UNC-CH School of Social Work
Clinical Lecture Series

# Treatment of Complex Trauma

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## What is Complex Trauma/PTSD

- It is not a diagnostic category recognized by the DSM or ICD systems
- Was coined by clinicians to reflect individuals who have compounded traumatic experiences

## What Contributes to Complex Trauma/PTSD

- Repetitive or prolonged trauma (cumulative ) occurring over long periods
- Can involve harm and abandonment
- Can occur at any age but often occurs during critical phases of childhood development when brain development is rapidly occurring or consolidating
- Most often perpetrated by caregivers and other adults charged with creating, stable, safe and secure environment for child

Lawson, Davis, Brandon, & Austin, 2013; Litt, 2013; Williams, 2006

## Examples of Complex Trauma Components

- Emotional
- Physical
- Sexual
- Neglect
- Witnessing family violence
- Human trafficking
- POW
- Child soldiers in war zones

## Typical Symptoms of Complex Trauma

- Decreased capacity for emotional regulation
- Altered self-perception
- Altered perception of the perpetrator
- Alterations in perceptions of others

## Impact of Context in which Complex Trauma Occurs

- Trauma occurring in context of caregiver system has more severe and profound effects—
  - Lack of sense of integrity—seeing self as "bad"
  - Self harm
  - Social isolation
  - Aggression
  - Dissociation
  - Interpersonal problems

## Consequences of Complex Trauma

- Impact biological and psychological systems (i.e., assaults body and mind)
- Coping strategies (defense mechanisms) are overwhelmed
  - Information coded in a manner that impacts cognition
    - Recall becomes both intrusive and fragmented—some memories refuse to disappear and others are fragmented and disjointed
  - Splitting, where self is reorganized to survive abuse
    - Decreases cohesion in self and in relationship with others
  - Removes baseline of physical calm or sense of comfort
- Reduces functioning in the left brain whose responsibility is analytical—helps to organize information (including emotional ones) in meaningful ways (i.e., modulation of affect)

## Client Presentation

- Client's sometimes do not present trauma information for several reasons
  - May not even recognize that what they experienced was traumatic (has been part of everyday life so considered "normal")
  - Unsure whether they can trust the clinician with such information
  - Not believing they can tolerate the pain and discomfort of talking about the trauma
  - Client might not think it is relevant since it happened so many years ago
  - Possible that although client presents with trauma-related symptoms they have no memory of it

## Client Presentation–Substance Use

- Clients substance use can be challenging
  - Especially if it is at borderline clinical levels or above
  - Consider that substance use might even include misuse of food
  - Substance use might have been part of the traumatization ritual (e.g., user given substances to make them more vulnerable)
  - Can also put client at greater risk for further victimization retraumatization (e.g., client going to dangerous places to obtain substances or engaging in destructive relationships to do the same)
- Client may use substances as their only means of coping—typically to manage emotionally difficult emotions and situations
  - Stimulants may be used against numbing
  - Alcohol and barbiturates for hyperarousal
  - Albeit for self-medicating purposes, substance use might take on a life of its own and require intervention

## Broad Treatment Goals

- Repairing the alliance—therapist provides a safe, consistent, and caring relationship
  - Parallels healthy attachment between parent and child
  - Permits client to alter ingrained relationship patterns
    - Insecurity
    - Mistrust
    - Manipulation

## Conceptual Model

- A meta model that irrespective of theoretical model used, generally follows a specific and careful sequence where each step builds on the other
  - Does not prescribe/mandate particular interventions but serves as a general guideline that emphasizes safety, security, and affect modulation as core principles
- Some clients can be done with Tx in this meta model in 6 to 12 months. Others require, months, years and even decades of Tx.

## Stages of the Meta Model

- Emerged from Herman's (1992) work
- Herman cautions that these are a "convenient fiction" and a means of bringing simple order to a complex issue.

## Stage 1

- Pretreatment (not focused on trauma narrative work)
  - Safety (may be long and arduous)
  - Including alliance building , sense of safety in the therapeutic environment, affect modulation, stabilization, psychoeducation, and skill building
  - Helping client gain control over impulsiveness, dangerous interpersonal situations, addiction, dissociation
  - Client learning self Care

## Stage 2

- Deconditioning
- Grief work (grieving what was lost)
- Resolution and integration of trauma
- Trauma narrative explored
- Gradual (not prolonged) exposure (calibrated to not totally overwhelm client)
- Narrative (story telling) encouraged

## The Therapists Role in Stage 2

- Be a guide and a coach on road back to health with guideposts that enable client to develop transformed and meaningful narrative
  - Helping client return from the isolation of trauma-related suffering to develop trust and empowerment via the therapeutic relationship

## Stage 3

- Self and relational development
  - Addressing unresolved developmental deficits
  - Developing trustworthy relationships, intimacy, sexual functioning, and parenting

## Treatment Process

- Broadly speaking Tx includes psychotherapy often supplemented by psychopharmacology
  - Psychopharmacology helpful in Tx of PTSD symptoms, depression anxiety, OCD, psychosis
- Trauma-focused cognitive behavior therapy (TF-CBT) has most empirical substantiation for treating classic forms of trauma—although sparse, recent studies have begun to show effectiveness for complex trauma

Courtois (2008)

## Treatment Types

- Typically either prolonged exposure (PE) or narrative exposure therapy (NET).
- Both PE and NET similar except that NET is designed for refugees who have experienced multiple traumas—its main focus is on narration (much newer than PE—hence less research conducted that supports its use)
- This presentation briefly details PE

## PE Treatment

- Focuses on the worst trauma recalled—with understanding that lessons learned can be applied to others (does not always work since what client thinks might be the worst could be relatively mild compared to unrecalled memories of even more traumatic experiences)
- Sessions are about 90 minutes long and sessions are often 10 to 15
- Use of audio recording that client listens to before the next session
- Proceeds in the order of assessment, psychoeducation, and exposure
  - Psychoeducation
    - Helping client learn that the symptoms they present are common responses to traumatic experience
    - Instilling hope that psychotherapy can be effective in relieving symptoms

## PE Treatment-Exposure

- Imaginal or in vivo—permits habituation and extinction
  - Designed to elicit anxiety (can be exacerbated and become overwhelming in first few sessions)
  - Providing a corrective information and experience when fear structure is activated
  - Includes breathing retraining to help client reduce anxiety (emphasis on exhaling slowly to reduce tension and distress—results in fear reduction)

## Challenges Trauma Therapists Face

- The dysregulated client—difficulty managing emotions within and/or outside the therapy room-reduces their chances of successful functioning in the world
  - Therapist might provide client with coping strategies—can be done in individual Tx or in groups (e.g., DBT groups)
- Substance abusing client
  - Alcohol and other types of abuse might be too complex for our ambulatory care and detox hospitalizations might be indicated
  - Belief that treatment of trauma might reduce or remove substances might be inaccurate—clients might need referral to an outpatient specialist but trauma therapist should still discuss substance use in treatment
  - It is also a myth that the clinician should refrain from therapy until the client is "clean"
- Must the client always address the trauma event(s)?
  - Not always—some clients can still receive benefit form therapy without ever directly addressing the actual trauma event(s)

## Challenges–Vicarious Traumatization—Risk Factors

- Therapists own trauma Hx (60% of trauma therapists report own trauma Hx, 83% of female trauma therapists report ≥ 1 trauma-based victimization)
- Therapist hears distressing narratives which increases the chance of vicarious traumatization (VT)
  - Emerges from cumulative empathetic engagement with traumatized individuals
    - Can result in subclinical levels of PTSD
  - Challenges therapists perception of reality resulting distorted and irrational perceptions
    - Therapist can begin to see world as a dangerous place

McCormack & Adams (2015)

## Preventing and Counteracting Vicarious Traumatization

- Have a diverse caseload with a relatively small number of trauma cases in general and even fewer complex trauma cases
- Revisit why you became a therapist—i.e., what attracted you to the field in the first place
- Remember that many people we work with including those with complex trauma do heal and get better.
- Remember to leave it at the office but recognize that you are human and that occasionally cases you work with might follow you home
- Do not forget to reconnect with family and friends after work