UNC CHAPEL HILL SCHOOOL OF SOCIAL WORK
CLINCAL LECTURE SERIES

PTSD in Complex Trauma: Assessment and Evidence-Based Approaches

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Defining Complex Trauma

- Chronic, early, and interpersonal traumatization
  - Harmed by primary caregivers or attachment figures, and/or
  - Lives involve ongoing traumatic exposure (e.g., war and genocide, refugee status, human trafficking and prostitution)
  - Medical events? One time, particularly tragic events? Neglect?

Complex Trauma: Attachment & Learning

- Self-regulation
  - Lack of modeling
  - Lack of direct teaching
  - Oversimplification of problem solving
  - Experience of agency
- Problematic contingencies
- Problematic learning about attachment and social development

Complex Trauma: Biology

- Structural and Functional Brain Differences
  - Neuroendocrine dysregulation; reduction in hippocampal, amygdala, and prefrontal cortex volume; and decrease in corpus callosum size
  - Trauma exposure affects brain development differentially depending on what region of the brain is developing most actively when the trauma occurs
- Secure attachment promotes development of brain structures critical for the regulation of stress (i.e., hypothalamic-pituitary-adrenal axis)

A word on the literature…

- Original PTSD criteria based on male combatants returning from war
  - Not generalizable
- Not diagnosable in DSM-5
  - DSM-5 criteria expanded specifically to address CPTSD presentations
- Currently diagnosable via ICD-11
  - Different diagnostic framework for PTSD/Complex PTSD
- Research efforts hampered by:
  - Mixed definitions
  - Diversity of outcomes
  - Symptom crossover

Assessment of Complex Trauma

- Criterion A trauma:
  Exposure (direct experience, witnessing, learning a close friend/family, extreme/repeated exposure via job) to:
  - actual or threatened death,
  - serious injury, or
  - sexual violence
  - …an argument for neglect and/or households with chaos d/t SUD, SMI, etc.
- Key points:
  - Must ask!
  - Must be behaviorally specific (unwanted sexual contact vs. rape)
  - Be collaborative, respect limits, offer options
  - Reassess further into treatment

Potential Assessment Measures

- Life Experiences Questionnaire, 5th Ed. (LEC-5)
- Trauma History Questionnaire (multiple languages)
- Trauma History Screen
- ACE Questionnaire*

Assessing for "Complex" Symptoms

(Coutois, 2008)

1. Emotion dysregulation **(ER)**
2. Alterations in attention and consciousness **(A/C)**
3. Alterations in relationships with others **(REL)**
4. Somatization and medical problems **(SOM)**
5. Alterations in systems of meaning **(MEAN)**
   - ✓ Self-perception
   - ✓ Perception of the perpetrator
   - ✓ Other

**Overreliance on avoidance; perceptual disturbance (A/C?)

ASSESSMENT TOOLS

- High endorsement across multiple symptom measures
- Difficulties with Emotion Regulation Scale
- Dissociative Experiences Measure, Oxford (Cognitive)
- SHUT-D scale (Somatization/Dissociation)
- Medical Records Review

Establishing a PTSD Diagnosis

1+ Intrusion symptoms

- Thoughts/memories
  - Often less prevalent d/t extreme avoidance
- Nightmares
  - More likely to be vague combinations of past experiences
- Flashbacks **(A/C)**
- Intense emotional distress to trauma-related stimuli (**REL**, **ER**)
- Intense physiological distress to trauma-related stimuli (**SOM**)

**Must consider type of trauma for context of possible cues
**Ask what happens if they STOP avoiding (sick, out of work)

1+ Avoidance

- Efforts to avoid distressing memories, thoughts, or feelings:
  - "Locking away"
  - Dissociation
  - Overscheduling self, distraction techniques, fostering of mindlessness?
- Efforts to avoid external reminders (people, places, conversations, activities, objects, situations)
  - Does not include perpetrators or other objectively unsafe stimuli
  - Assessment:
    - What things would they be doing if not plagued by fear, shame, etc.?
    - What things do they "white knuckle" through?
    - Magic wand question?

2+ Alterations in Mood/Cognition

- Inability to remember important aspects of trauma **(A/C)**
- Persistent, extreme negative beliefs about self, others, word **(MEAN)**
- Distortions about cause of trauma (blame of self or others) **(MEAN)**
- Persistent negative emotional state **(ER)**
- Diminished interest or participation in activities
- Detachment/estrangement from others **(REL)**
- Inability to experience positive emotions **(ER)**

ASSESSMENT TOOLS

- PTSD Checklist, 5th Edition

You can download PTSD Checklist for *DSM-5* (PCL-5) at **www.ptsd.va.gov** website: PCL-5 (PDF) | PCL-5 with Criterion A (PDF) | PCL-5 with LEC-5 and Criterion A (PDF)

*Developed by staff at VA's National Center for PTSD and is in the public domain and not copyrighted. In accordance with the American Psychological Association's ethical guidelines, this instrument is intended for use by qualified health professionals and researchers.

https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp#obtain

A word on risk assessment…

- Suicidality
- Homicidality
- NSSI
- High risk situations
- Sexual behaviors
- Aggression (IPV, child abuse)
- IPV

TREATMENT OPTIONS

- For folks who exhibit marked skill deficits, most experts agree on a phase based approach
  - DBT/PE
  - STAIR/NST
  - Informal skills building/PE or CPT
- Prolonged Exposure
- Cognitive Processing Therapy

TREATMENT THEMES

- Skills phase?
  - Emotional regulation
  - Behavioral regulation
  - Interpersonal regulation
- Trauma Phase
  - Emotional approach/engagement
    - Minimizing avoidance
  - Trauma narrative/impact/meaning
  - Challenging unhelpful and inaccurate cognitions

Dialectical Behavior Therapy (DBT)- Marsha Linehan

- A higher level of therapeutic intervention for individuals with chronic, pervasive difficulties with emotional, interpersonal, and behavioral dysregulation
  - Treatment resistance
- Includes:
  - Individual therapy
  - Weekly skills training group
  - Phone coaching
  - Peer consultation group

DBT continued…

- Phase based (up to 4 phases)
  - 1st phase: skills acquisition, reduction of behaviors which interfere with life, therapy, and quality of life
    - Skills Group
      - Mindfulness
      - Distress Tolerance
      - Emotion Regulation
      - Interpersonal Effectiveness
    - Individual
      - Insight and self-monitoring
      - Identification of common controlling variables
      - Application of skills to unique situation
  - 2nd phase: trauma-focused work (most often PE)

Prolonged Exposure (PE)- Edna Foa

- 8-16 session treatment, 60-90 minutes
- Exposure as main mechanism of action
  - Psychoeducation
  - In vivo exposure
    - Trauma stimuli/cues
    - Activities avoided or endured (that are meaningful to goals/life)
    - Previously enjoyed (or desired) activities
  - Imaginal (narrative exposure)
    - Index or representative trauma
      - Occasionally, will do more than one round, if traumas have markedly different themes
    - Processing (learning consolidation)

Cognitive Processing Therapy (CPT)- Patty Resnick

(12 sessions, 60 minutes)

- Treatment components:
  - Psychoeducation
  - Impact statement
  - Identification of "stuck points"
  - +/- written trauma narrative
  - ABC worksheets
  - Patterns of Problematic Thinking
  - Challenging Questions
- Trauma modules:
  - Safety
  - Trust
  - Power/Control
  - Esteem
  - Intimacy
- Final impact statement

Skills Training in Affective and Interpersonal Regulation and Narrative Story Telling (STAIR/NST) - Marylene Cloitre

- Phase Based, Phase 1:
  - Affect Regulation
    - Emotion identification
    - Basic emotion regulation strategies
    - Emotionally engaged living (goal setting, pros/cons, acceptance of negative affect)
  - Interpersonal Regulation:
    - Identification of relationship patterns, interpersonal schemas
    - Revision of expectations via cognitive challenging and behavioral experiments
    - Psychoeducation of basic personal rights
    - Assertiveness skills

STAIR/NST

- Narrative Story Telling (Similar to Prolonged Exposure)
  - Trauma hierarchy
  - Narrative exposure
  - Exploration of meaning/impact/self-conceptualization
  - Identification of interpersonal schemas, which guide behavioral experiments

*** Dismantling studies

How do I choose?

- Dialectical Behavior Therapy
  - Suicidality/homicidality
  - High risk behaviors (to self or others)
  - Ongoing engagement in abusive environment
  - Treatment interfering behaviors
  - Previous treatment resistance or failed trials of therapy
  - Minimal assertiveness/coping skills

**Once stability is attained, move to stage 2 (trauma-focused)

How do I choose?

- STAIR/NST
  - Clear, impairing skills deficits
    - Could this person do interpersonally based exposures?
    - Could this person tolerate emotions brought on by exposures?
    - Does this person have a solid understanding of their rights in relationships?
  - Low to moderate levels of SI, risk taking, etc.
  - Low buy-in, high concern for drop out
  - Unsafe environment
  - Wide array of trauma experiences and themes (which are unlikely to be captured by a single index trauma)

How do I choose?

- PE or CPT vs. Phase based
  - Moderate to high levels of
    - Emotional Awareness
    - Insight
    - Willingness to trust/rapport
    - Regulation skills
    - Assertiveness skills
  - No active mania or psychosis
    - Primary dx of schizophrenia or bipolar is ABSOLUTELY FINE!
  - Environment is safe and relatively stable
  - Evidence of PTSD or Other Trauma/Stressor Related Disorder

How do I choose?

- Prolonged Exposure
  - High levels of dissociation
  - Historically high levels of invalidation
  - Some memory of the trauma (or, if organic memory loss, the aftermath)
  - High levels of avoidance
    - Emotional
    - Memory
    - Activities
    - Over-intellectualization

How do I chose?

- Cognitive Processing Therapy
  - Minimal trauma-related memory
  - Unwillingness to do exposure
  - Strong symptom focus on negative beliefs
    - Environment which can support challenging negative beliefs

Is this person:	
Engaging in high risk behaviors? (especially those which put them at risk for re-victimization or arrest)	**DBT**
High safety risk? (chronic or passive SI does not count, nor does chronic or passive HI towards perpetrator)	**DBT**
Notable treatment interfering behaviors, numerous failed psychotherapy trials?	**DBT**
Have severe skills deficits? (complete avoidance and unwillingness to change behavior)	**DBT**
Living in an abusive environment?	**DBT or STAIR**

Living with previous perpetrators? (who are no longer perpetrating physical/sexual abuse)	**DBT or STAIR**
Have low to moderate skills deficits?	**STAIR/NST**
Have minimal knowledge of personal rights, healthy relationship functioning?	**STAIR/NST**
Low ability to intentionally use coping skills?	**DBT or STAIR**
Low insight into relationship patterns?	**DBT, STAIR, CPT**

Primary issues with avoidance? (either memory/emotional or external reminders)	**PE**
Primary issues with unhelpful cognitions, low avoidance?	**CPT**
High levels of dissociation?	**DBT, STAIR, PE**
High levels of intellectualization/emotional avoidance?	**PE**
Minimal memory of trauma event(s)?	**CPT**
Willing to do the treatment?	whichever
Consider goals. (stop beating myself up versus engage with my child)	whichever