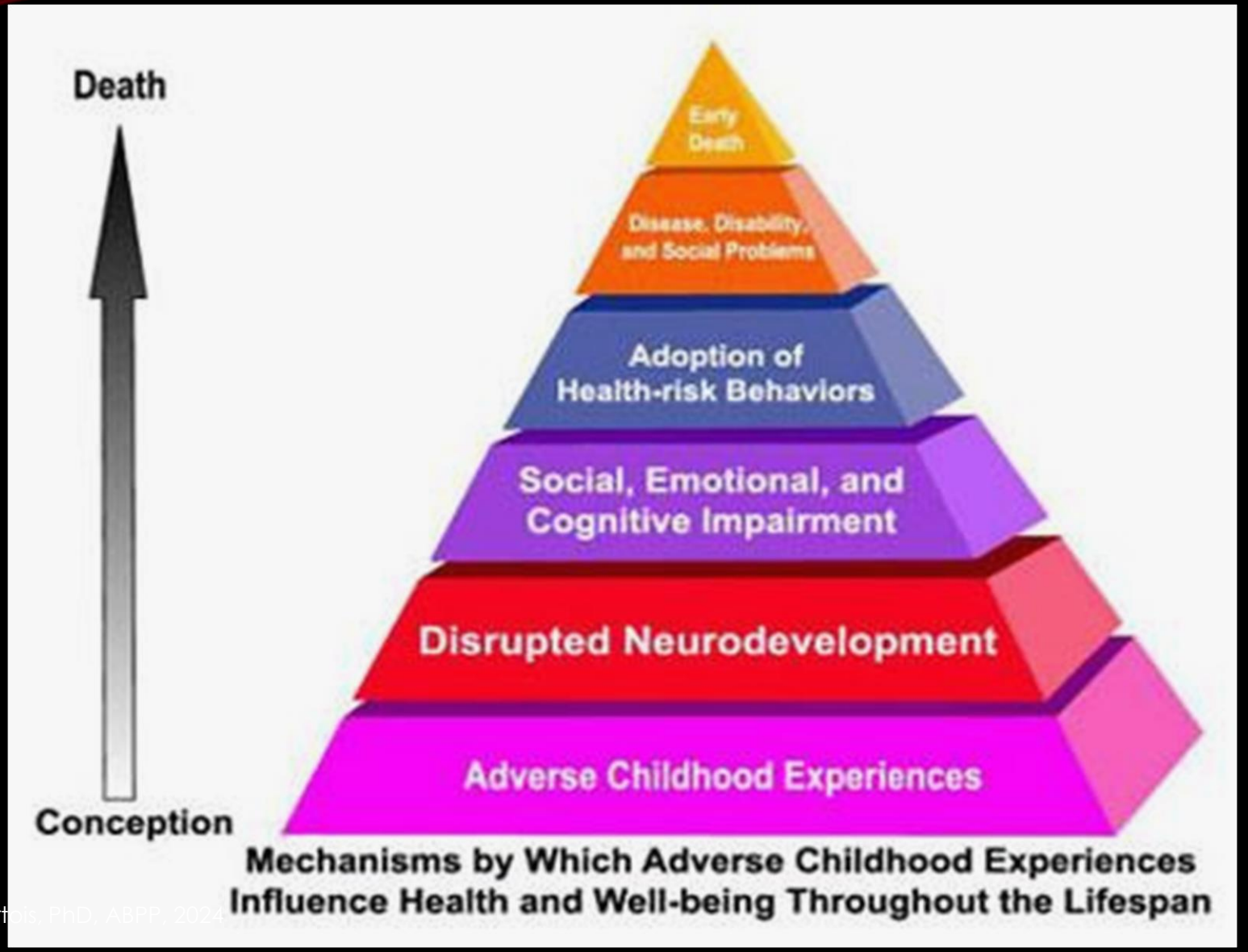
COMPLEX TRAUMA IN CHILDHOOD

- Adverse Childhood Experiences
- Relational/attachment trauma
- Child abuse—sexual, physical, verbal, emotional neglect, disregard, & abandonment
- Separation from caregivers
- Sudden loss
- Domestic violence
- Intergenerational and diversity influences
- Community violence; mass shootings
- Discrimination/bullying
- Revictimization
- Other….

ACES STUDIES:

THE MEDICAL/LIFE IMPACT OF ADVERSE CHILDHOOD EVENTS/TOXIC STRESS, IN ADDITION TO THE PSYCHOSOCIAL/NEUROLOGICAL IMPACT

ACES STUDIES AND FINDINGS



Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

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

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:
  - gives a diagnostic home that is less stigmatizing
    - An umbrella diagnosis
  - promotes more insurance reimbursement
  - supports research funding
  - provides better science for developing 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

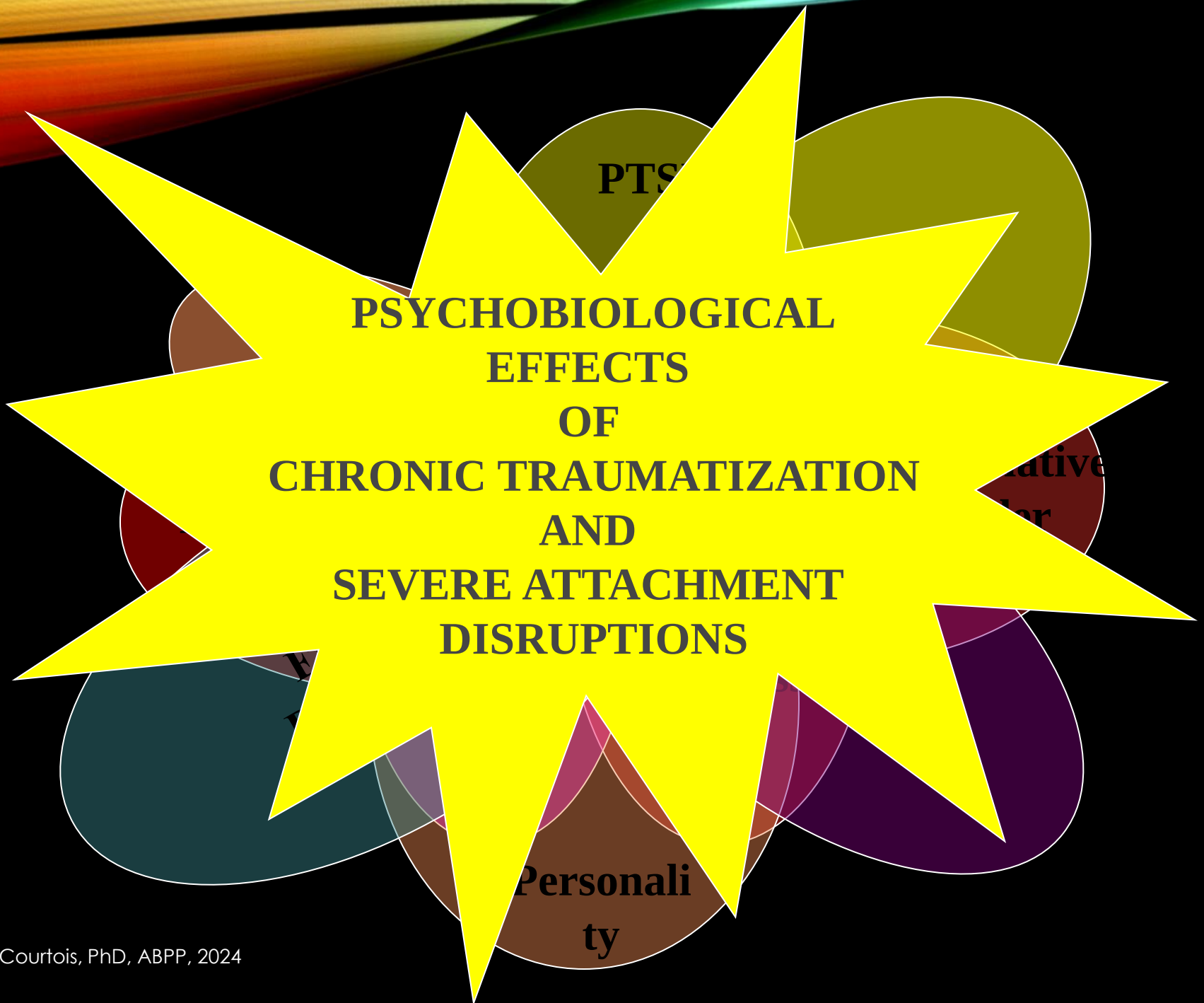
- **PTSD**
  - **Re-experiencing** nightmares, flashbacks **in** here-and-now, as if it were happening (vs. rumination)
  - **Avoidance** of thoughts, feelings, places people associated with the trauma
  - **Sense of current threat** manifest by hypervigilance or an enhanced startle reaction
- **DSO (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, avoidance and mistrust, difficulties in feeling close to others, having little interest in engagement

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

Dissociative Disorders
Anxiety Disorders
Depression
Personality Disorders
Sleep disorders
Other affective disorders (bipolar, etc.)
Medical illnesses
Many other idiosyncratic reactions & complications

Developmental Trauma Disorder (DTD)
Addictions/Substance Abuse*
Eating Disorders
Obsessive-Compulsive Disorder
Brief reactive psychosis
Somatization

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



PSYCHOBIOLOGICAL EFFECTS OF CHRONIC TRAUMATIZATION AND SEVERE ATTACHMENT DISRUPTIONS

REACTIONS, ADAPTATIONS, SYMPTOMS, AND DIAGNOSES

LAYERING AND INTERTWINING OF REACTIONS OVER TIME

EXPRESSION OF REACTIONS/SYMPTOMS:

CONTINUOUS/HIGH DISTURBANCE
EPISODIC/BREAKTHROUGH
DELAYED EXPRESSION/SURPRISE

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)

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

CLINICAL PRACTICE GUIDELINES FOR "CLASSIC" PTSD [27]

- Treatment outcomes: ***decrease of PTSD symptoms, remission of diagnosis***
- Trauma-Focused Treatments (TFTs), those with most research evidence of these outcomes
- Benefits: They work!
  - Ever increasing data
  - Mixed samples of different and diverse populations
- Limitations: Not for everyone!
  - Usually single vs. combined treatment
  - Dropout rates high; harms/adversity not addressed
  - Generalizability & feasibility

CPG: 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)
- Narrative Exposure Therapy (NET)

- Psychopharmacology: 3 main classes
- Interpersonal Psychotherapy (IPT)
- Present-Centered Therapy (PCT)
- STAIR Narrative (STAIR NPT)

SOME LIMITATIONS OF RECOMMENDATION FOR PTSD 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
- Application to diverse populations?
  - Applicability and generalizability in question
- No inclusion of qualitative studies
- Limited attention relationship variables and information
- Little information on adverse effects; drop-out is significant

EVIDENCE- BASED RELATIONAL VARIABLES (EBR) OMITTED

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

QUESTION OF APPLICABILITY AND GENERALIZABILITY

FROM RESEARCH SETTING TO "REAL WORLD"

AND TO CPTSD

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LACK OF DATA DOES NOT MEAN LACK OF EFFICACY

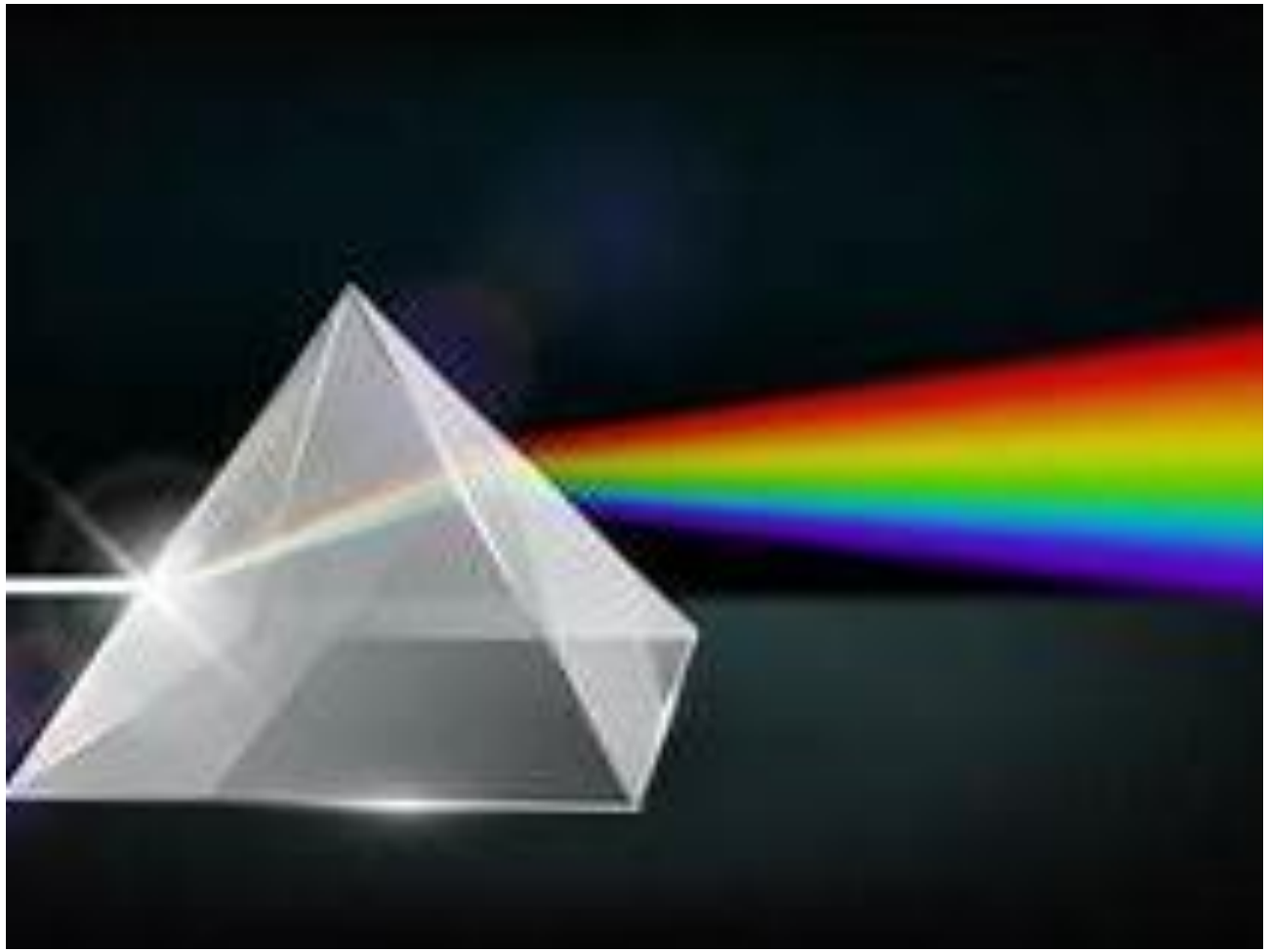
RESEARCH IS UNDERWAY FOR CPTSD (AND DISSOCIATION) TREATMENT

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

* ALSO FOR DISSOCIATION, WITH MODIFICATIONS

THE *PRISM* META-MODEL

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



PRISM

- Personalized/phenomenological
- Person-centered
- Priorities identified
- Pacing taught
- Psychophysiological/ neurobiological approaches
- Preferences of client attended to
- Past and-present-centered but future-oriented
  - Possibilities/posttraumatic growth
  - Present hope
  - Personal engagement
- Personalization vs. disowning
- Presentification vs. past-oriented
- Philosophy and principles of treatment: TIC
- Preparation and training of therapist
- Professionalism of therapist; professional responsibilities
- Practice what you preach!!
- Psych-education
- Problem-solving approach

PRISM

- Relational
- Respectful/unconditional positive regard
- Resonant/attuned
- Reflexive and not reactive
- "Reinforce the right thing" (Linehan)
- Reinforce choice and empowerment; collaboration
- Reverse negative cognitions and beliefs about selt
- Resolution of trauma
- Resilience enhancing
- Restore and reinstate *Self, identity,* and relational capacity
- Recovery-oriented; relapses during healing
- Risk management

PRISM

- Individualized
- Identity development
- Integrative
- Intensity titrated
- Intersectionality and context considered
- Impact on the client and others
- Impact on the therapist
  - Negative and positive transformation possibilities: VT, secondary traumatic stress and posttraumatic growth

PRISM

- Sequenced
- Strategic/Selective
- Security of relationship and support
  - "Safe Haven"
  - Security of attachment "earned"
- Safety as priority: safety planning
- Self-regulation of therapist and client
- Self-identification and development
- Somatosensory/neurobiology
- 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 maybe sychedelics?

PRISMA (ITALIAN)!

- Attachment-oriented
- Attachment style of the therapist:
  - Secure or "earned secure"
- Attuned
- Active involvement and interest
- Active collaboration
- Active support and reinforcement
- Affect regulation
- Avoid avoidance
- Avoid rescue, "authority with answers", or detachment

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 consultation and supervision as needed
- 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
  - Expect challenges and barriers: "lessons of abuse"
  - Expect treatment traps and relapses
  - Expect to feel de-skilled and helpless at times

RELATIONSHIP

- Evidence-based Psychotherapy Relationships (EBRs)
  - Quality of relationship is of central concern
  - A working alliance, attuned (not tuned out!) therapist
  - Responsive, noticing, inviting, consistent/regulated
  - Empathetic and experiential
    - Notice and focus client back on themselves
    - Encourage self-exploration and experimentation
    - Encourage client self-disclosure
    - Work to reverse shame
  - Relational ruptures and importance of repair
  - Demeanor, self-awareness and professionalism

ATTACHMENT BASED AND POLY-VAGAL STRATEGIES

- Secure: generally easier to work with; have more resources
- Insecure/anxious: must soothe, be reliable and predictable, attuned and teach modulation, directly and by modeling
- Insecure/detached avoidant: get "under their defenses": challenge and support them; don't readily abandon them or let them quit
- Disorganized: inconsistent, emotionally dysregulated, incoherent, challenging and upsetting for therapist. Maintain consistency, encourage exploration, teach emotional regulation and ways to change, reinforce the right thing.

- Poly-vagal: Move client from conditions of alarm and hyper/hypo-vigilance and encourage social connection, conditions of safety; prosidy, voice tone, music?

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 therapist to be victimized by client: grounds for negotiation of contract and even 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, 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
- NET: (Schauer et al.) Narrative Exposure Therapy

- EFT: (Greenberg; Johnson, for couples) Emotionally Focused Treatment
- EFTT: (Paivio & Leone) Emotionally Focused Trauma Treatment; Narrative format (Paivio & Angus)
- IPT: (Markowitz) Interpersonal Psychotherapy
- IRRT: (Smucker & Dancu) Imaginal Restructuring and Reprocessing
- 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)

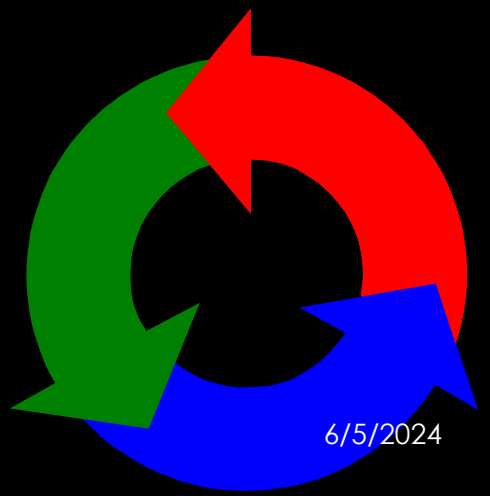
Customization is needed

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: intro, 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. Re-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 dx
- Identify strengths and resilience
- Collaborate on client goals: what is achievable and reasonable?
  - Client preferences
  - Client identity issues: gender, gender orientation, racial and cultural issues and 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

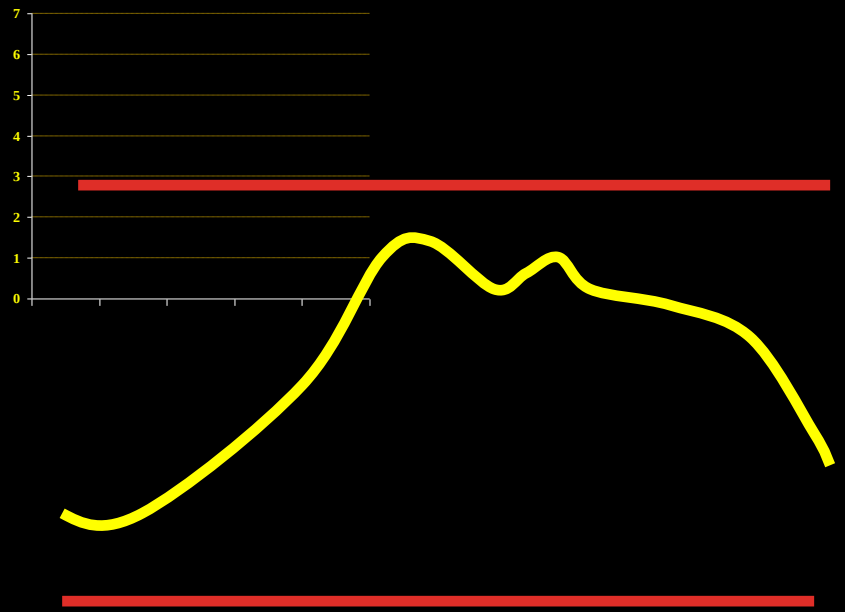
- Emotional regulation: Affect identification and modulation
  - Somatic and psychological approaches
- Identity: Attunement and reflection of individual
  - Somatic and psychological approaches
  - Attachment style/personality and related issues
  - Cognitive errors & distortions
- Relational:
  - Security 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?
  - with 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 LIFE INTEGRATION

- 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 LIFE INTEGRATION

- 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
  - Neuroscience approaches
    - Vegal nerve and other
    - 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: algorithms?
- 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 education and training to do this work
  - Often lacking in formal training 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 an ongoing basis
  - Train in different treatment methods
  - Certification where available
- Get ongoing consultation and supervision
- Join professional organizations & attend conferences
- Beware applying treatments haphazardly or without training

SUMMARY

- Complex trauma, complex reactions, complex treatment (Courtois & Pearlman)
- Complex trauma increasingly recognized as more common than single-event/impersonal 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, 2023)
- 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

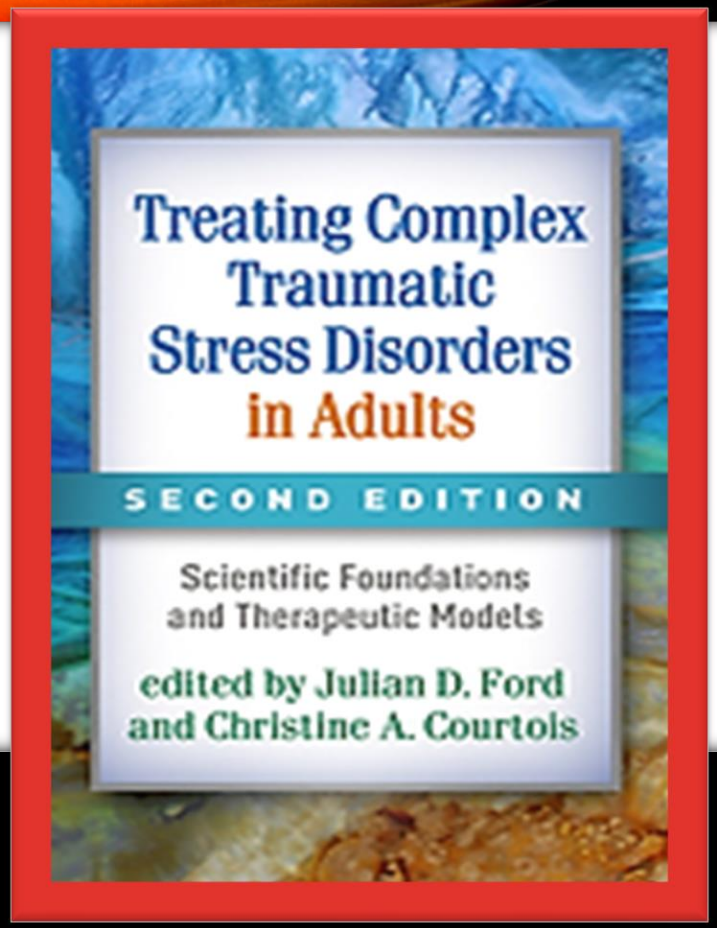
- Courtois, 1999
- CREST, 2003
- Courtois, Ford, & Cloitre, 2009; 2020
- Blue Knot Australia (Keselman & Stavropolous, 2018, 2012)
- ISTSS complex trauma expert consensus survey, Cloitre et al., 2011, *JTS*; Cloitre et al., 2012--available at ISTSS.org)
- UK Psychological Trauma Society (2017)
- Joint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

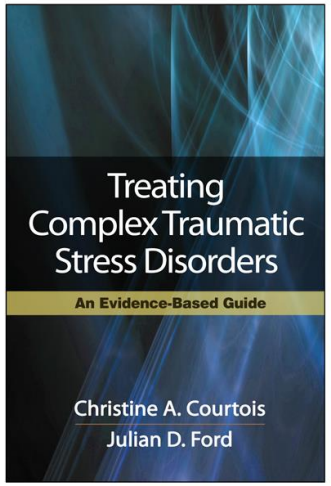
OTHER RELEVANT TREATMENT GUIDELINES

- 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, training tapes)
- APA Div. 56: Psychological Trauma traumadivision@apa.org
- Child Trauma Academy.org





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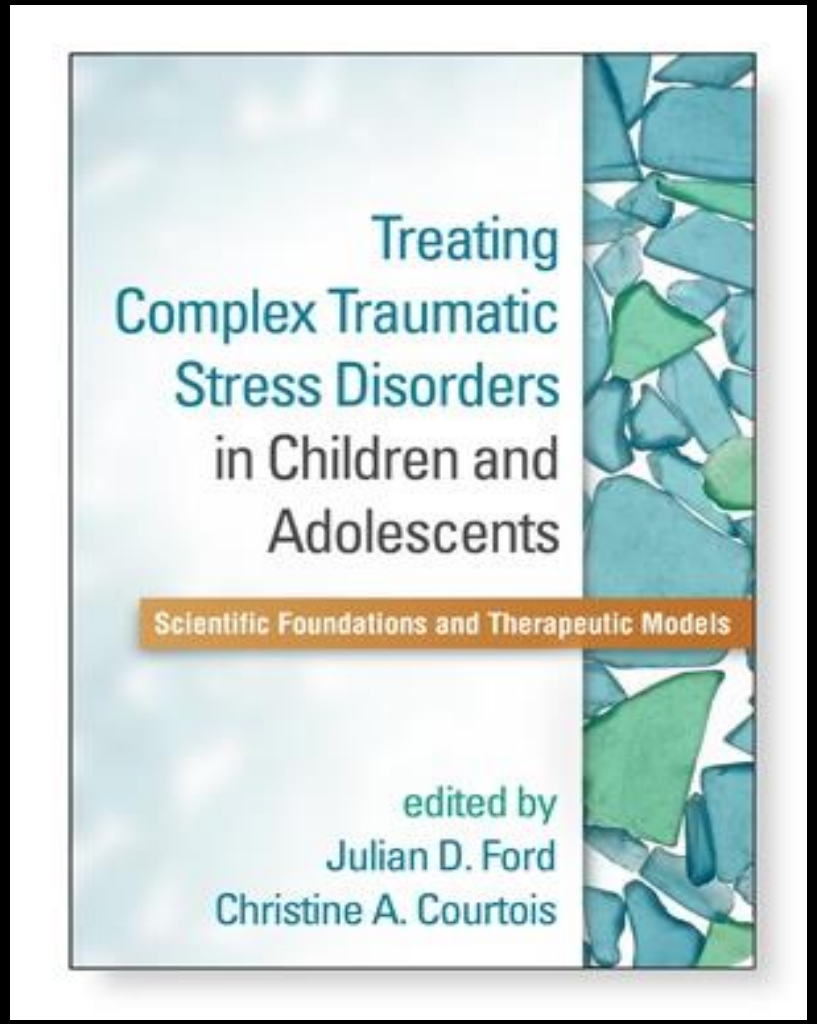

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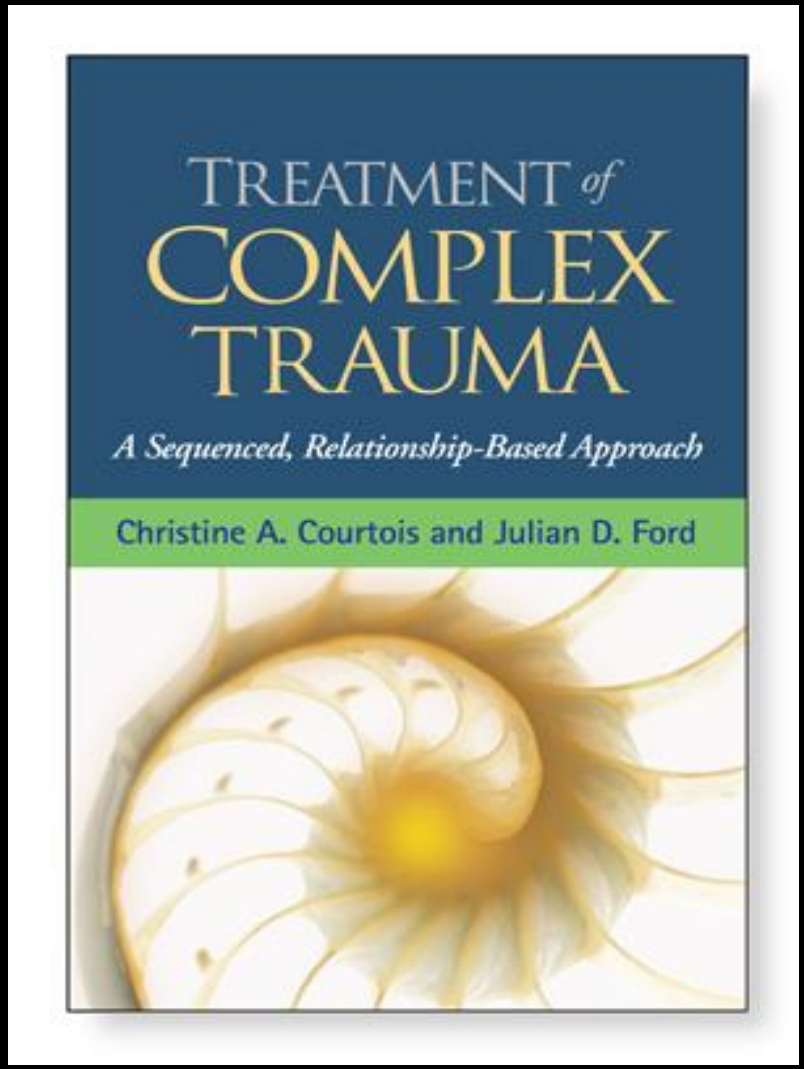

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A trade book for survivor/ consumers and supporters