Complex PTSD: Assessment and Management

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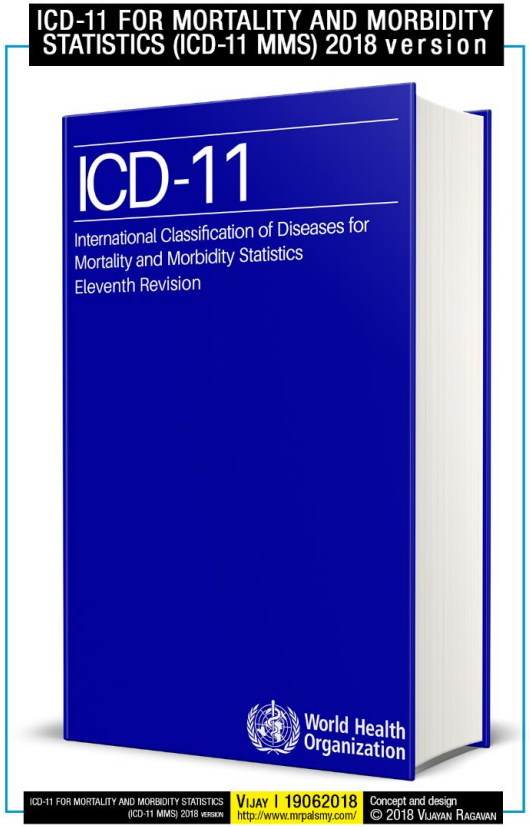
Plan

- Overview of the ICD-11 criteria for PTSD & complex PTSD
- PTSD and CPTSD assessment tools
- Other assessment considerations
- Interventions for CPTSD: what's the evidence
- Intervention principles

ICD-11 PTSD

- Disorders specifically associated with stress
- Exposure to traumatic event
- Re-experiencing
- Avoidance
- Persistent perception of heightened current threat



ICD-11PTSD Trauma Exposure Criteria

- PTSD is a syndrome that develops following exposure to an extremely threatening or horrific event or series of events:
  - e.g. experiencing natural or man-made disaster, combat, serious accident, life-threatening illness, sexual assault or rape, or the sudden, unexpected or violent death of a loved one; witnessing the violent death of others. Traumatic events also include experiences that may be repeated or occur for long periods of time from which escape was difficult or impossible such as being the victim of torture, childhood sexual or physical abuse or domestic violence, other forms of sustained violence.

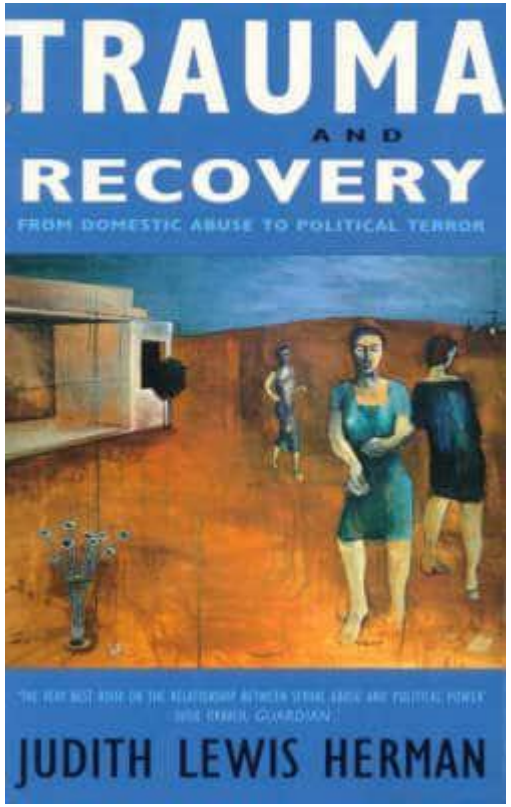
Management of PTSD

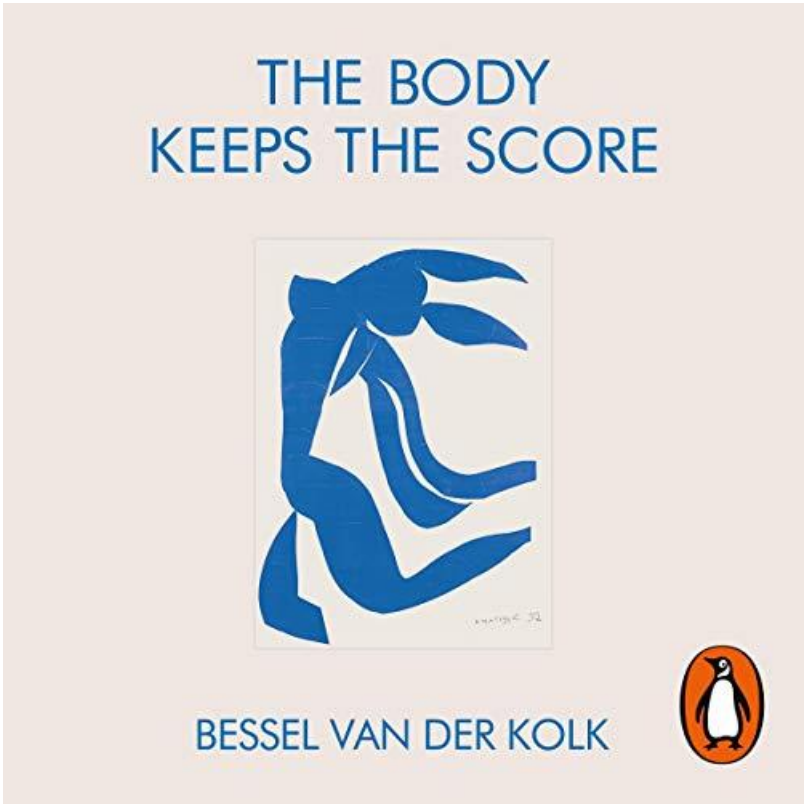
- Well established psychological interventions
  - Trauma focused CBT
  - EMDR
  - Guided self help
- Number of evidence based pharmacological treatments
  - SSRIs
  - Prazosin for nightmares
- Non-psychological and non pharmacological interventions
- Emerging evidence
  - Acupuncture, yoga, neurofeedback, transcranial magnetic stimulation

Multiply Traumatised

- Population versus diagnosis
  - E.g., adult survivors of CSA and other abuse, asylum seekers, refugees, IDPs, military veterans, domestic violence
- Many presentations
  - Often complex
  - Significant comorbidity
  - Difficulties with trust
  - Often different
- Physical, mental health and social issues

Evolution of the concept of complex PTSD





Debated CPTSD features

- Emotion regulation difficulties
  - E.g. self harm, rage
- Disturbance in relational capacity
- Altered attention and consciousness
  - E.g. dissociation
- Adversely affected belief systems
- Self perception
- Somatic distress or disorganisation

Classification

- No such diagnosis until 2018
- PTSD plus X
- Enduring Personality Change Following Catastrophic Stress
  - Hostile, mistrustful attitude; social withdrawal, emptiness/hopelessness; chronic feelings of being on edge or threatened; estrangement
- Disorders of Extreme Stress Not Otherwise Specified
- Dissociative Disorders
- Borderline Personality Disorder

ICD-11 PTSD

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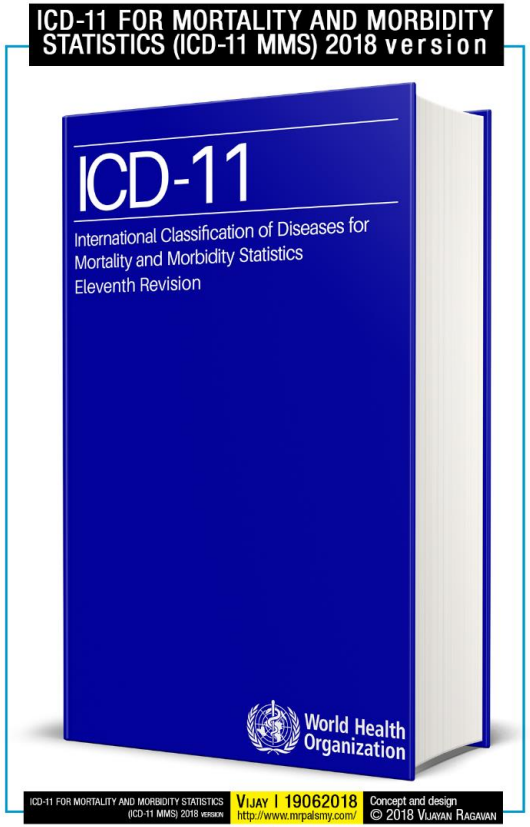

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Complex PTSD Trauma Exposure Criteria

- CPTSD is also a syndrome that develops following exposure to an extremely threatening or horrific event or series of events

- … *most commonly* prolonged or repetitive events from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse).

CPTSD features

- Core symptoms of PTSD + pervasive and chronic disturbance in self organisation in (DSO) in 3 areas.

1. Severe and pervasive problems in affect regulation
   - EITHER hyperactivation - problems regulating emotions characterized by heightened emotional reactions to minor stressors.
   - OR deactivation - e.g. numbing or dissociation
2. Persistent negative self concept
   - E.g. worthlessness, failure, shame, guilt
3. Persistent difficulties in sustaining relationships and in feeling close to others
   - Fearful or relationships, difficulties trusting and feeling safe with others

- Trauma related

ICD11 PTSD & Complex PTSD

06 B 00 “Gatekeeper” Criterion: Traumatic Stressor	
06B40 PTSD	06B41 Complex PTSD
Re-experiencing	Re-experiencing
Avoidance	Avoidance
Persistent perception of heightened current threat	Persistent perception of heightened current threat
	Emotion dysregulation
	Negative self concept
	Interpersonal disturbances
Functional impairment	Functional impairment

Important Features of ICD-11 CPTSD

- Diagnosis based on the symptom profile
- NB personal factors (e.g., ACE exposure/ temperament/ genetic) and environmental (e.g., social support) risk and protective factors
- Type of trauma is a risk factor
  - Individuals who experience repeated childhood abuse but also obtain positive and enduring support may develop PTSD rather than CPTSD, or neither disorder
  - Individuals who experience a particularly horrendous single event in adulthood and have psychological vulnerability and/or poor social support might develop CPTSD

DSM5 Complex PTSD

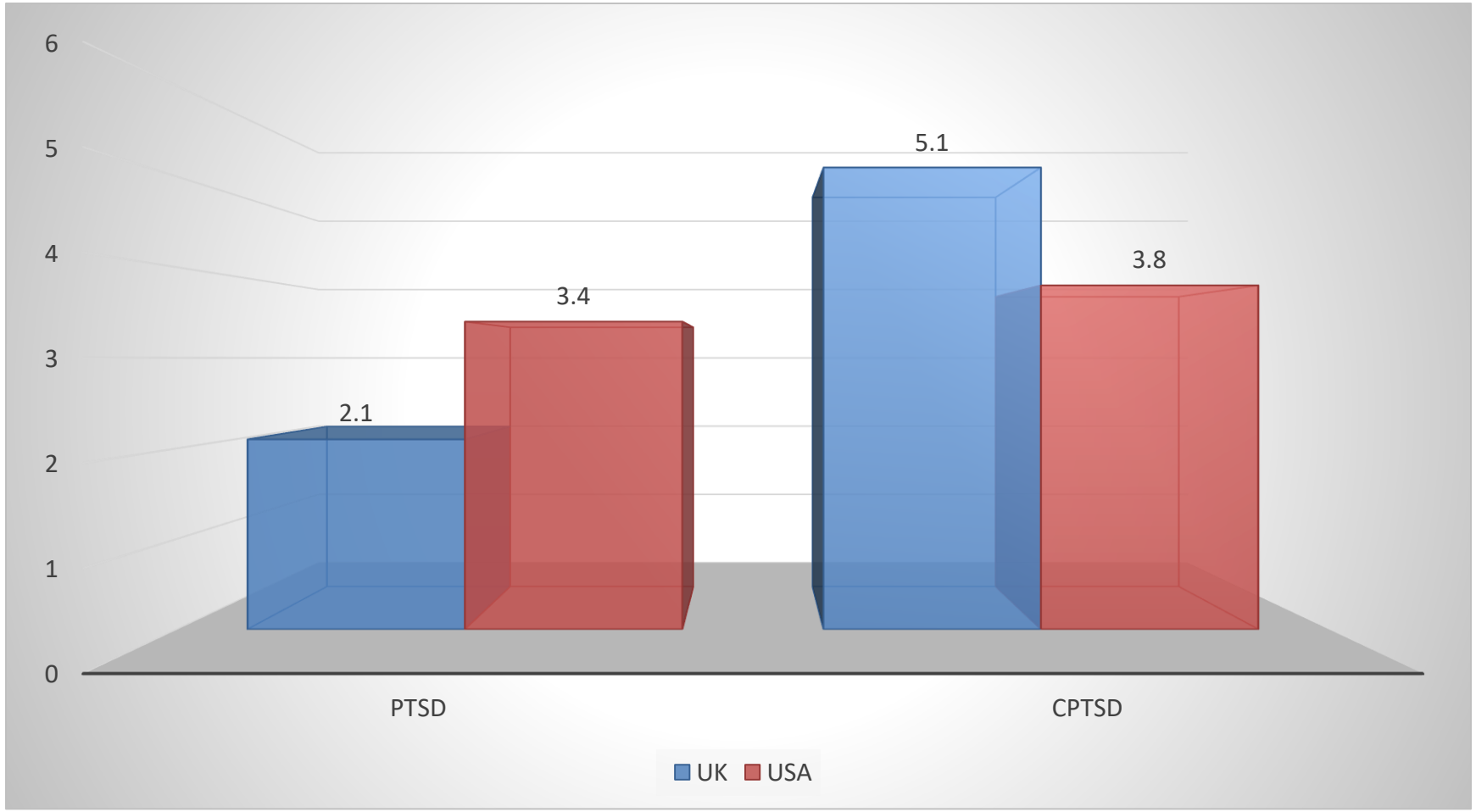
- Not a diagnosis
- PTSD with dissociative symptoms
  - Depersonalisation
  - Derealistation
- NB negative alterations in cognitions and mood
    - Dissociative amnesia
    - Shame/guilt
    - Detachment/estrangement
    - Inability to experience positive emotions

Prevalence & Comorbidity

- Limited data available
- US sample (N=1839); UK sample (N=2653)
- CPTSD:PTSD
  - More psychologically distressed
  - Increased rates and severity of MDD and GAD
  - Lower psychological wellbeing
- Type of trauma risk factor

Cloitre et al (2018); Karatzias et al (2019)

PTSD Community Prevalence



Complex PTSD and EUPD

CPTSD	Shared features	EUPD/ BPD
• Trauma exposure • Reexperiencing • Avoidance • Hyperarousal		
• Internalised difficulties regulating emotion	• Emotion regulation difficulties (difficulties calming self, dissociation, numbing)	• Intense anger • Impulsivity
• Persistent negative self concept	• Negative self concept	• Unstable sense of self
• Disconnected/ lack of closeness	• Disturbed relationships	• Intense and unstable relationships • Fear of abandonment
		• Suicide attempts and self injurious behaviour • High risk of suicide • Paranoia

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	Treatment	
• Focuses on the effects of trauma • Trauma focused in nature		• Diagnosis and effective treatment is organised around these issues

Distinguishing CPTSD from EUPD

- Study of 280 women with a hx of CSA
- Unstable sense of self
- Unstable and intense pattern of interpersonal relationships
- Impulsiveness
- Frantic efforts to avoid abandonment

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4165723/pdf/EJPT-5-25097.pdf

CLINICAL RESEARCH ARTICLE

Distinguishing PTSD, Complex PTSD, and Borderline Personality Disorder: A latent class analysis

Marylène Cloitre[1,2*], Donn W. Garvert[1], Brandon Weiss[1,3], Eve B. Carlson[1] and Richard A. Bryant[4]

Assessment

Small group exercise

- In 2s or 3s
- You are asked to see someone who has a history of domestic violence
- You wonder if these might have complex PTSD
- What would you want to know?
- What would you want to ask?

Assessment considerations

- Full biopsychosocial assessment
- Making assumptions
  - What's bothering the person most?
  - What are they seeking help for?
- Trauma history
- Family history
  - Relationships with family members, adverse childhood experiences (ACEs)
- Personal History
  - School, relationships, bullying, academic

Assessment considerations (contd)

- Occupational experience
- Current circumstances
- Current difficulties
- Functioning before the trauma
  - How have things changed?
- Mental and physical health history
- Alcohol and drug use
- Risks
- Medication
- Strengths and resources

Current difficulties

- Identify what the individual feels are their main problems first
- Ask about problems associated with the identified traumatic event(s)
- Include information about re-experiencing (**trauma related** nightmares, flashbacks, intrusive memories), **trauma related** avoidance, increased arousal and alertness and perceptions of threat, emotion regulation difficulties, negative self-concept/ poor self-esteem, relationship difficulties.
- Ask about other common symptoms, including sleeping difficulties, chronic pain, depression, anxiety, panic disorder, self-harm, emotional numbing, detachment from others, dissociation
- Other comorbidities (e.g. psychotic symptoms, disordered eating)

PTSD and Complex PTSD assessment tools

International Trauma Questionnaire (ITQ)

Acta Psychiatrica Scandinavica

Original Article

The International Trauma Questionnaire: development of a self-report measure of ICD-11 PTSD and complex PTSD

M. Cloitre, M. Shevlin, C. R. Brewin, J. I. Bisson, N. P. Roberts, A. Maercker, T. Karatzias, P. Hyland

First published: 03 September 2018 | https://doi.org/10.1111/acps.12956 | Citations: 257

Available from: https://www.traumameasuresglobal.com/itq

PTSD items

	Not at all	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
P1. Having upsetting dreams that replay part of the experience or are clearly related to the experience?	0	1	2	3	4
P2. Having powerful images or memories that sometimes come into your mind in which you feel the experience is happening again in the here and now?	0	1	2	3	4
P3. Avoiding internal reminders of the experience (for example, thoughts, feelings, or physical sensations)?	0	1	2	3	4
P4. Avoiding external reminders of the experience (for example, people, places, conversations, objects, activities, or situations)?	0	1	2	3	4
P5. Being “super-alert”, watchful, or on guard?	0	1	2	3	4
P6. Feeling jumpy or easily startled?	0	1	2	3	4

DSO items

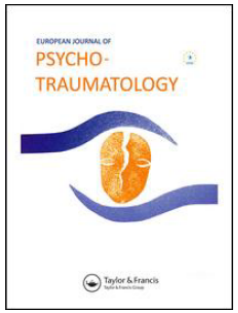
How true is this of you?	***Not at all***	***A little bit***	***Moderately***	***Quit a bit***	***Extreme***
C1. When I am upset, it takes me a long time to calm down.	0	1	2	3	4
C2. I feel numb or emotionally shut down.	0	1	2	3	4
C3. I feel like a failure.	0	1	2	3	4
C4. I feel worthless.	0	1	2	3	4
C5. I feel distant or cut off from people.	0	1	2	3	4
C6. I find it hard to stay emotionally close to people.	0	1	2	3	4

International Trauma Interview (ITI)

- Clinician administered measures considered to be the gold standard in PTSD assessment
- Roberts, Cloitre, Bisson & Brewin
  - Sweden, Lithuania, Chile, Denmark, Japan, Germany, Korea, Hungary, Portugal
- 18 item structured interview
- Assesses the 3 ICD-11 PTSD criteria (6 items) plus the 3 DSO criteria (6 items)
- For each symptom, standardized questions and probes are provided

- ITI PTSD symptom *severity* ratings are based on symptom ***frequency*** and ***intensity***
- ITI DSO symptom ratings are based on the presence of a **severe** and **persistent and pervasive pattern** of problems associated with the relevant item; and their **trauma relatedness**

ITI Evaluations

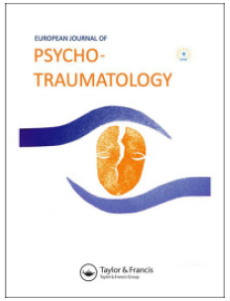


European Journal of Psychotraumatology

ISSN: 2000-8198 (Print) 2000-8066 (Online) Journal homepage: https://www.tandfonline.com/loi/zept20

Validation of a clinician-administered diagnostic measure of ICD-11 PTSD and Complex PTSD: the International Trauma Interview in a Swedish sample

Kristina Bondjers, Philip Hyland, Neil P. Roberts, Jonathan I. Bisson, Mimmie Willebrand & Filip K. Arnberg



European Journal of Psychotraumatology

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/zept20

Validation of the International Trauma Interview (ITI) for the Clinical Assessment of ICD-11 Posttraumatic Stress Disorder (PTSD) and Complex PTSD (CPTSD) in a Lithuanian Sample

Odeta Gelezelyte, Neil P. Roberts, Monika Kvedaraite, Jonathan I. Bisson, Chris R. Brewin, Marylene Cloitre, Agniete Kairyte, Thanos Karatzias, Mark Shevlin & Evaldas Kazlauskas

Item 1 – Nightmares

Recurrent distressing dreams in which the content and/or affect of the dream is related to the event(s). Nightmares should be accompanied by feelings of fear or horror (this is not necessary when dreams are associated with childhood sexual abuse).

In the past month, have you had any upsetting dreams that replay part of (EVENT) or are clearly related to (EVENT)? **Describe a typical dream. (What happens?)** [If not clear:] **(Do they wake you up?)** [If yes:] **(What do you experience when you wake up? How long does it take you to get back to sleep?)** [If reports not returning to sleep:] **(How much sleep do you lose?)** [If not clear:] **Do the dreams normally include feelings of fear or horror? Yes No** **How much do these dreams bother you?** Circle: Distress = Minimal Clearly Present Pronounced Extreme **How often have you had these dreams in the past month?** # of times _____ **Key rating dimensions = frequency / intensity of distress** **Moderate = distress clearly present, less than 1 hour sleep loss/ at least 2 X month** **Severe = pronounced distress, more than 1 hour sleep loss/ at least 2 X week**	**0 Absent** **1 Mild / subthreshold** **2 Moderate / threshold** **3 Severe / markedly elevated** **4 Extreme / incapacitating**

Item 7a Affect Dysregulation (Hyperactivation)

A severe and persistent pattern of problems regulating emotions characterized by heightened emotional reactions to minor stressors

i) When you are upset how easy is it for you to calm down? **Can you give me some examples of what makes you upset and how you react?** (Any other examples? Do other people notice when you are upset? What do they see?) [if not clear:] **How do you react when you have a minor argument or if you feel that you have made a mistake, are being misunderstood or criticized?** **Do you think that you find it harder to calm yourself than other people usually do?** [if not clear:] In what way do you think your reaction is different to that of other people? [if not clear:] **Typically, how long does it take you to calm down?** [if not clear:] **On average, how often do you react in these sorts of ways?**	0 1 2 3 4	**Describes a severe and persistent pattern of problems** **Not at all** **A little bit** **Moderately** **Very much** **Extremely**

Scoring guidance

- Moderately:
  - Describes the **presence** of a tendency to overreact to minor stressors, on average **at least on a weekly basis**. The individual's reaction is usually **prolonged** with **some difficulty calming down**. The problem has been present for about 3 months or more. The interviewee may be able to calm himself or herself relatively quickly some of the time.
- Very much:
  - A tendency to more **markedly overreact to minor stressors** (e.g. .become pre-occupied by thinking about the event, unable to complete goals or tasks, throwing things, upsetting others, extensive crying) and **typically takes more than an hour to calm down**. The interviewee has **difficulty calming** themselves **most of the time** and may require assistance from others. Incidents of overreaction typically occur at least **twice a week**, with at least one episode of marked overreaction.

Item 7b Affect Dysregulation (Deactivation)

A **persistent and pervasive pattern** of problems regulating emotions when confronted with minor stressors, characterized by a tendency towards emotional numbing or dissociation.

Do you often feel emotionally numb or shut down? **[if endorsed] What makes you feel numb or emotionally shut down? *Anything else?* [if the respondent only describes one situation] *Does this occur in a variety of situations? Like what?*** **[if not clear:] Can you give me some examples of what it's like when you are feeling that way?** **How often does this happen?** **[if not clear:] Would you say you get numb or emotionally shut down when you feel overwhelmed by difficult situations? [if not clear:] This might include situations where you get into an argument with someone or have a frightening thing happen you. It can also include circumstances that remind you of your trauma.** **Is it easy to bring yourself out of this state? [if not clear:] How do you bring yourself out of this state? How long does it take you to come out of this state?**		**Describes a severe and persistent pattern of problems** **0 Not at all** **1 A little bit** **2 Moderately** **3 Very much** **4 Extremely**

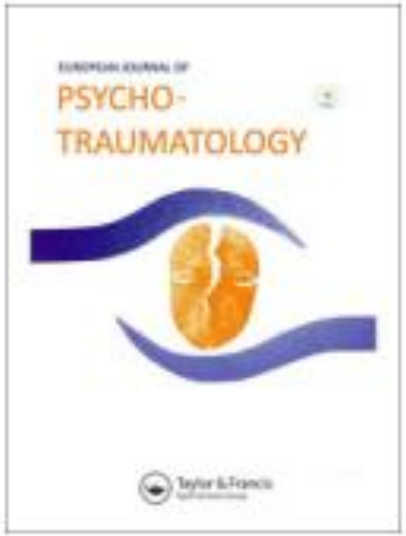
Scoring guidance

Moderately

- Describes the presence of a tendency to deactivate to minor or trauma related stressors, on average at least on a weekly basis, with deactivation being clearly present and lasting at least several minutes. The problem has been present for about 3 months or more.

Very much

- A tendency to more markedly deactivate to minor or trauma related stressors (e.g. become very disconnected from surroundings) and typically taking more than an hour to recover at least once a week on average. Episodes of deactivation typically occur at least twice a week.



Taylor & Francis
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European Journal of Psychotraumatology

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/zept20

A clinician rating to diagnose CPTSD according to ICD-11 and to evaluate CPTSD symptom severity: Complex PTSD Item Set additional to the CAPS (COPISAC)

Franziska Lechner-Meichsner & Regina Steil

https://www.tandfonline.com/doi/full/10.1080/20008198.2021.1891726

(CO3) Difficulties in sustaining relationships and in feeling close to others.

Do you have any close relationships? Can you tell me more about these relationships? [*If not clear*: Do you feel close to others?] How long do your relationships normally last? Do you have any relationships (like friendships and intimate relationships) that last for a long time or are your relationships fairly short? [*If not clear*: Do you feel that relationships are more difficult for you than for others?]	Persistent and pervasive problems 0 Absent 1 Mild/subthreshold 2 Moderate/threshold 3 Severe/markedly elevated 4 Extreme/incapacitating

Key rating dimensions

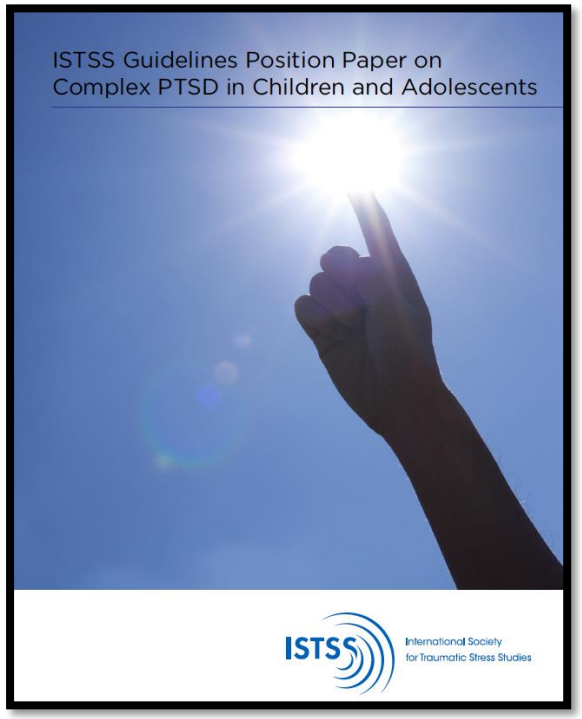
Moderate = difficulties to begin and sustain relationships some of the time, tendency to avoid or withdraw from relationships. Some emotionally close and trusting relationships exist.

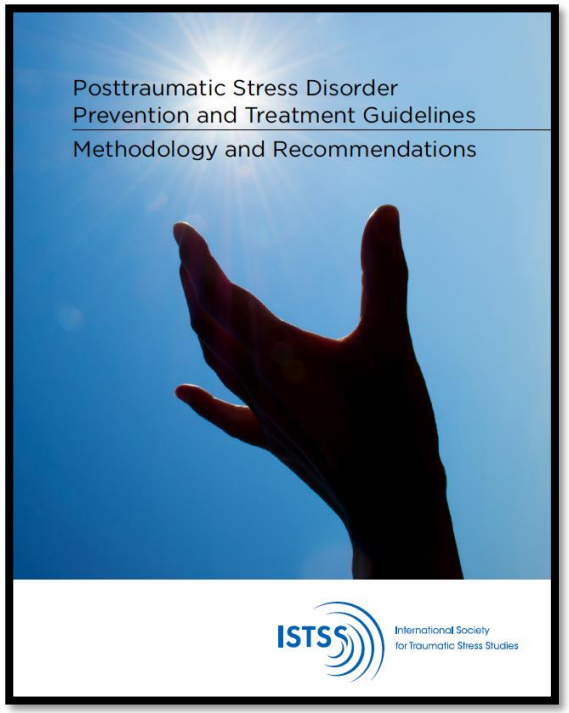
Severe = pronounced difficulties beginning and maintaining relationships most of the time. Relationships are generally avoided or broken off when intensive negative emotions arise.

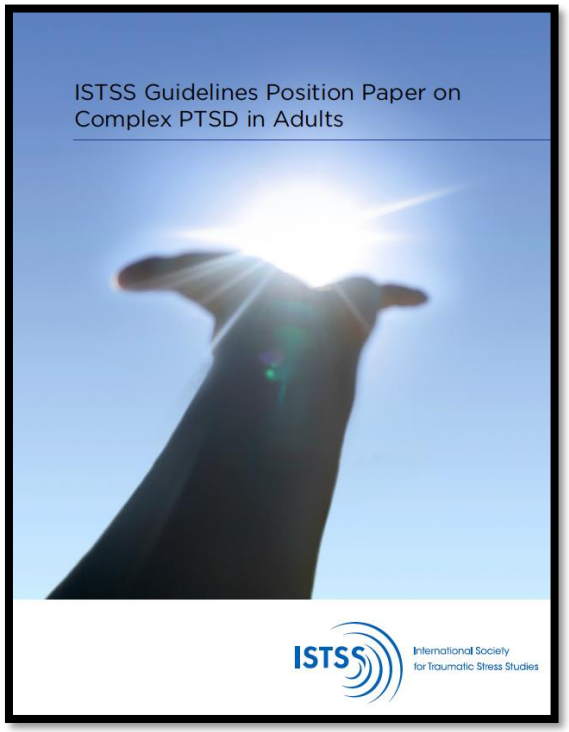
Treatment and management of complex PTSD

The evidence base

https://www.istss.org/treating-trauma.aspx







Management of complex PTSD

- Often involves greater diversity of treatment interventions
  - Psychoeducation
- Personalised and formulation-based care
- Co-produced management plan
- Multiagency, multidisciplinary
- Often requires longer duration of treatment
- Phased approach
  - Usually social, psychological and pharmacological elements
  - Need debated – emotion regulation

The Evidence Base

RESEARCH ARTICLE

Psychological and pharmacological interventions for posttraumatic stress disorder and comorbid mental health problems following complex traumatic events: Systematic review and component network meta-analysis

Peter A. Coventry[1,2]*, Nick Meader[1], Hollie Melton[1], Melanie Temple[3], Holly Dale[4], Kath Wright[1], Marylène Cloitre[5,6], Thanos Karatzias[7], Jonathan Bisson[8], Neil P. Roberts[8,9], Jennifer V. E. Brown[1,2], Corrado Barbui[10], Rachel Churchill[1], Karina Lovell[11], Dean McMillan[2,12], Simon Gilbody[2,12]

PLOS Medicine | https://doi.org/10.1371/journal.pmed.1003262 August 19, 2020

Coventry et al (2020)

- Complex traumatic events
  - Non-diagnostic approach
  - Multiple, prolonged, interpersonal
  - Veterans, refugees, victims of childhood abuse, domestic violence, war affected populations
- PTSD symptom reduction most common outcome
- 116 studies included
- 94 (n=6,158) RCTs in meta-analyses
- 47% military combat, 13% child sexual abuse
- Mean post-treatment follow-up 11.5 weeks
- Duration of treatment 7-18 hours input
- Network meta-analysis

Findings

- Psychological treatments are effective for treating PTSD, anxiety, and depression and improving sleep in people with a history of complex traumatic events.
- Pharmacological interventions were less effective than psychological interventions for treating PTSD symptoms and improving sleep.
- Trauma-focused treatments were the most effective approaches, but these treatments tended to be less effective in veterans and war-affected popular
- Multicomponent interventions that included two or more components were the most effective for treating PTSD symptoms, and these approaches were promising for the management of disturbances of self-organisation

- Psychological Medicine 2019, 49, 1761-1775

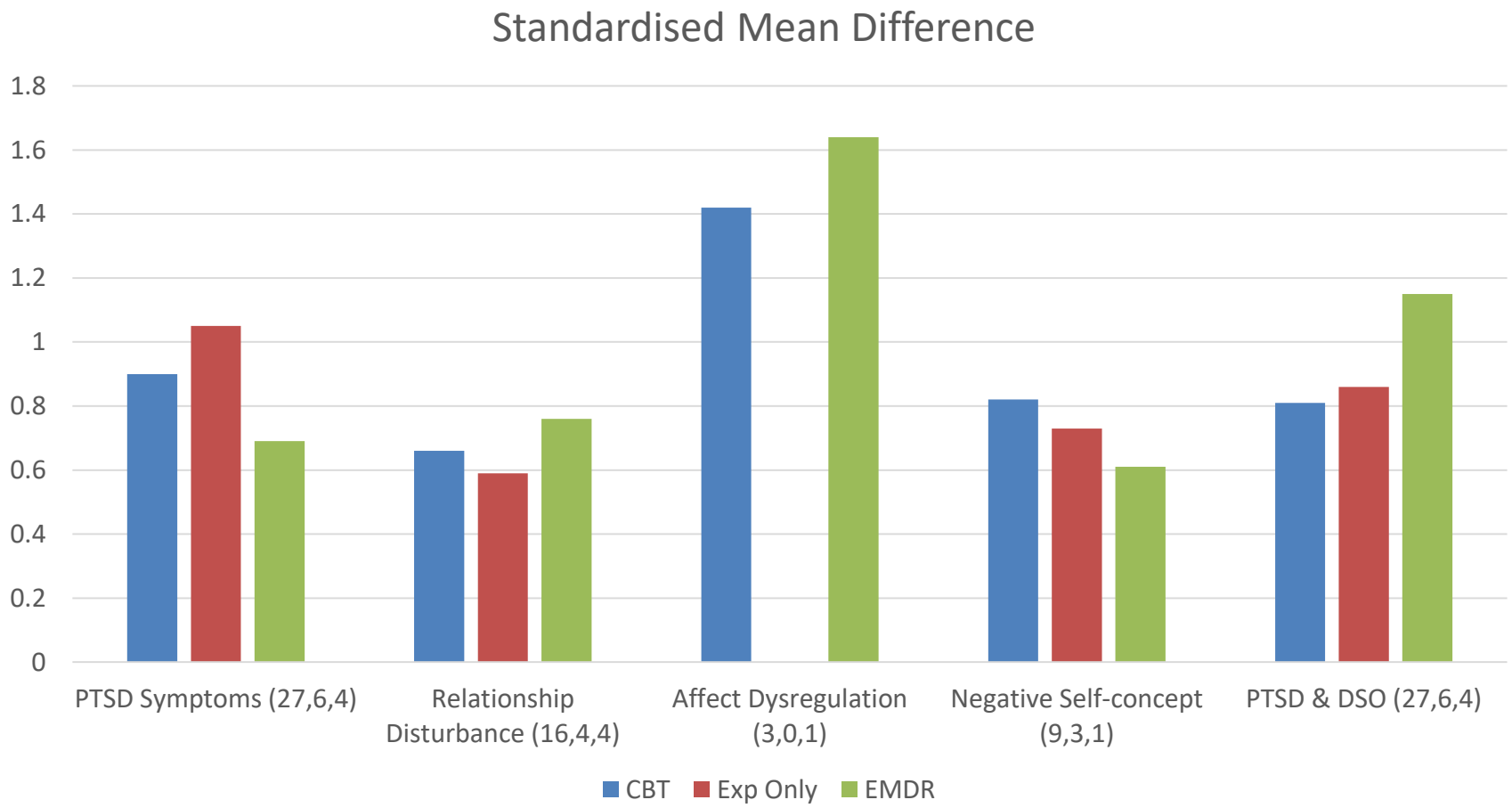
Psychological interventions for ICD-11 complex PTSD symptoms: systematic review and meta-analysis

Thanos Karatzias[1,2], Philip Murphy[1], Marylene Cloitre[3,4], Jonathan Bisson[5], Neil Roberts[5,6], Mark Shevlin[7], Philip Hyland[8], Andreas Maercker[9], Menachem Ben-Ezra[10], Peter Coventry[11], Susan Mason-Roberts[1], Aoife Bradley[1] and Paul Hutton[1]

Karatzias et al (2019)

- RCTs published to Jan 2018
- Psychological interventions only
- PTSD with likely clinically significant baseline DSO symptoms
- 51 RCTs included
- PTSD and DSO reductions as primary outcomes

Karatzias et al (2019)



Evidence Synthesis

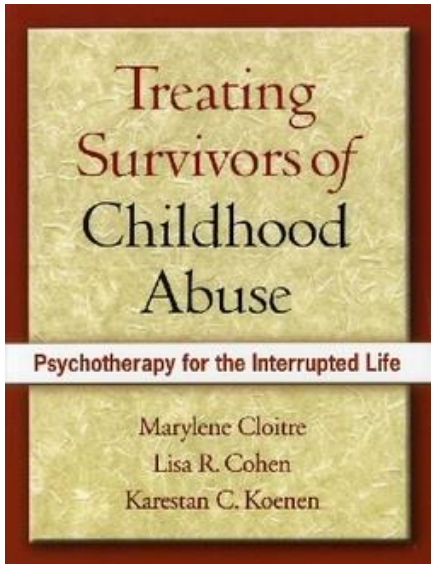
- Disturbances in Self Organisation
  - CBT-TF most effective for negative self-concept
  - Phase-based leading candidate for interpersonal problems
  - Few studies reported emotional dysregulation data
- Childhood-onset trauma was associated with a poorer outcome
- Recommend using TFPT and skills-based strategies in a flexible manner
- Important to think beyond PTSD alone
- Mindfulness and IPT promising results

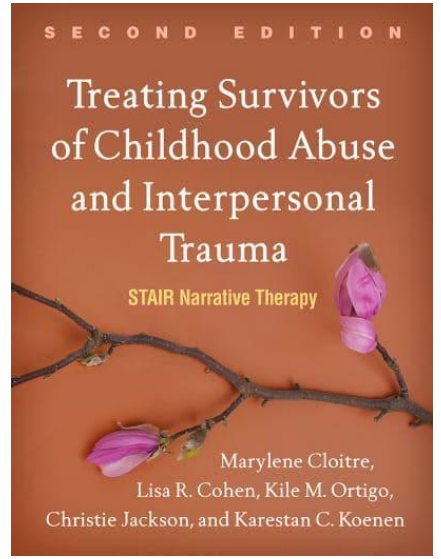
So where is the field going?

- No need for new interventions
- STAIR/ NST
  - ESTAIR
- DBT based approaches

STAIR Narrative Therapy

- A Phase-Based Treatment for the Multiply Traumatized
- Designed for women with PTSD related to childhood sexual abuse
- 8 x one hour of STAIR and NT with handouts & homework





Cloitre et al, 2002 & 2020

Skills Training in Affective and Interpersonal Regulation

- Derived from generic CBT and DBT
- Emotional awareness development
- Skills to regulate affect
- Learning how patterns learned in early relationships continue to guide current relationships
- How to use emotion regulation skills in relationships

- Randomised controlled trial evidence of effect

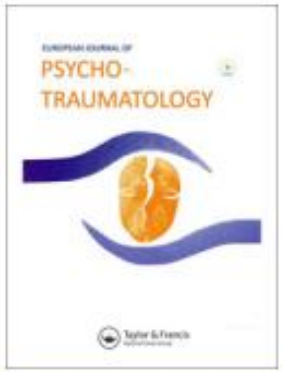
Cloitre et al, 2002 & 2020

Enhanced Skills Training in Affective and Interpersonal Regulation (ESTAIR)

- Developed for ICD-11 Complex PTSD
- Phased multicomponent approach
- Recognises the importance of symptoms or problems can vary greatly between people with CPTSD
- Self concept module added based on CFT
- Allows interventions to be tailored to specific individual needs
- 25 one-hour sessions
  - Formulation Session
  - Four modules of six sessions

Cloitre M, Karatzias T & McGlanachy E (2019)

But … a word of caution



European Journal of Psychotraumatology

2021

N=149

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/zept20

Effect of Prolonged Exposure, intensified Prolonged Exposure and STAIR+Prolonged Exposure in patients with PTSD related to childhood abuse: a randomized controlled trial

Danielle A. C. Oprel, Chris M. Hoeboer, Maartje Schoorl, Rianne A. de Kleine, Marylene Cloitre, Ingrid G. Wigard, Agnes van Minnen & Willem van der Does

DBT for PTSD

JAMA Psychiatry | Original Investigation

Dialectical Behavior Therapy for Posttraumatic Stress Disorder (DBT-PTSD) Compared With Cognitive Processing Therapy (CPT) in Complex Presentations of PTSD in Women Survivors of Childhood Abuse

A Randomized Clinical Trial

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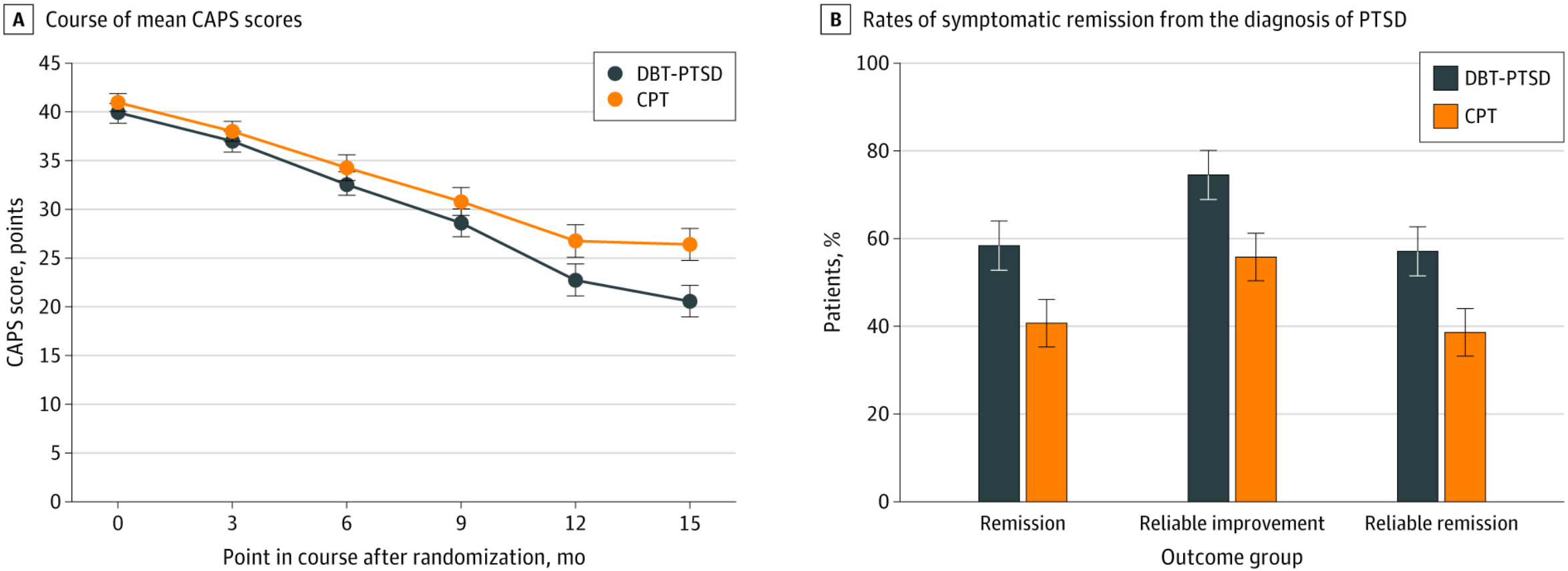

A
Course of mean CAPS scores
DBT-PTSD
CPT
CAPS score, points
45
40
35
30
25
20
15
10
5
0
0
3
6
9
12
15
Point in course after randomization, mo
B
Rates of symptomatic remission from the diagnosis of PTSD
DBT-PTSD
CPT
Patients, %
100
80
60
40
20
0
Remission
Reliable improvement
Reliable remission
Outcome group

Ongoing questions

- Multimodal/ multicomponent vs uni-modal approaches
- Duration of treatment
- Fixed sequencing vs flexible delivery
- Guided self help based approaches

Intervention principles

Small group exercise

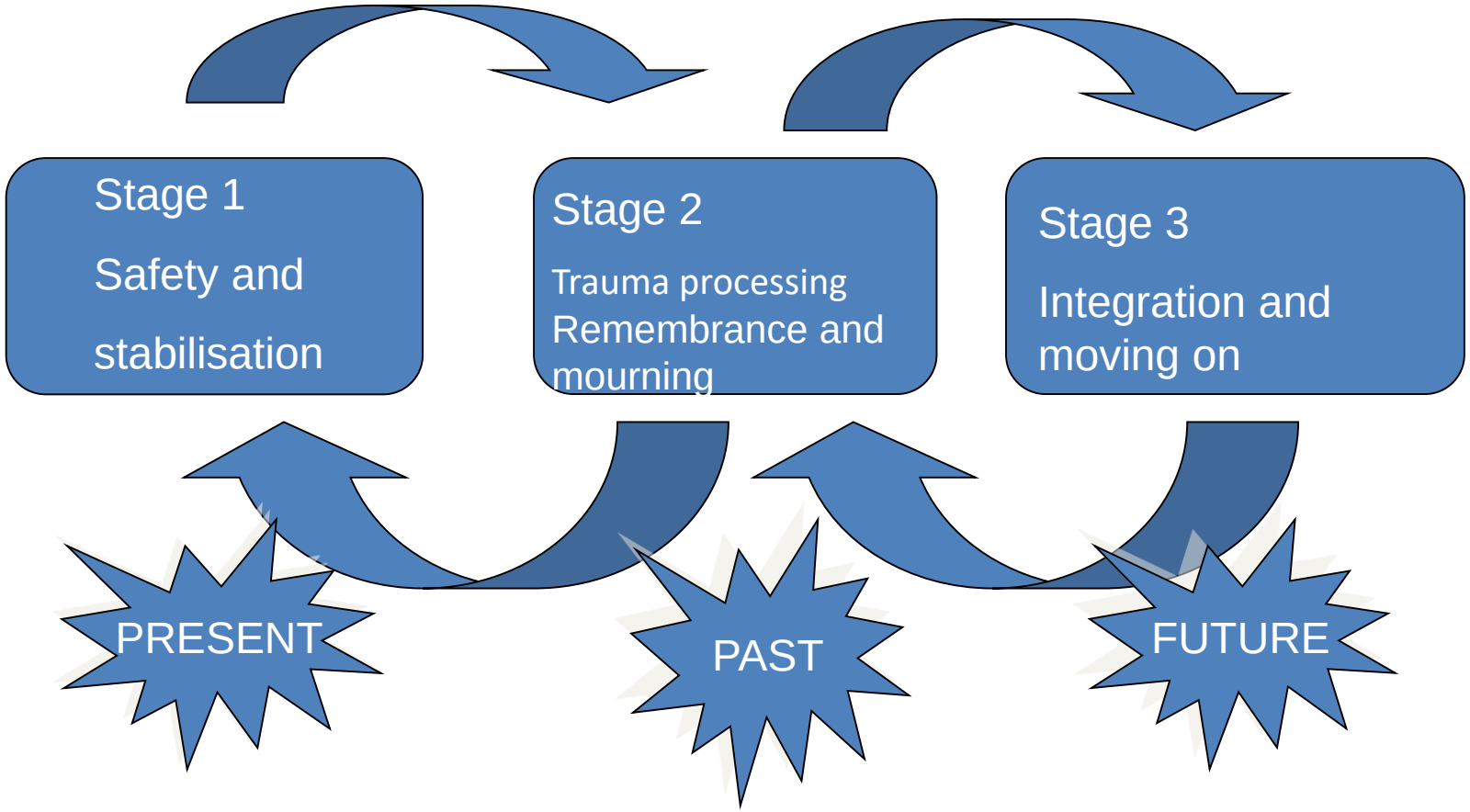
- In 2s or 3s
- What principles should guide intervention planning for someone with complex PTSD?

Guideline for the treatment and planning of services for complex post-traumatic stress disorder in adults

- Awareness of possible difficulties with trust
- Gender preferences
- Awareness of the risks of dissociation and consideration of possible management plan
- Consider the need for safety and stabilisation work before trauma processing

Phased Intervention Model

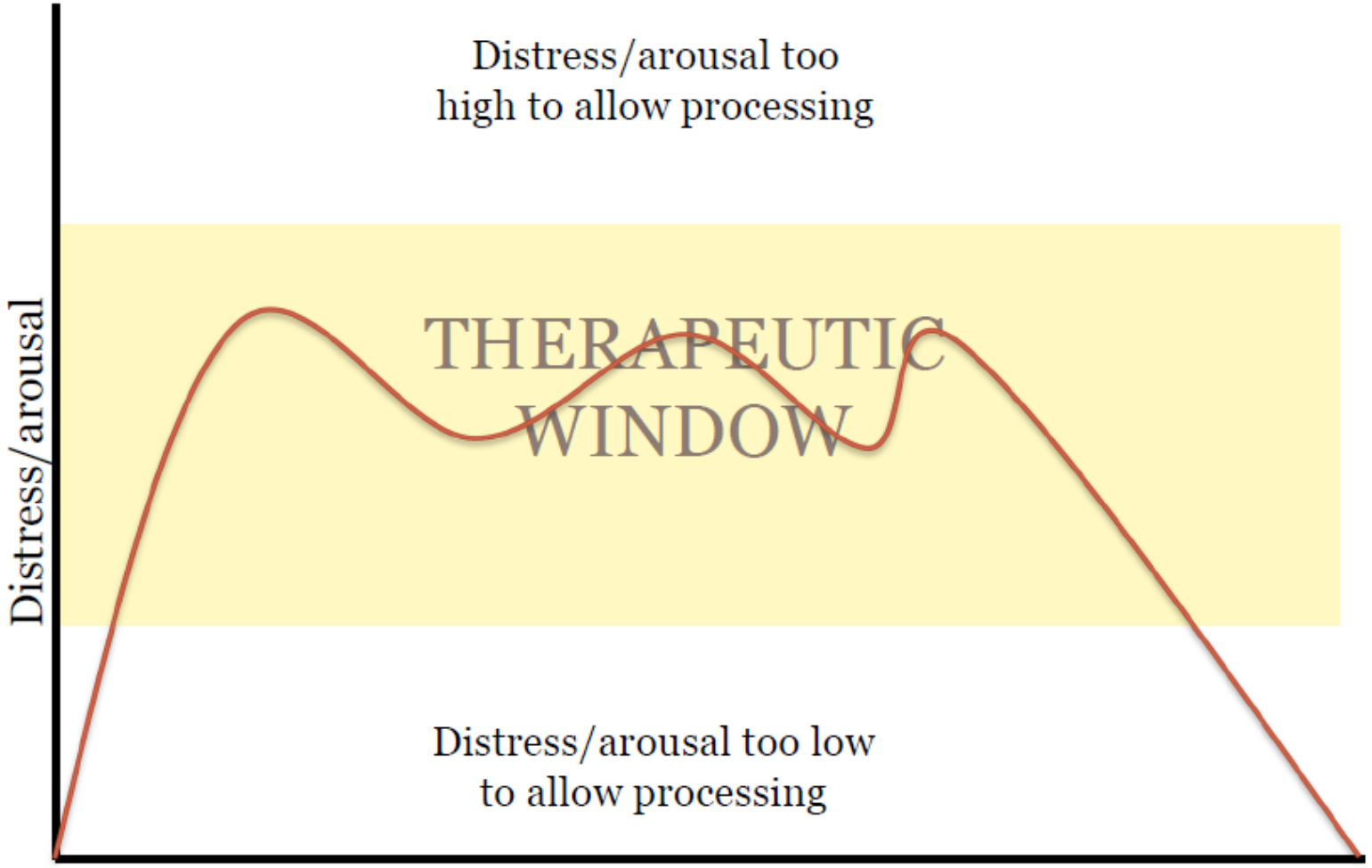
(Herman 1992)



Possible stage 1 considerations: Establishing emotional stability, safety and readiness for therapy

- Is the trauma passed?
- Risk behaviours
  - Emotion regulation work
- Establishing a therapeutic relationship and creating hope
- Psychoeducation
  - models of simple PTSD and how multiple trauma complicates presentation (memory models)
  - explaining the impact of developmental trauma
  - explaining windows of tolerance (level of arousal tolerable to client)
  - explaining dissociation
  - explaining symptoms and emotional responses
- Grounding and stimulus discrimination training
- Management of:
  - Mood, sleep, nightmares, panic, pain
- Compassion focused intervention
- EMDR resource building
- Need for medication?

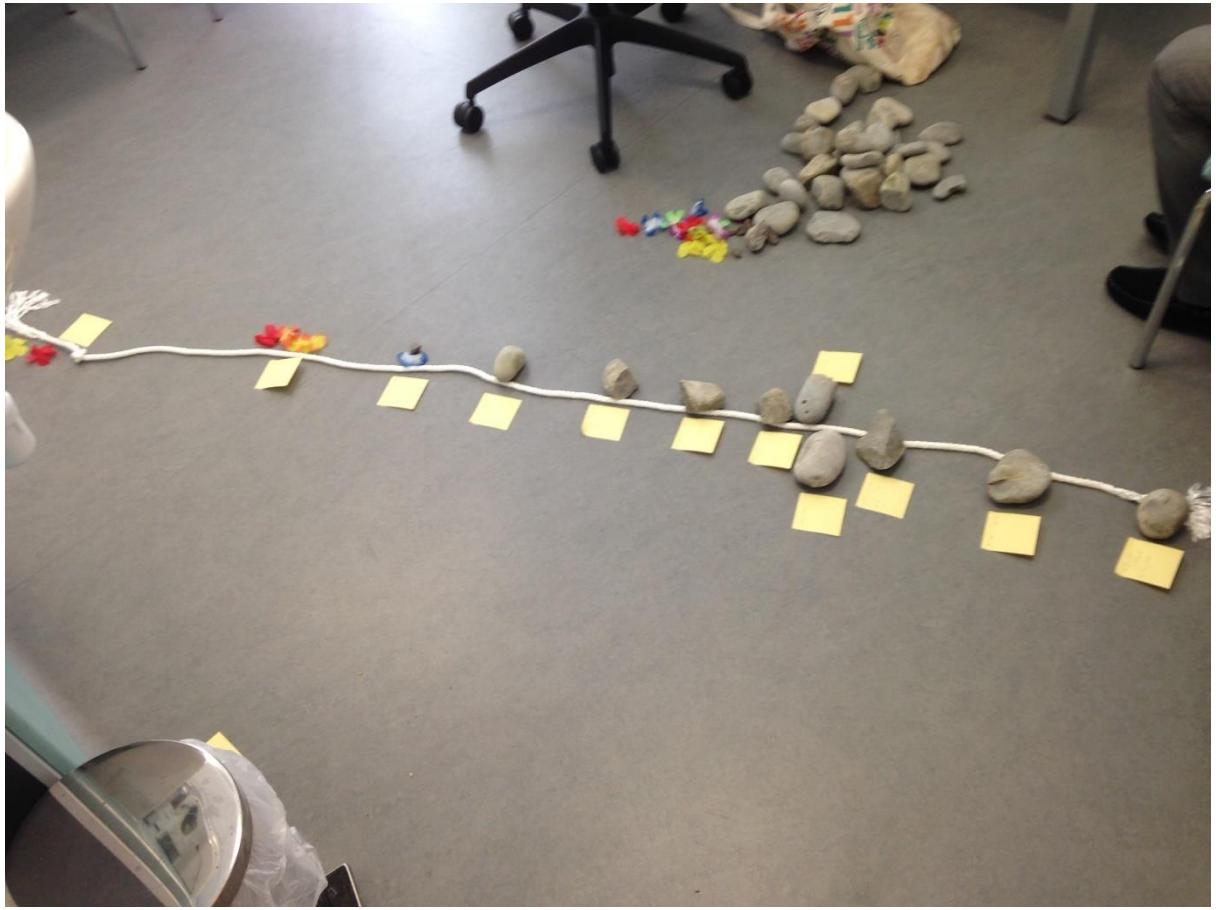
Window of tolerance

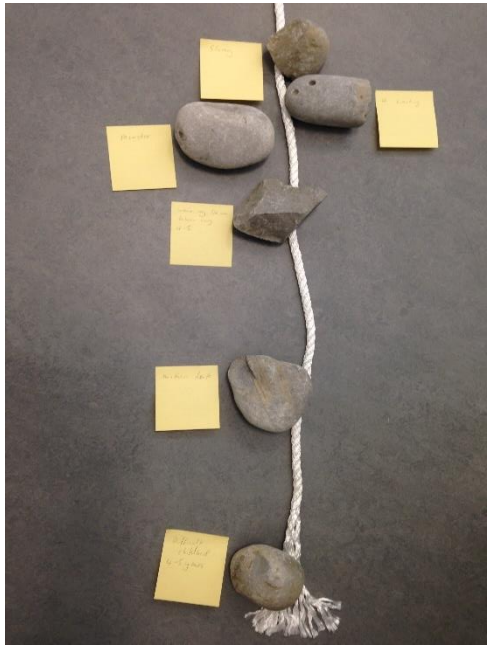


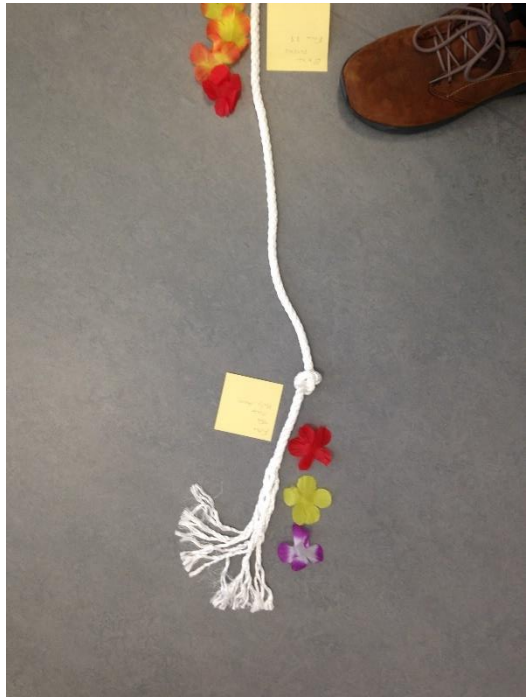
Stage 2: Trauma processing

- Time line?
  - Stones and flowers
- Where to start?
  - Target events related to reexperiencing
  - First, worst, typical, last, a more manageable event??
- EMDR or TF-CBT
- Staying within the therapeutic window
  - Modulating exposure
- Imaginal exposure vs written narrative
- Focus on underlying meanings and schemas
- Connecting multiple memories into a coherent narrative
- Imagery rescripting

Stones and flowers: David







Stage 3: Integration and moving forward

- Reclaiming your life and goals setting work can begin early
- Behavioural experiments
- Therapist as cheer leader
- Goals may change
- Connection and reconnection
- Some people may not previously have had a positive past world to return to

Supervision

Thank you

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