Treating CPTSD

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History- PTSD

- Pierre Janet (1911)- first to describe repeated intrusion of traumatic memory
- Developed DSM – III Vietnam veterans
- Criterion A initially – how it has progresses
- Distinct disorder

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History-CPTSD

- Proposed as a distinct disorder from PTSD
- Accepted by the World Health Disorder as a distinct diagnosis in the ICD-11 (2018)
- APA rejected CPTSD and distinctly different from PTSD and adjusted the definition of PTSD in the DSM-5 but did not include CPTSD

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Core Symptoms- PTSD

- Re- experiencing in the present
- Avoidance of traumatic reminders
- Sense of current threat

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PTSD (DSM-5, 2013)	PTSD (ICD-11, 2018)
A. Exposure to actual or threatened death, serious injury, or sexual violence	• Exposure to an extremely threatening or horrific event or series of events
B. Intrusions	• Re-experiencing
C. Avoidance	• Avoidance
D. Changes in cognitions and mood	
E. Arousal & reactivity	• Persistent perceptions of heightened current threat
F. Duration more than 1 month	• Must last for at least several weeks
G. Clinically significant distress or impairment of function	• Significant impairment in personal, family, social, educational, occupational, or other important areas of functioning
H. Due to event, not due to physiological effects of a substance or medical condition	

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Exhibit 1.3-4 DSM-5 Diagnostic Criteria for PTSD

Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see the DSM-5 section titled "Posttraumatic Stress Disorder for Children 6 Years and Younger" (APA, 2013a).

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

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Core Symptoms- CPTSD

- Re- experiencing in the present
- Avoidance of traumatic reminders
- Sense of current threat
- Disturbances of Self Organization (DSOs)
  - Emotional regulation difficulties
  - Relationship difficulties
  - Negative self- concept

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Distinct Nature of PTSD

- Involuntary re-experiencing of traumatic event as unique characteristic [6]
  - Re-experiencing of traumatic event often accompanied with painful emotions
  - Abnormal memory phenomenon
  - No consensus as to cause

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Theories of PTSD

- Two- factor learning theory [6]
  - Fear conditioning
  - Flashbacks don't extinguish due to avoidance behaviours
  - Treated with imaginal exposure (non- avoidance)
- Stress response theory [6]
  - Cognitive models are incompatible with traumatic experience
  - Triggers psychological defence mechanisms
  - Flashbacks are information overload
  - Treatment includes establishing a new cognitive model

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Theories of PTSD

- Cognitive model [6]
  - Negative appraisal of traumatic event and self-protective strategies
  - Strong perceptual priming leads to flashbacks
  - Treatment includes addressing maladaptive narratives and providing narrative to traumatic memories to reduce priming strength

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Mechanisms of Change

- Improvements in maladaptive trauma- related beliefs and appraisals appear to be the core mechanism of change in PTSD specific treatments [3]
- Some suggestions of increased hope
- Common factors
  - Therapeutic alliance (client buy in)
- Emotional regulation/ inhibitory learning
- There is little to no evidence that indicate that contextualization of trauma memories or sensory (somatic) based memories into verbally accessible ones is a mechanism of change [3]

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Memory Wars

- Repressed trauma memories- mixed to limited evidence
  - 24.1% of Clinical Psychologists [in USA] agree in repressed memories and 8.6% of Cognitive Psychologists [5]
- Children coping through dissociative avoidance coding style- mixed to limited evidence
- Fragmented memories – scarce peer reviewed evidence of fragmented or dissociated memories [1] [2][4]

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CPTSD Criteria

- Exposure to an event or series of events of an extremely threatening or horrific nature, **most commonly prolonged or repetitive events from which escape is difficult or impossible.**
- Following the traumatic event, the development of all **three core elements of Post-Traumatic Stress Disorder,** lasting for at least several weeks
- **Severe and pervasive problems in affect regulation**. Examples include heightened emotional reactivity to minor stressors, violent outbursts
- **Persistent beliefs about oneself** as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to the stressor.
- **Persistent difficulties in sustaining relationships** and in feeling close to others. The person may consistently avoid, deride or have little interest in relationships and social engagement more generally. Alternatively, there may be occasional intense relationships, but the person has difficulty sustaining them.

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Distinct Nature of CPTSD

- DSOs
- Recurrent trauma, mostly when feel cannot escape
- Impact on ongoing schema development
- Onset

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DSOs

- Loss of integrated and stable identity
  - Self of self ("who am I?" "what makes me unique" "what makes me worthwhile and worthy") is unstable and at times completely undeveloped
- Results of attempt to cope with existential threats
- Developed from the disruption of essential developmental relationships
- Involve a blockage, disruption, and distortion of developmental trajectory

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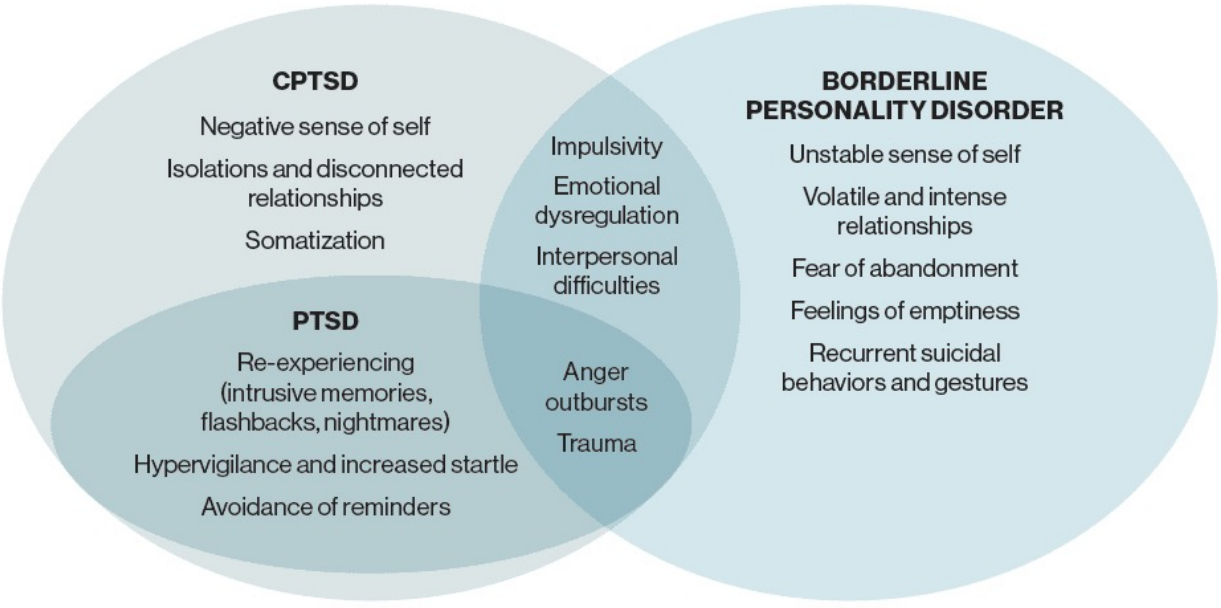
FIGURE. Unique and Overlapping Symptoms of CPTSD and BPD



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Childhood Development and Trauma

Early childhood experiences shape development

Traumatic events during formative years can have profound and lasting impacts on mental health and well-being.

schema development

Early experiences shape how children form mental representations and conceptual frameworks.

low-grade inflammation

Childhood abuse was associated with low-grade inflammation. Chronic inflammation has been established as the overlying mechanism demonstrating how the immune system contributes to disease development.

Understanding the implications of stress on childhood development is crucial for providing appropriate support and interventions.

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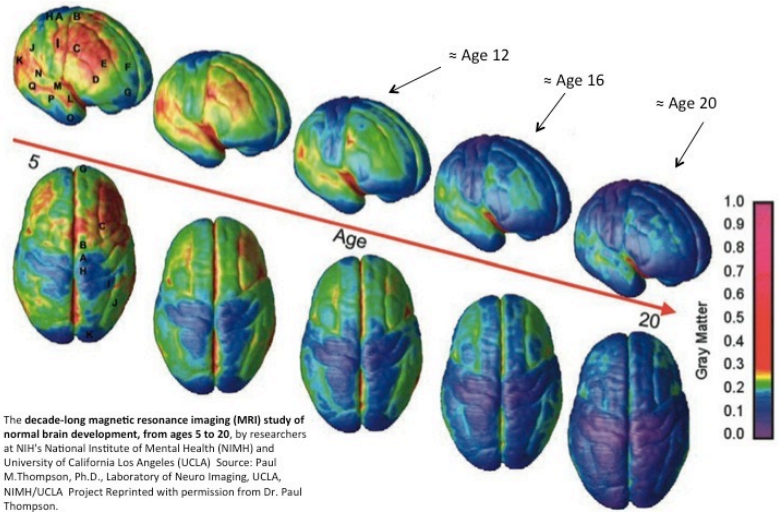
Brain Development



The **decade-long magnetic resonance imaging (MRI) study of normal brain development, from ages 5 to 20**, by researchers at NIH's National Institute of Mental Health (NIMH) and University of California Los Angeles (UCLA) Source: Paul M.Thompson, Ph.D., Laboratory of Neuro Imaging, UCLA, NIMH/UCLA Project Reprinted with permission from Dr. Paul Thompson.

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Attachment

- Developed in early childhood
- Influences a child's capacity to form mature intimate relationships in adulthood
- Influence cognitive schemas

"Patterning and organization of attachment relationships during infancy is associated with characteristic processes of emotional regulation, social relatedness, access to autobiographical memory, and the development of self—reflection and narrative" (Siegel, 1999, p.67)

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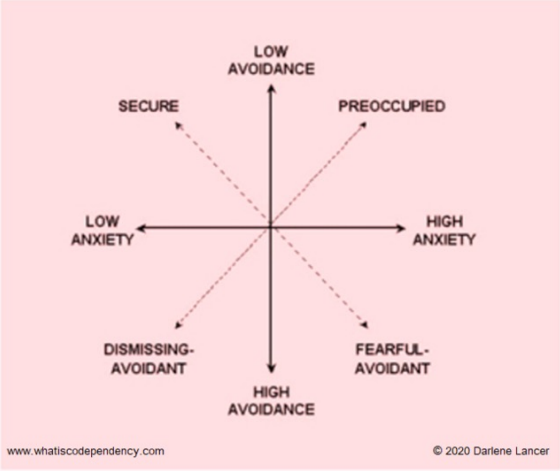
Secure Attachment-
- Have adaptive emotional regulation abilities through sustained problem-solving efforts



Anxious Attachment-
- Crave close relationships
- Engage in strategies that sustain or even exacerbate their distress

Avoidant Attachment-
- Suppress or deactivate emotional reactions
- Fearful of vulnerability and emotions

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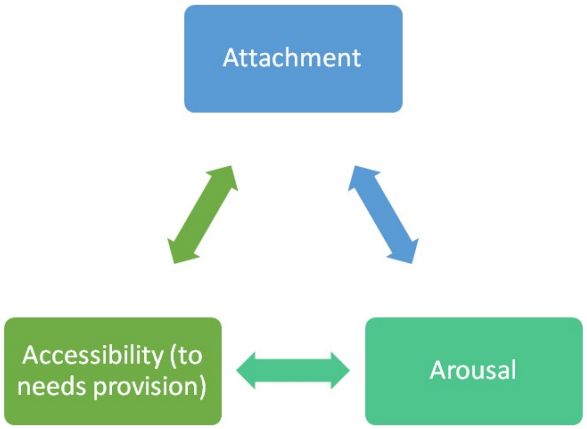
Lost Attachment



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Assessment

- PCL- 5
  - https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp
- Inventory of Psychosocial Functioning
  - https://www.ptsd.va.gov/professional/assessment/functioning-other/ipf_psychosocial_function.asp
- Trauma Symptom Inventory (TSI-2)
  - https://www.parinc.com/products/TSI-2

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CPTSD Treatment

- Phased treatment first proposed by Judith Herman in 1999
- Considered the complexity of symptoms and co-morbidities (Depression and anxiety)
- Increased chance of continuation of symptoms throughout life
- Veterans and war- affected populations less responsive to treatment
- Cognitive restructure with imaginal exposure evidenced as most effective [12]

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Phase 1- Stabilization

- Focus is preparation for trauma specific treatment
- Focused on coping with emotional regulation , improvement of social skills
- Intended to reduce drop out rates [12]
- Alexithymia [11]
  - Correlated with childhood maltreatment and other causes of CPTSD
  - Difficulty in distinguishing affective from somatic states- manifests as frequent use of physical sensations to describe emotions
  - Feel physically uncomfortable when they are emotional but are not able to describe the nature or source of this sensation
  - Impairments in emotional processing

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Emotional Regulation

- "Survival brain"
  - Distinct neural profiles of CPTSD and PTSD during threat response [9]
- Humans have a unique ability to use cognition to alter fear responses [10]
- Stress impacts the ability of the PFC and subcortical regions implicit in threat control
- Evidence that a history of childhood abuse reduces grey matter in the PFC
- fMRI studies indicate that ongoing PTSD symptoms are contributed by impairment with the PFC
- TMS may help
- Emotional awareness

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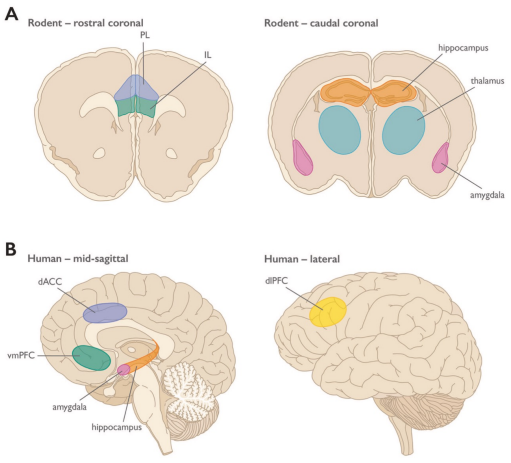

Fig. 1 Threat regulatory neurocircuitry across species. **a** Rodent anatomy highlighting regions involved in threat learning, extinction, avoidance, and the contextual modulation of threat expression; **b** Human anatomy highlighting regions involved in threat learning, extinction, avoidance, cognitive regulation, and the contextual modulation of threat expression. PL = prelimbic cortex, IL = infralimbic cortex; dACC = dorsal anterior cingulate cortex, vmPFC = ventromedial prefrontal cortex, dlPFC = dorsolateral prefrontal cortex.

[10]

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Sleep

- Modulates threat control in humans [10]
- Enhances threat learning and generalization of extinction learning

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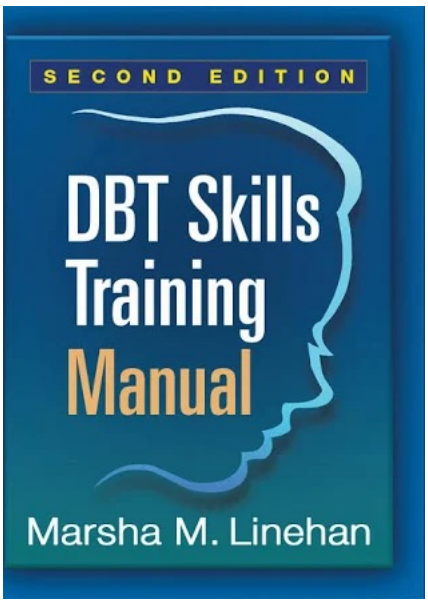

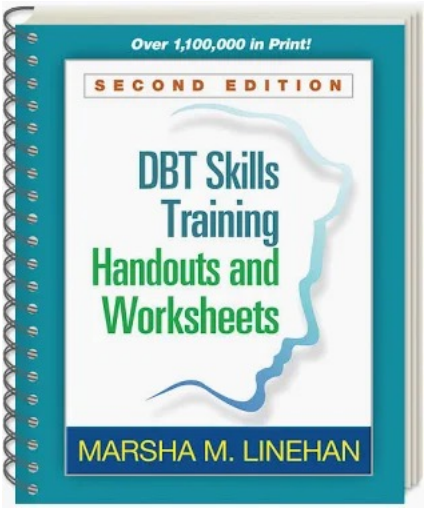

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DBT

- Mindfulness (Self-awareness)
- Distress Tolerance
- Emotional Regulation
- Interpersonal skills

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DISTRESS TOLERANCE HANDOUT

TIPP Skill

Changing Your Body Chemistry

Temperature

(To calm down fast)
Hold your breath and put your face in a bowl of cold water
Hold ice in your hands (no more than 30 seconds)
Wet a washcloth in cold water and place where desired
Drink ice cold water

Intense Exercise

(To calm down your body when overwhelmed w/emotion)
Engage in intense exercise for only a short while
Expend your body's stored up energy by running, sprinting, walking fast, jumping jacks, doing sit ups, etc.

Paced Breathing

(Pace your breathing by slowing it down)
Deep Belly/Abdominal breathing
4-4-8 or 4-7-8 breathing
Wet a washcloth in cold water and place where desired
Drink ice cold water

Paired Muscle Relaxations

(Calming down using Paired Muscle Relaxation w/Breathing)
Close your eyes and focus on tensing and relaxing each muscle group for 2 to 3 seconds. Start with your feet and toes, and then move up to your knees, thighs, chest, arms, hands, neck, jaw, and eyes. Maintain deep, slow breaths the entire time.

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DBT- PTSD

- Phase 1 – Commitment [13]
  - Brief structured interview records active, dysfunctional behavior patterns
  - Crisis and emergency plan
- Phase 2- Trauma Model and Motivation
  - Psychoeducation on CPTSD/ PTSD
- Phase 3- Skills and Cognitive Elements
  - Learn to identify early signals of begining dissociative states

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DBT- PTSD

- Phase 4- Skill- Assisted Exposure
  - Learn to maintain the level of aversive arousal within a tolerable range and to prevent dissociative symptoms
  - Activation of trauma associated emotions and awareness of the present moment
  - Exposure to primary trauma associated emotions, such as powerlessness, disgust, anxiety, and pain

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DBT- PTSD

- Phase 5- Radical Acceptance
  - Linked to exposure phase with exercises in acceptance and embracing what has been experienced
- Phase 6- A Life Worth Living
  - Explore new areas of life or actively seek improvements to those factors which stand in the way of a meaningful life worth living

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DBT- PTSD

- Phase 7- Farewell
  - Addresses fear of abandonment common in CPTSD

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Phase 2- Trauma Treatment

- Acceptability of intervention
- Address maladaptive cognitions

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Emotion Processing Theory

- Fear Structure- mental framework for reacting to a fear stimulus
- Can become distorted – individuals do not reflect sufficiently upon the initial event and associated emotions so harmless stimulus are interpreted as dangers
- Treatment based on this theory (such as Prolonged Exposure) involves the repetitive exposure to the event memory in a safe (therapeutic) environment. Recoding of the fear response
- Proposed by psychologist Edna Foa and Michael J. Kozak

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Necessity of Exposure?

- Exposure- systematic confrontation of a feared stimuli
- Habituation – reductions of fear over time and exposure
  - Often measures through Subjective Units of Distress (SUDS)
- Little research supporting the belief that in session decrease in distress (a.k.a. evidence of habituation) is linked to treatment success
- New evidence is indicating that exposure is not needed and is actually less about reducing fear than helping people adapt to their experience of fear [7]
- ”Therapeutic efforts are better directed towards toleration of distress within a structure that enhances the consolidation and retrievability of exposure-based inhibitory learning over context and time.” [7]

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EMDR

- Eye movement (not bilateral stimulation)- found to be effective for distraction during the recollection of traumatic memories which decreases imaginal inflation. [4]
  - Other distraction techniques- counting backwards, attentional breaking, computer game Tetris also effective
  - Slow eye movements found to be more effective than fast
  - Helps with not only distressing memories but also imagined future threats (anxiety)
- Precise mechanism mediating the effects of lateral eye movement on memory remain unknown [4]
  - Experiencing a weakened form of the averse memory could encourage reappraisal

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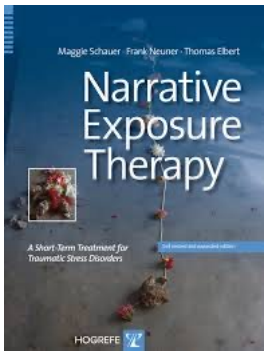
Narrative Exposure Therapy



- Small group or individual
- Establish a chronological narrative of life
- Contextualizes experiences
- Redefine traumatic stories
- Client describes emotions, thoughts sensory information
- Engages their entire life story

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CT- PTSD

- https://oxcadatresources.com/
- CT maintains that PTSD symptoms are maintained via three processes
  - Meanings that arise from the way an individual has appraised the traumatic event or its aftermath
  - The nature of the trauma memories- disjointed autobiographical memories
  - Maladaptive cognitive and behavioural coping strategies (avoidance)

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CT- PTSD

- Treatment focuses
  - Reclaiming/ rebuilding your life assignments
  - Changing problematic appraisals
  - Updating trauma memories
  - Stimulus discrimination training with triggers of re-experiencing
  - Replacing unhelpful coping strategies

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10 Misconceptions about CBT for PTSD [14]

1. Trauma-focused treatments are not suitable for complex / multiple trauma
2. Stabilization is always needed before memory work
3. Talking about trauma memories is “retraumatizing”
4. Some traumas shouldn’t be relived
5. CT- PTSD is a talking therapy
6. PTSD can’t be treated remotely
7. Dissociation rules out work on trauma memories

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10 Misconceptions about CBT for PTSD [14]

8. PTSD is about fear
9. Exposure needs to be graded
10. CT- PTSD is protocolized and inflexible

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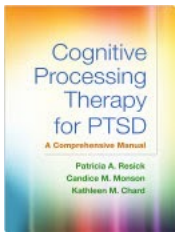
CPT + A



Session 1 – Overview of CPT
Session 2- Examining the impact of trauma
Session 3- Working with events, thoughts, and feelings
Session 4- Examining the index event
Session 5- Using the challenging questions worksheet
Session 6- Patterns of problematic thinking worksheet and introduction to challenging beliefs worksheet

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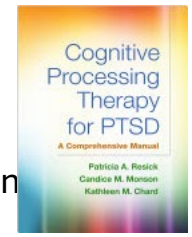
CPT + A



Session 7- Challenging beliefs worksheets and introduction to modules

Session 8- Processing safety and introducing trust

Session 9- Processing trust and introducing power/ control

Session 10- Processing power/ control and introducing esteem

Session 11- Review of esteem and introducing intimacy

Session 12- Processing intimacy and the final impact statement

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Phase 3- Integration

- Increased chance of continuation of symptoms throughout life

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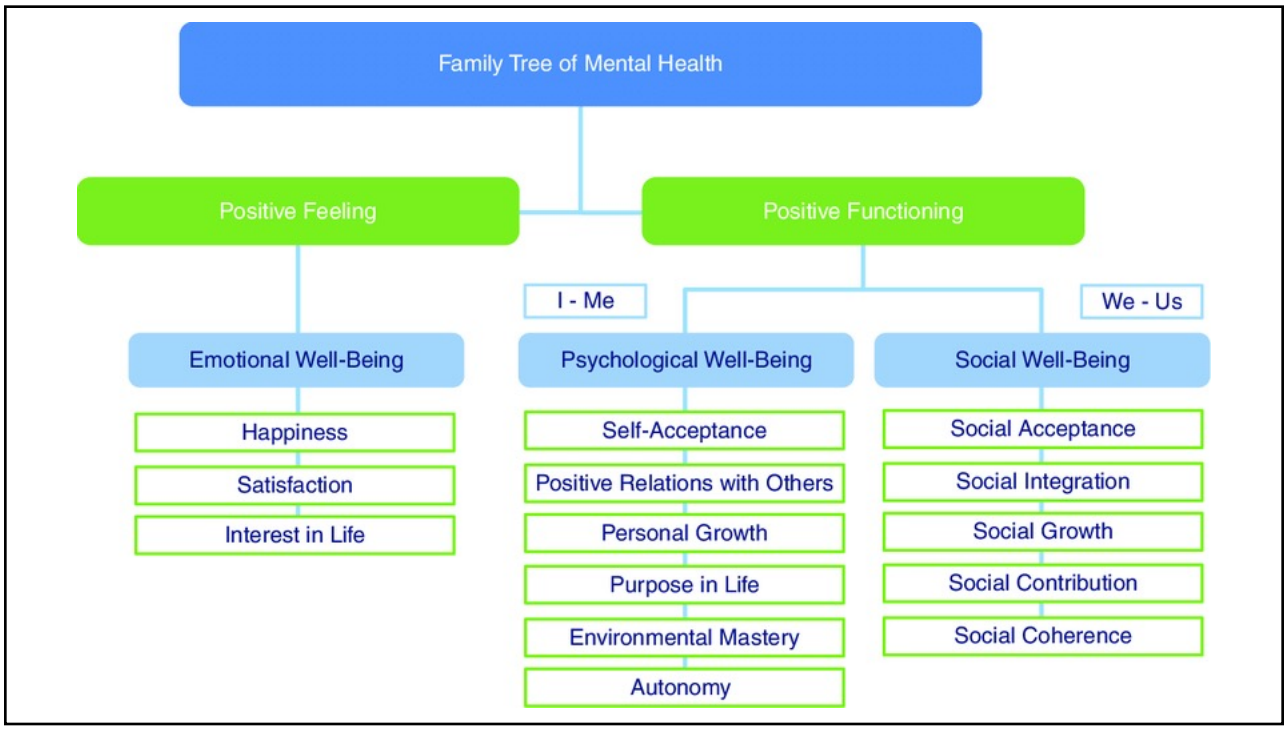
Family Tree of Mental Health
Positive Feeling
Positive Functioning
I - Me
We - Us
Emotional Well-Being
Psychological Well-Being
Social Well-Being
Happiness
Satisfaction
Interest in Life
Self-Acceptance
Positive Relations with Others
Personal Growth
Purpose in Life
Environmental Mastery
Autonomy
Social Acceptance
Social Integration
Social Growth
Social Contribution
Social Coherence

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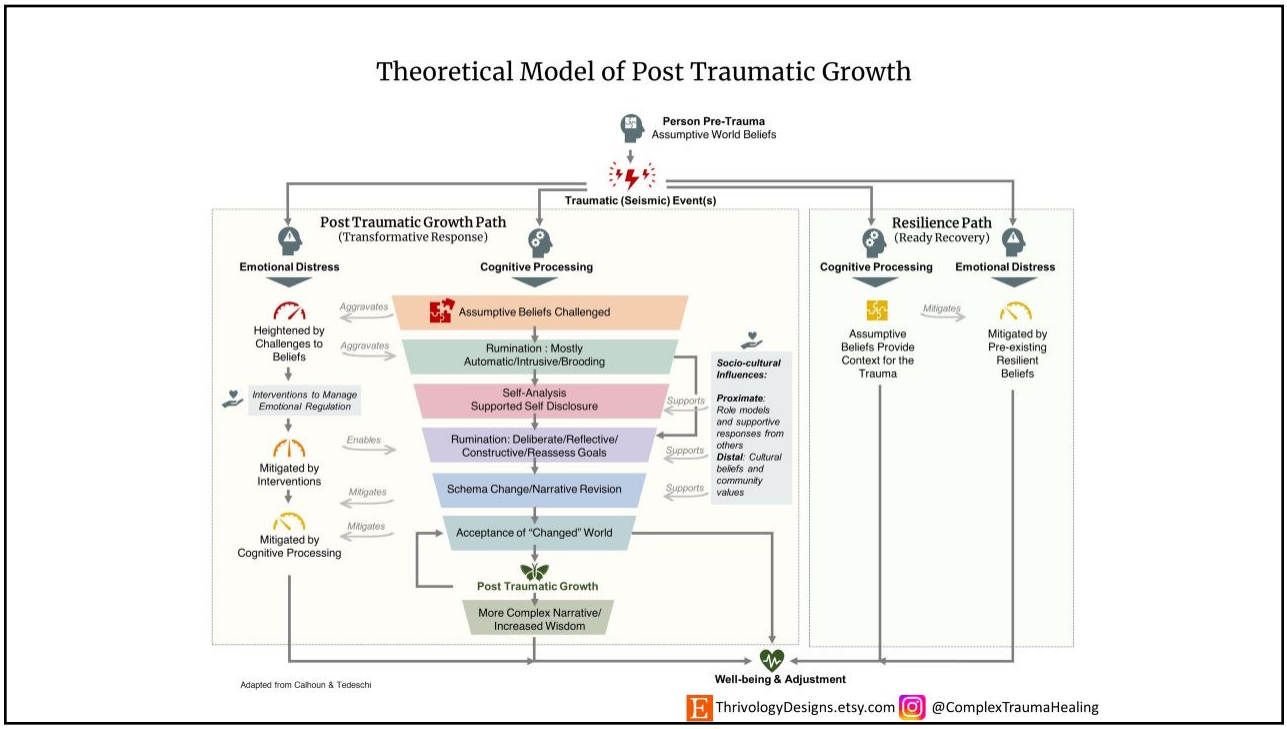
Theoretical Model of Post Traumatic Growth
Person Pre-Trauma
Assumptive World Beliefs
Traumatic (Seismic) Event(s)
Post Traumatic Growth Path
(Transformative Response)
Resilience Path
(Ready Recovery)
Emotional Distress
Cognitive Processing
Cognitive Processing
Emotional Distress
Heightened by Challenges to Beliefs
Aggravates
Assumptive Beliefs Challenged
Aggravates
Rumination : Mostly Automatic/Intrusive/Brooding
Interventions to Manage Emotional Regulation
Self-Analysis
Supported Self Disclosure
Supports
Socio-cultural Influences:
Proximate: Role models and supportive responses from others
Distal: Cultural beliefs and community values
Enables
Rumination: Deliberate/Reflective/ Constructive/Reassess Goals
Supports
Mitigated by Interventions
Mitigates
Schema Change/Narrative Revision
Supports
Mitigates
Mitigated by Cognitive Processing
Acceptance of "Changed" World
Post Traumatic Growth
More Complex Narrative/ Increased Wisdom
Assumptive Beliefs Provide Context for the Trauma
Mitigates
Mitigated by Pre-existing Resilient Beliefs
Well-being & Adjustment
Adapted from Calhoun & Tedeschi
ThrivologyDesigns.etsy.com
@ComplexTraumaHealing

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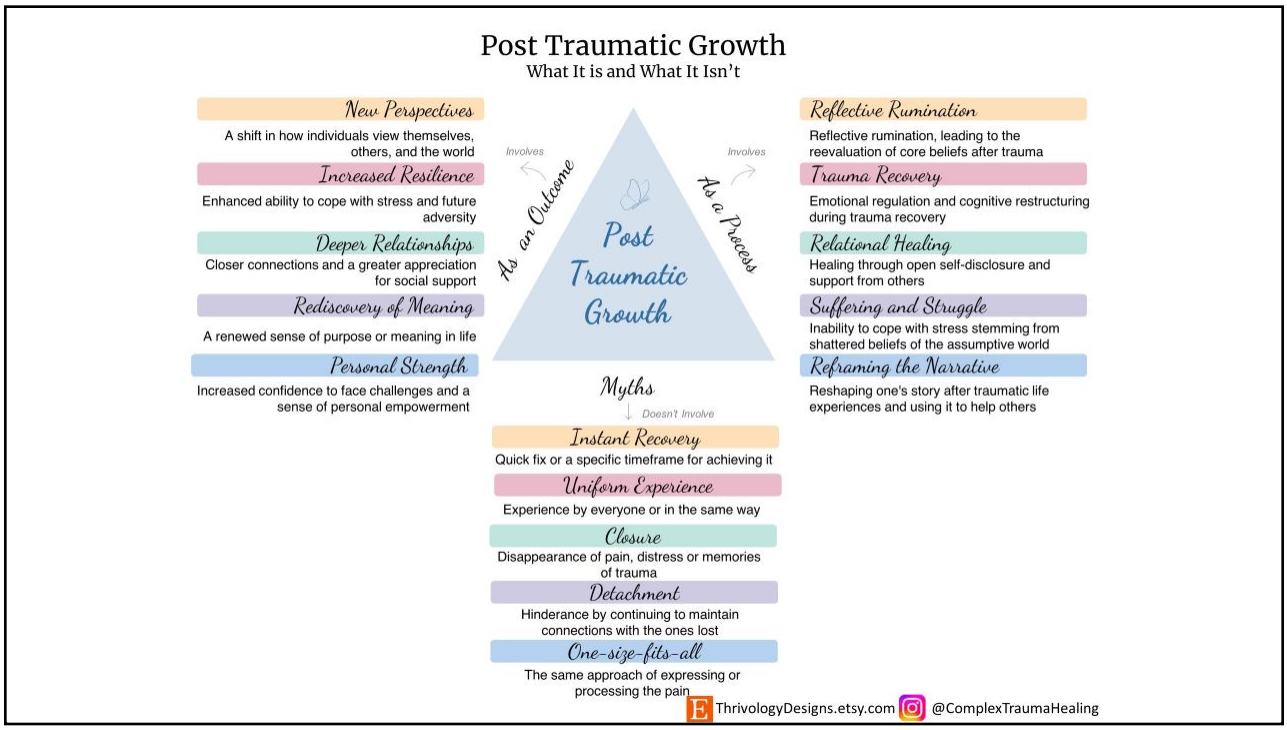
Post Traumatic Growth
What It is and What It Isn't
New Perspectives
A shift in how individuals view themselves, others, and the world
Increased Resilience
Enhanced ability to cope with stress and future adversity
Deeper Relationships
Closer connections and a greater appreciation for social support
Rediscovery of Meaning
A renewed sense of purpose or meaning in life
Personal Strength
Increased confidence to face challenges and a sense of personal empowerment
Involves
As an Outcome
Involves
As a Process
Post Traumatic Growth
Reflective Rumination
Reflective rumination, leading to the reevaluation of core beliefs after trauma
Trauma Recovery
Emotional regulation and cognitive restructuring during trauma recovery
Relational Healing
Healing through open self-disclosure and support from others
Suffering and Struggle
Inability to cope with stress stemming from shattered beliefs of the assumptive world
Reframing the Narrative
Reshaping one's story after traumatic life experiences and using it to help others
Myths
Doesn't Involve
Instant Recovery
Quick fix or a specific timeframe for achieving it
Uniform Experience
Experience by everyone or in the same way
Closure
Disappearance of pain, distress or memories of trauma
Detachment
Hinderance by continuing to maintain connections with the ones lost
One-size-fits-all
The same approach of expressing or processing the pain
ThrivologyDesigns.etsy.com
@ComplexTraumaHealing

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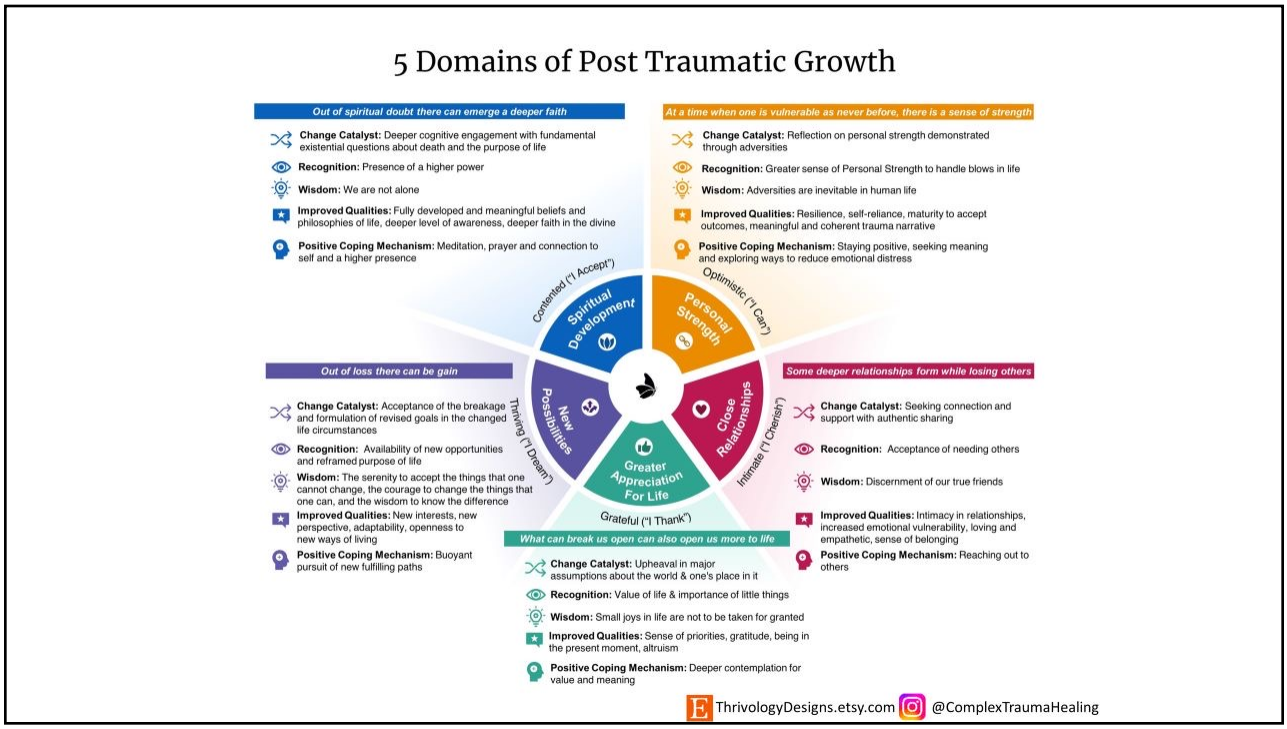
5 Domains of Post Traumatic Growth
Out of spiritual doubt there can emerge a deeper faith
Change Catalyst: Deeper cognitive engagement with fundamental existential questions about death and the purpose of life
Recognition: Presence of a higher power
Wisdom: We are not alone
Improved Qualities: Fully developed and meaningful beliefs and philosophies of life, deeper level of awareness, deeper faith in the divine
Positive Coping Mechanism: Meditation, prayer and connection to self and a higher presence
Contented ("I Accept")
Spiritual Development
At a time when one is vulnerable as never before, there is a sense of strength
Change Catalyst: Reflection on personal strength demonstrated through adversities
Recognition: Greater sense of Personal Strength to handle blows in life
Wisdom: Adversities are inevitable in human life
Improved Qualities: Resilience, self-reliance, maturity to accept outcomes, meaningful and coherent trauma narrative
Positive Coping Mechanism: Staying positive, seeking meaning and exploring ways to reduce emotional distress
Optimistic ("I Can")
Personal Strength
Out of loss there can be gain
Change Catalyst: Acceptance of the breakage and formulation of revised goals in the changed life circumstances
Recognition: Availability of new opportunities and reframed purpose of life
Wisdom: The serenity to accept the things that one cannot change, the courage to change the things that one can, and the wisdom to know the difference
Improved Qualities: New interests, new perspective, adaptability, openness to new ways of living
Positive Coping Mechanism: Buoyant pursuit of new fulfilling paths
Thriving ("I Dream")
New Possibilities
Some deeper relationships form while losing others
Change Catalyst: Seeking connection and support with authentic sharing
Recognition: Acceptance of needing others
Wisdom: Discernment of our true friends
Improved Qualities: Intimacy in relationships, increased emotional vulnerability, loving and empathetic, sense of belonging
Positive Coping Mechanism: Reaching out to others
Intimate ("I Cherish")
Close Relationships
Greater Appreciation For Life
Grateful ("I Thank")
What can break us open can also open us more to life
Change Catalyst: Upheaval in major assumptions about the world & one's place in it
Recognition: Value of life & importance of little things
Wisdom: Small joys in life are not to be taken for granted
Improved Qualities: Sense of priorities, gratitude, being in the present moment, altruism
Positive Coping Mechanism: Deeper contemplation for value and meaning
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Thanks!

Questions?

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