TREATING COMPLEX TRAUMA:

A SEQUENCED, RELATIONSHIP-BASED APPROACH

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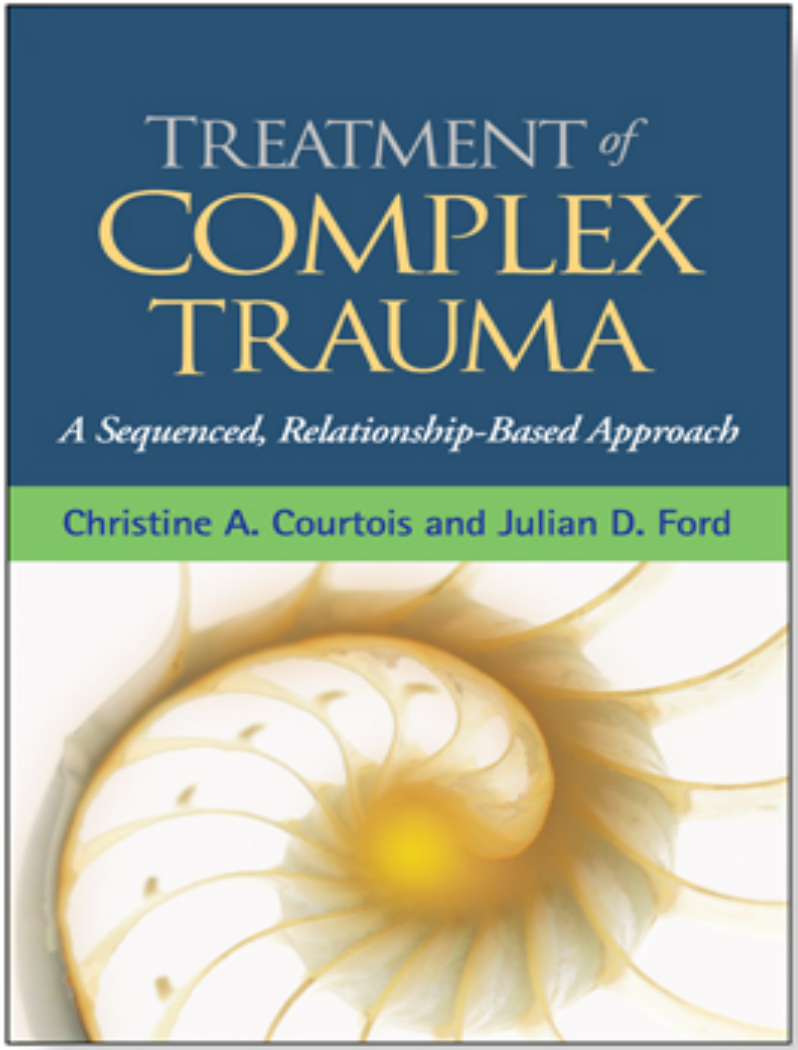

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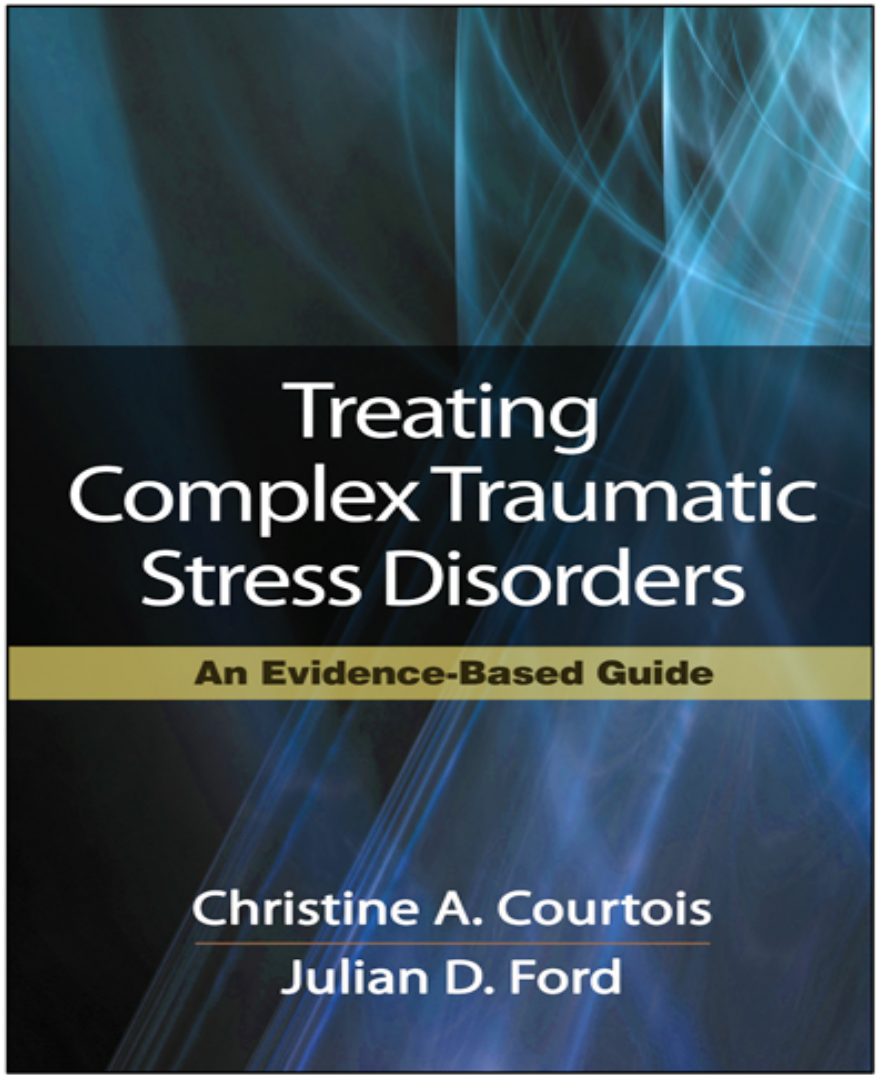

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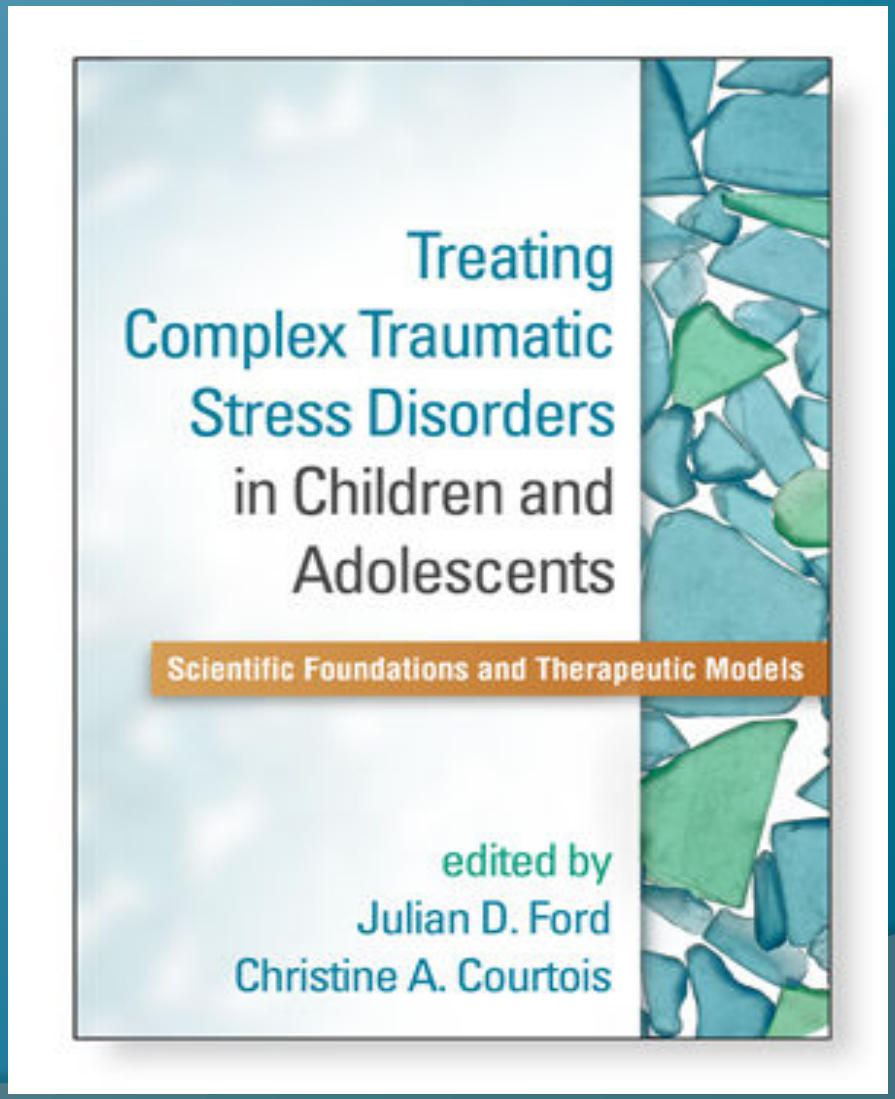


Forthcoming, October 2014

- *Spiritually-Oriented Psychotherapy for Trauma*
  - Co-edited by
  - Donald Walker
  - Christine A. Courtois
  - Jamie Aten
- American Psychological Association Press

Types of Trauma

- I. Accident/Disaster/"Act of God"
  - Sudden, unexpected, one-time or time-limited
  - Chronic illness, injury, disability (w/ care & treatment)
- II. Interpersonal
  - Sudden, unexpected, one-time or time-limited (stranger)
  - Anticipated, repeated, chronic (known, related)
- III. Identity/ethnicity/gender
  - Lifelong or episodic vulnerability
- IV. Community/group membership
  - Lifelong or episodic vulnerability
- V. Cumulative/continuous, complex

Types of Interpersonal Trauma

- Relational/attachment trauma
  - Occurs with primary caregivers and other relationships of significance
    - active and passive
    - deliberate intent and not
    - ambient or ongoing
    - impairment of caregiver: illness & addiction
    - lack of response, availability, protection
    - mis-attunement
    - non-response/neglect
    - antipathy/attack
    - caregiver as the source of *both* fear and comfort

Types of Interpersonal Trauma

- Betrayal trauma
  - involves betrayal of a role or relationship
- Second injury/institutional betrayal
  - involves lack of assistance and/or insensitivity on the part of those who are supposed to help or intervene

Complex Trauma

- Interpersonal
- Child or adult onset
- Layered
- Repeated/chronic
  - Affects development, especially in children
- Pervasive
- Progressive in severity
- Cumulative/continuous/lifelong?
  - Sets the stage for revictimization

Child-Onset Complex Developmental Trauma

- Children are extremely vulnerable
- Trauma can severely impacts the developing child's:
  - Neurophysiology
  - Psychophysiology
  - Bio-psycho-social maturation & development, including personal identity and attachment capacity/style
  - Vulnerability to revictimization over the lifespan

Child-Onset Complex Developmental Trauma

- Associated with chronic, pervasive, cumulative trauma or adverse events in childhood, often on a foundation of attachment/relational trauma
  - Attachment trauma
  - Insecure attachment, *especially disorganized*
  - Child abuse and neglect
  - Other types of trauma in the family and community
    - DV
    - Community violence
    - Bullying/harassment
    - Chronic illness
    - Poverty
    - Combat, political, religious violence
    - Other…

Adult-Onset Complex Cumulative Trauma

- Other forms of chronic trauma:
  - Domestic violence/IPV
  - Community violence
  - Combat trauma: warrior or civilian, POW, MSA
  - Political trauma: refugee status, displacement, political persecution, “ethnic cleansing”
  - Trafficking, slavery/forced servitude and prostitution
  - Chronic illness/disability w/ invasive treatment
  - Bullying
  - Sexual harassment
  - Other...

Posttraumatic Stress Disorder

- A complex **dynamic** entity
  - fluctuating, not static
  - variable in form, presentation, course, degree of disruption
- A multidimensional **bio-psycho-social-spiritual-gender**

  stress response syndrome
- An **allostatic** condition

DSM-5 PTSD Criteria

- Criterion A: The stressor
  - Still little emphasis on non-physical trauma
- Four symptom clusters (rather than 3 in *DSM-IV*)
  - B. Intrusive re-experiencing: Flashbacks, dreams
  - C. Avoidance: Internal and external reminders
  - D. Negative alterations in cognitions/mood beginning in/after trauma: Numbing, amnesia, distraction, anhedonia, negative identity, alienation
  - E. Altered arousal or reactivity beginning in/after trauma: Hyperarousal and hypervigilance, sleep disturbance, startle

Dissociative Subtype of PTSD

- Emotional overmodulation:
  - excessive corticolimbic inhibition
- Derealization
- Depersonalization
- Freeze responses
  - Polyvagal system: A different pathway than fight-flight and hyper-arousa (Porges)
  - Different responses in different areas of the brain (Lanius et al.)

Defining Dissociation

Dissociation is:

a psycho-physiological process with psychodynamic triggers which produces an alteration in ongoing consciousness.

"escape where there is no escape"

Putnam, 1985

Pre-School Sub-type of PTSD

- *Children respond as children, not as little adults*
  - work of Terr, Putnam, Pynoos, Perry, Teicher has been instrumental to early understanding of childhood trauma
- Children are very vulnerable, yet resilient
  - on average, takes less to traumatize them

Developmental Trauma Disorder (Proposed)

(van der Kolk, 2005; Ford & van der Kolk, 2011)

- Domains of impairment in children exposed to complex trauma:
  - Attachment/relationship capacity
  - Biology
  - Affect regulation
  - Dissociation
  - Behavioral control
  - Cognition
  - Self-concept

Complex PTSD

(Disorders of Extreme Stress Not Otherwise Specified)

- **"PTSD plus or minus"**
  - above and beyond the classic symptoms
  - absent the classic symptoms
  - involves dissociation
  - related to repetitive, chronic forms of trauma, disorganized attachment
  - often/usually highly co-morbid

Complex PTSD/DESNOS

- Remains controversial
- Not a formal *DSM* diagnosis: remains an associated feature of PTSD
- Nevertheless, a useful way of organizing symptoms and treatment
- A less pejorative way of understanding and approaching the treatment of those who often look and behave like BPD
- Empirical investigation building

Complex PTSD (ISTSS, 2012)

- Core symptoms of PTSD *and*
- Range of disturbances in self-regulatory capacities
  - Emotion regulation
  - Relational mistrust and distress
  - Attention and consciousness (dissociation)
  - Altered belief systems/self-concept
  - Somatic distress or disorganization

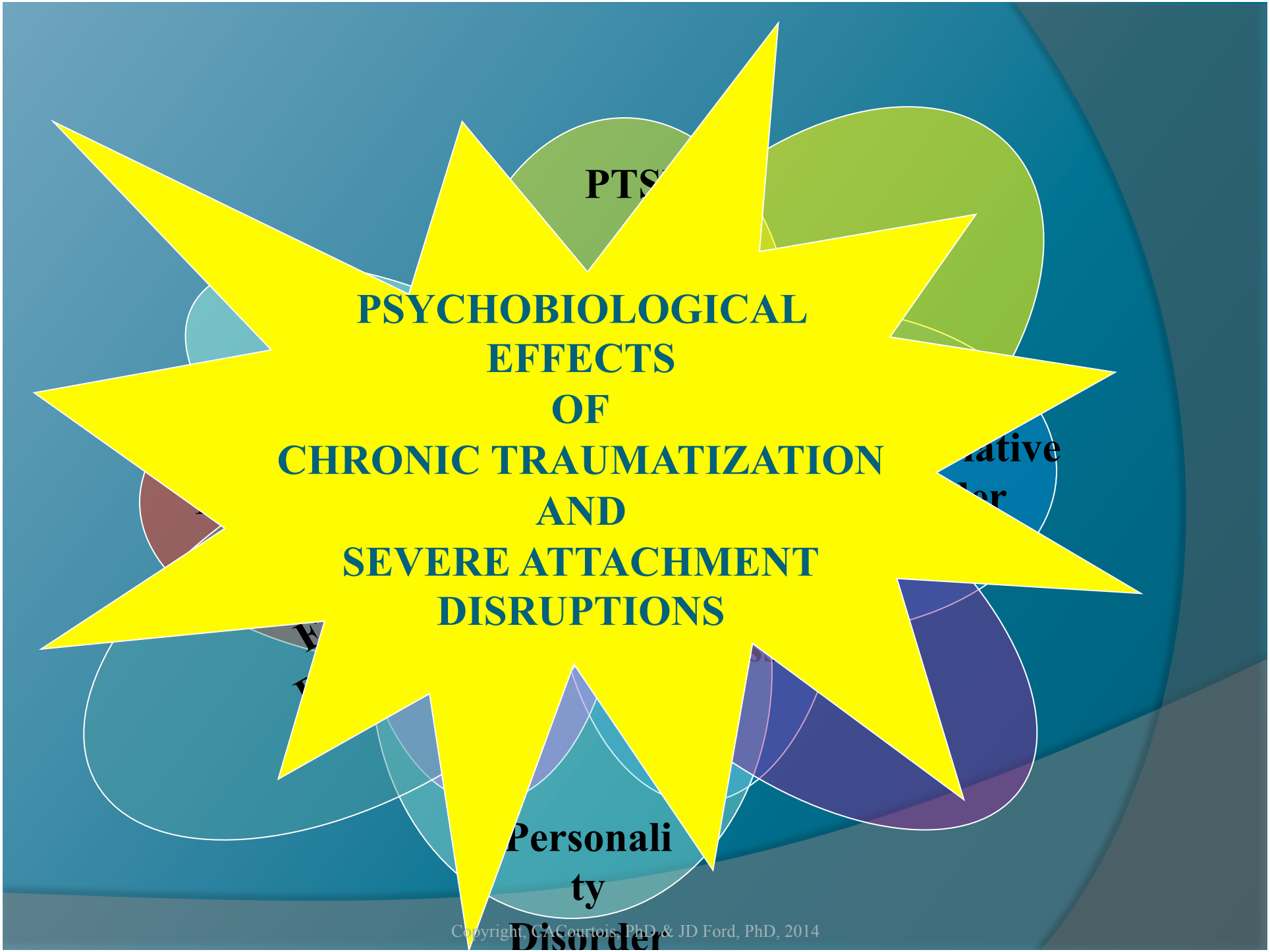
Complex PTSD in the *ICD-11*
(Draft Beta Version)

"… the PTSD core elements accompanied by the following persistent and pervasive features:

- difficulties in emotion regulation
- beliefs about oneself as diminished defeated or worthless
- difficulties in sustaining relationships

Associated Problems

- Substance and process addictions:
  - drugs, alcohol, sex, food, shopping, gambling, etc.
- Risk-taking and impulse control along with suicide, self-injury
- Personality disorders:
  - dependent, avoidant, borderline, narcissistic, sociopathic, mixed
- Medical illnesses and risk
- Others…



Evidence-Based Treatment

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

American Psychological Association Council of Representatives Statement, August 2005

Treatment

For Posttraumatic Disorders,

comprehensive treatment must be

BIO-

PSYCHO-

SOCIAL/SPIRITUAL

&

Culture and Gender Sensitive

(attentive to other diversities)

In many ways, resembles addiction treatment

Complex Trauma Treatment

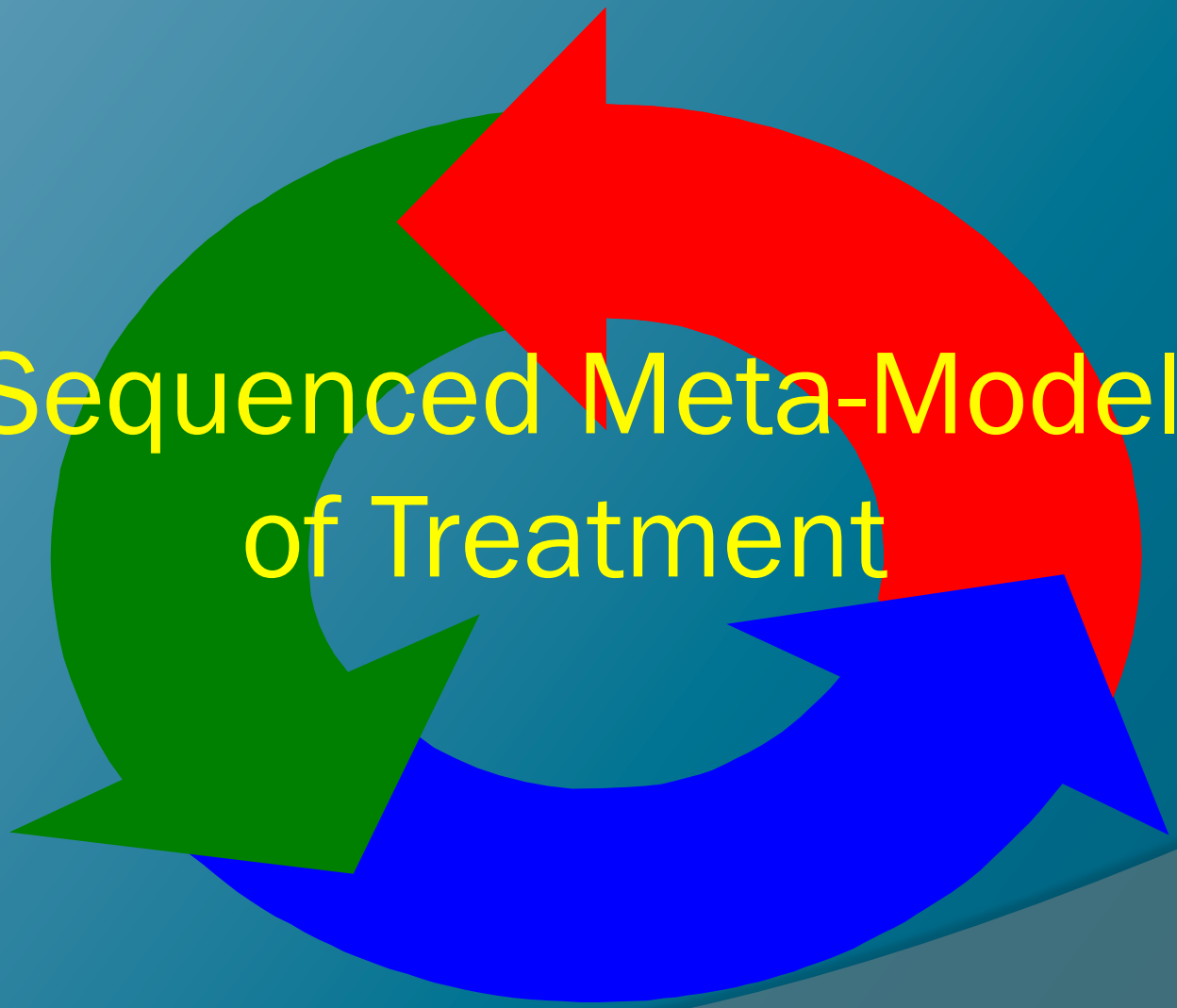
- Sequenced meta-model
- Multi-theoretical and multi-systemic
  - Integrative
- "Not trauma alone" (Gold, 2000)
  - Addresses attachment/relationship issues, life issues, trauma symptoms, and processing of traumatic material
- Varies according to problem and acuity
- Varies according to individual goals and capacities
- Takes context into consideration

Treatment of Complex PTSD

- Dual relationship and problem-solving/skill building/emotional regulation approach
- Dyadic regulation of psychophysiology, and establishment of secure attachment
- Adaptive skills to replace maladaptive behaviors
  - Attention to developing mentalization

(Steele)

Sequenced Meta-Model of Treatment



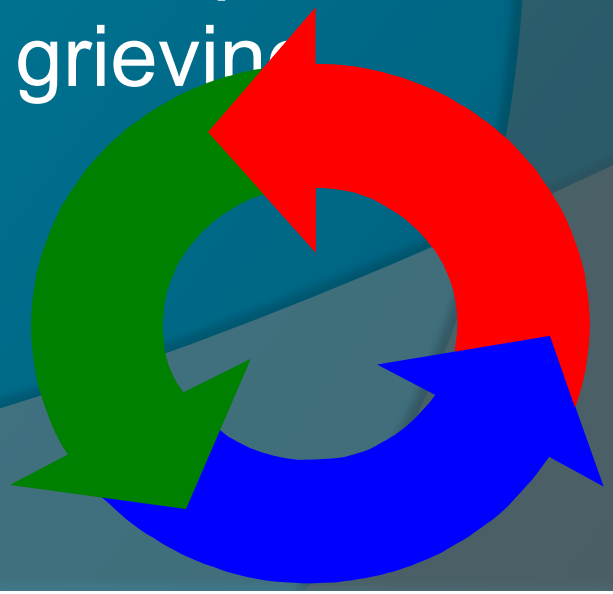
Complex Trauma Treatment Sequence

~ Pre-treatment, assessment, treatment planning

1. SAFETY, stabilization, skill-building, education, building of relationship

2. Trauma processing: narrative development, gradual and prolonged exposure, grievin meaning-making

3. Re-integration to life, self and relational development



Rationale for Sequencing

- Create a foundation of safety
  - Move out of chaos, acute crisis
  - Build treatment relationship(s)
- Provide education and teach skills
  - Trauma, posttraumatic reactions, relation of trauma and addictions
  - Emotional regulation, sobriety, life skills
- Avoid over-stimulation
  - Titrate support and challenge
  - Within window of tolerance
- Identify and treat dissociation
- Natural change and growth model: strength-based
- Relapse model

Pre-treatment Stage: Assessment and Contracting

- Assessment and contracting *before* decisions about treatment
- Follow normal intake procedures, complete a *comprehensive* psychosocial evaluation
  - inquire broadly about a range of symptoms
  - inquire about DV, all forms of abuse/trauma/crises
  - follow up with specialized and/or collateral assessment
- Take time to assess and assimilate information
- Inquire about ongoing/pending/considered legal action

Pre-treatment Stage: Assessment and Contracting

- Ask about safety and assess risk
  - of self, by self and others
  - to and from others
  - may need to begin safety planning immediately
- Current state of individual's health and healthcare
- Ask about resources
  - funding of health care
  - living expenses and arrangements
  - ***support network***
- Ask about current and previous treatment (request records)

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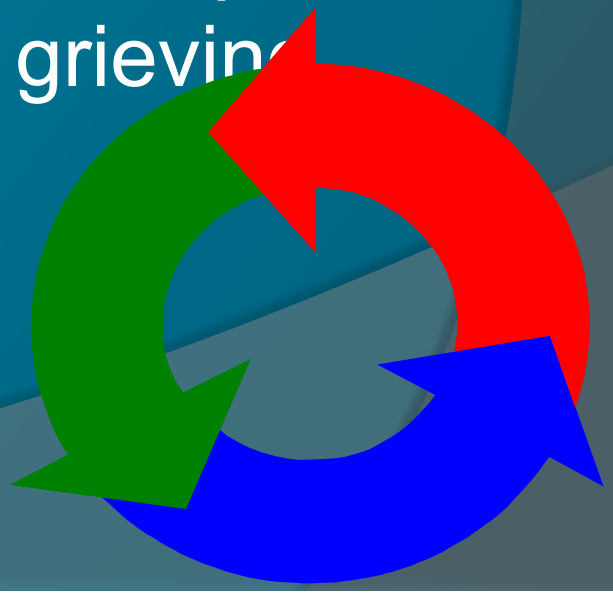


Early Stage: Alliance-building, Safety, Skill-building, Self-management

Stage measured in mastery of skills and healing tasks, not time!

Therefore, often a problem for patient and for managed care; however, good stage 1 work often saves time in the long run

Early Stage: Psychological Components of Treatment

- Therapeutic alliance as essential but takes time
- Safety as essential, not to be ignored
  - safety planning: collaborative problem-solving vs. time-limited contracting
    - involves a hierarchy of interventions and actions, internal and external and the agree-upon use of supports including voluntary hospitalization, if indicated
  - trauma work cannot be conducted without safety
    - ***expect and plan for relapses***

Early Stage: Psychological Components of Treatment

- Affect processing and change
- Attachment style/personality and related issues/defenses
- Identifying/undoing cognitive errors & distortions, erroneous beliefs & info
- Grounding and stabilization skills for numbing and/or re-experiencing symptoms
- Life skills
  - assertiveness, problem-solving, decision-making, organization, career, financial and life planning

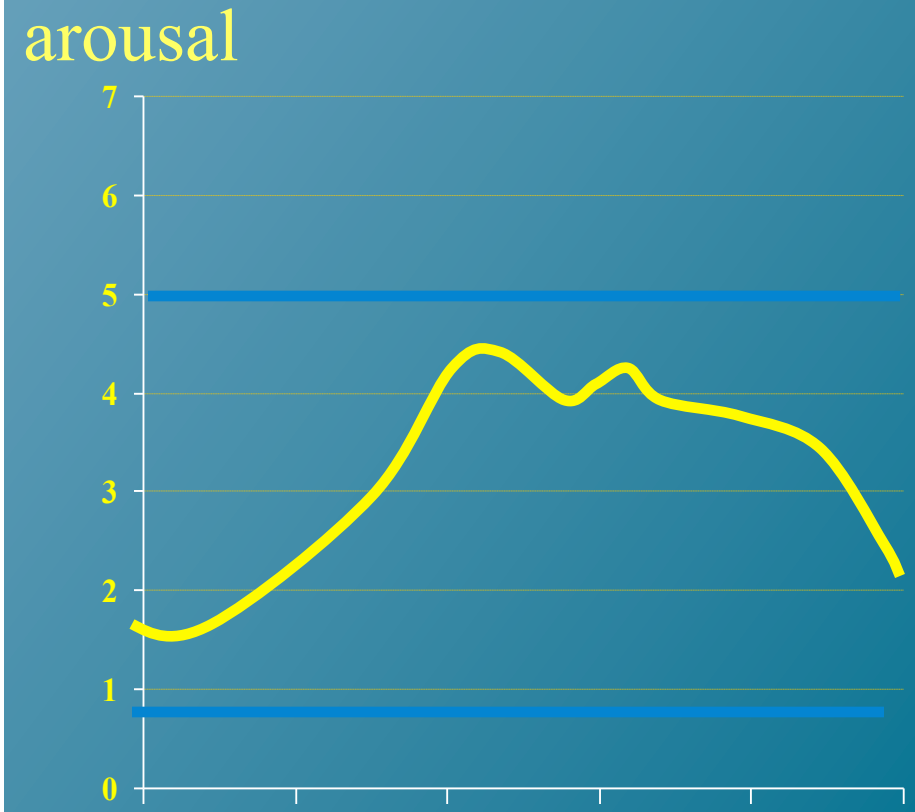
Middle stage: Trauma processing, de-conditioning, resolution

- When to move forward
- What does trauma/emotional processing mean?
- Motivation enhancement
- Process of change & relapse planning
- Titration

Middle stage: Trauma processing, de-conditioning, resolution

- Revisiting and reworking the trauma
  - in the interest of resolution, not to retraumatize
  - only after stabilization skills have been learned--even with careful pacing, work is destabilizing
  - plan for possible relapse
- Graduated exposure and de-conditioning
  - careful 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” or “affect edge”
  - with therapist’s support & empathy

Window of Tolerance: Dominate physiological systems



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

- Expression of emotion and resolution of core issues/affect/cognitive distortions/schema
  - guilt, shame
  - responsibility, self-blame
  - fear, terror
  - mistrust, ambivalent attachment, 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

- Creating a narrative over time
  - increased understanding and resolution
  - Coherence of narrative and new meaning
- 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

Middle stage: Trauma processing, de-conditioning, resolution

- Special techniques (empirically supported)
  - Cognitive-behavioral Protocols
    - exposure, stress inoculation, anxiety management, etc.
  - EMDR (Eye Movement Desensitization and Reprocessing)
    - for resource installation and for memory processing
  - EFTT
  - EFT/couples
  - Special treatment programs and protocols
    - STAIR, ATRIUM, SS, TARGET, TREM

Middle stage: Trauma processing, de-conditioning, resolution

- Collateral work
  - w/ cautions, preparation, training
    - 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

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 symptoms?

Late stage:
Self and relational development

- Career/vocational issues, as applicable
- Continued development of connection with others/restitutive relationships
  - intimacy
  - sexuality
  - family of origin: nuclear and extended
  - children and parenting
  - friendships
  - colleagues

“Alphabet Soup” of Techniques

Techniques & Approaches

- ACT
- AEDP
- ATRIUM
- CBT
- CPT
- CRM
- DBT
- DNMS
- EFT
- EFTT
- EMDR
- IEDP
- IFS
- MBSR
- PE
- SE
- SIT
- SPI
- SS
- STAIR
- TARGET
- TFT
- TREM
- Etc., etc.

Effective Treatments for PTSD*

- Psychopharmacology (esp. US)
- Psychotherapy, especially cognitive-behavioral/PE; CPT, EMDR, SIT, NET, psycho-dynamic/ attachment/relational)
- Psych-education

Other supportive interventions

*Few studies have evaluated using a combination of approaches, although combination treatment commonly used and may have advantages

Effective Treatments for CPTSD

- EMDR (Shapiro)
- PE and CPT, applied later (Foa; Resick)
- SIT (Meichenbaum)
- EFTT: Emotionally Focused Tx for Cmplx Trauma (Paivio & Pascal-Leone)
- EFT: Emotionally Focused Tx (Johnson)
- STAIR-NST (Cloitre)
- TARGET (Ford)
- Some group models (Classen; Lubin & Read: Herman et al)

Relational Healing for Interpersonal Attachment (Relational) Trauma

The Therapeutic Relationship

- Empathic, kind
- Mindfulness
  - observing, open, available, interested/curious, active, collaborative
- Safe
  - stable, reliable, consistent, responsive, boundaried
- Attuned and reflective
- Mis-attunement is an opportunity for repair
  - When ruptures occur, an opportunity for communication, problem-solving, and repair

Relational Issues

- Relational approach: RICH model
- Treatment relationship defined and delimited
  - Ethics and risk management
- Attachment-based understanding & approaches
- Interpersonal neurobiology
- Use of relationship to understand the client
  - transference, countertransference, enactments, VT
- Support & consultation for therapist

Interpersonal Neurobiology

(Schore, Seigel, others)

- The crucial significance of being with a responsive therapist
  - Offers reassurance of the other's presence
  - The client is NO LONGER ALONE
  - Attention and attunement reflects SELFHOOD and SELF-WORTH back to client
    - through emotional attunement & reflection
    - communicates being *worthy* of attention
  - May be difficult to accept but may be craved
  - Titrate to window of tolerance: "Can you accept a bit more? What does it feel like? Are you open to more?"

Interpersonal Neurobiology

(Schore, Seigel)

- Right brain to right brain attunement: implicit factors, somatosensory: "bottom up approach"

- Development of new neuronal pathways: "neurons that fire together wire together" (Hebbs)
  --enables genetic expression
  --allows association /integration vs. dissociation

- "Earned secure" attachment through secure base of the therapeutic relationship
  - Freedom to explore: self, affect, emotions, physical reactions, relations with others, etc

Interpersonal Neurobiology

(Schore, Seigel)

- Affect regulation: from co-regulation to auto-regulation
- Development of the pre-frontal cortex: ability to think/judge before acting (inhibit/override stress alarm—amygdala/limbic system)
  - learn to differentiate responses: separate past from present
  - other ways to self-soothe including through the use of internalized others
  - “therapist and others on your shoulder”, offering support, counsel, acceptance

Interpersonal Neurobiology

(Schore, Seigel)

- Allows the hippocampus to come online
  - autobiographical memory more available
- Putting it into words: development of a coherent narrative due to processing and integration of what had been split off and incoherent/unspoken (left brain)
- Knowing vs. unknowing/unconscious
- Integration rather than dissociation

The Importance of Relational Repair

- Consistent, reliable relationship, *not perfect!*
- "Good enough"
- Accepting: non-punitive, non-judgmental
- Encourage collaboration, curiosity
- Encourage reflection and reflective functioning
- Therapist self-disclosure about feelings *in the moment* (Dalenberg research)
  - especially anger
- Therapist owns own mistakes and apologizes (carefully)
  - negotiates relational breach and repairs
  - may be the most significant moments in treatment

Boundary Issues

- Potential for boundary violations (indiscretions, transgressions, and abuse) (vs. crossings) common with this population
  - Playing out of attachment style and issues
  - Playing out the roles of the Karpman triangle, plus:
    - victim, victimizer, rescuer, passive bystander
    - potential for sado-masochistic relationship to develop
  - Roles shift rapidly, especially with dissociative clients
  - Therapist must try to stay steady state *and* emotionally resonant

Boundary Issues

- Safety of the therapeutic relationship is essential to healing
- Responsibility of therapist to
  - Maintain integrity of the frame
  - Be thoughtful and clear about boundaries/ limits but not rigid
    - re: availability, personal disclosure, touch, fees, gifts, tolerance for acting out behavior, S-I, suicidality, social contact, Googling, Facebook, etc.
    - May need to revisit and revise

Boundary Issues

- On average, start with tighter boundaries
  - Teach limits and boundaries, “rules of the road”
- Reinforce the right thing!!
- Expect boundary challenges and disorganized attachment
  - Teach negotiation and collaboration
  - Hold to important boundaries but have some flexibility and engage in problem-solving
- *Be conditional while being unconditional*

Boundary Issues

- Expect shifts in transference/ attachment according to different self-states or states of mind
  - try to respond with equanimity/ acceptance, especially with “state switches”
- Avoid dual roles wherever possible
- Engage in ongoing continuing education, consultation/supervision, peer support
  - an ethical imperative!!!
- Engage in personal therapy as necessary

Boundary Issues

- Rescuing-revictimization "syndrome"
  - "vicarious indulgence" as a treatment trap, especially for novice therapists and those prone to caretake or who are enticed by the client
  - may give client permission to overstep boundaries, ask for and expect too much
  - then can lead to resentment/rage on the part of the therapist and abrupt, hostile termination for which the client is blamed (triple bind)
  - may relate to malpractice suits, in some cases (see BPD literature)

Boundary Issues

- Progression of boundary violations: the "slippery slope"
- It is **NEVER *OK*** to sexualize the relationship
  - client may seek to sexualize directly or indirectly
  - therapist may develop sexual feelings
- Guideline:
  - welcome and discuss *when presented by client*; hold the line, keep your seat, do not touch, DISCUSS.
  - When belongs to the therapist, seek consultation. Only discuss if therapeutically warranted and then, very carefully w/ ownership

Resources

- ISST-D.org
  - 9 month-long courses on the treatment of DD's--various locations internationally, nationally, and on-line beginning Sept-Oct
- ISTSS.org
- **www.ChildTraumaAcademy.org**
- NCPTSD.va.gov (info and links)
- NCTSN.org (child resources)
- Sidran.org (books and tapes)
- APA Div. 56: Psychological Trauma—new!! (traumadivision@apa.org)