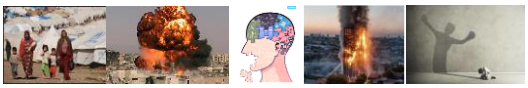
1

Working with complicated and Complex PTSD

Kerry Young[1,2]
Bespoke Mental Health February 2022

[1] Woodfield Trauma Service, London
[2] Oxford Rose Clinic, John Radcliffe Hospital, Oxford



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About Kerry Young

- Clinical psychologist since 1994
- Worked in specialist traumatic stress services since 1997
- Currently Clinical Lead, Woodfield Trauma Service, London UK (Refugee PTSD) and Oxford Rose Clinic (FGM)
- Sidelines:
  - Haven Paddington (NHS/police sexual assault referral centre)
  - Department Psychiatry, Oxford University developing imagery-based interventions for Bipolar population
  - Grenfell Health and Wellbeing Service
  - Lóa Project (remote, scalable interventions for PTSD; UK, Iceland, Sweden)
- Advise UK government on treatment services for refugees, co-designed national IAPT training for working with PTSD, Complex PTSD and refugees and asylum seekers

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Woodfield Trauma Service (WTS)

Central and North West London NHS Foundation Trust

National Health Service trauma service for refugees and asylum seekers suffering with Post-traumatic Stress Disorder (PTSD)

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Timings

9.30-10.30 teaching
10.30-10.45 break
10.45-11.45 teaching
11.45-12.00 break
12.00-13.00 teaching
13.00-14.00 break
14.00-15.00 teaching
15.00-15.15 break
15.15-16.30 teaching

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Plan

- Introduction to complicated/Complex PTSD presentations.
- Clinical pathway to follow:
  - How to assess and formulate more complicated/Complex PTSD
  - What to consider and what to do about difficulties with engagement
  - What to consider and what to do about difficulties with emotional regulation
  - How to understand and manage dissociation in this group
  - How to treat complicated/Complex PTSD using Ehlers et al's tCT-PTSD as a guiding framework
  - How to work with some of the themes common in complicated/Complex PTSD e.g. shame, guilt, loss, contamination

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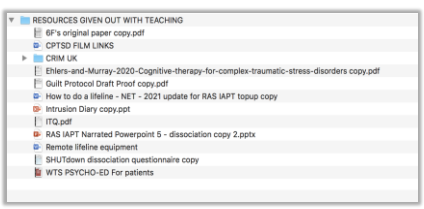
Resources folder



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First of all…..

Most of clinical examples drawn from my work with refugees, but equally applicable to adult survivors, veterans, DV..

Stuff we talk about quite easily may be upsetting for some/all of you. Please turn off/walk away as you need to

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So what is different for more complex cases?

Really important message:

- To treat more complex PTSD cases DO NOT THROW THE BABY OUT WITH THE BATH WATER
- Use the same model and flex it
- The same techniques are required for PTSD and CPTSD
- Get to the memory work asap – end of!

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Flexibility within fidelity to a model

	Techniques *Tight*	**Techniques *Loose***
Principles *Tight*	Competent adherence	Metacompetent adherence
Principles *Loose*	Rigid practice	Unfocused practice

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CT-PTSD for Complex Cases

Kerry Young
Woodfield Trauma Service, CNWL
Hannah Murray
Oxford Centre for Anxiety Disorders and Trauma, University of Oxford

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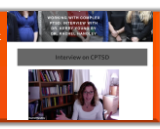
‘Complex PTSD’ vs a Complicated PTSD case

See interview about CPTSD diagnosis and treatment

https://vimeo.com/524927758/e48ac4e4ef



Thanks to Rachel Handley for permission to use

Made for NHSE PTSD ‘top up’ for IAPT

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Complex PTSD ICD-11

Complex PTSD arises after exposure to a stressor typically of an extreme or prolonged nature and from which escape is difficult or impossible, such as torture, concentration camps, slavery, genocide campaigns and other forms of organized violence, domestic violence, and childhood sexual or physical abuse.

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Complex PTSD ICD-11

- Core symptoms of PTSD
- **plus**
- Persistent and pervasive Disturbances in Self Organization:
  - **Emotions**: affect dysregulation, heightened emotional reactivity, violent outbursts, tendency towards dissociative states when under stress
  - **Identity**: persistent beliefs about oneself as diminished, defeated or worthless; pervasive feelings of shame, guilt
  - **Relationships**: difficulties in forming or sustaining relationships or feeling close to others.

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Complex PTSD ICD-11- is it a good idea?

- **9/10 studies support distinction PTSD and CPTSD**
- **5/5 support differences in level of impairment**
- **Stronger association childhood trauma CPTSD vs PTSD**
- **Distinguishable from other disorders (especially BPD)**
- **Distinguishable by clinicians**
- **So far, also applicable to children and adolescents**


A review of current evidence regarding the ICD-11 proposals for diagnosing PTSD and complex PTSD

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But it's not Borderline Personality Disorder

BPD can be distinguished from CPTSD because people suffering with BPD have:

1. A more unstable sense of self
2. Unstable and intense interpersonal relationships
3. Impulsiveness
4. Frantic efforts to avoid abandonment

(Cloitre et al, 2014)

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ICD-11: International Trauma Questionnaire – PTSD

Below are a number of problems that people sometimes report in response to traumatic or stressful life events. Please read each item carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

	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
In the past month have the above problems:					
P7. Affected your relationships or social life?	0	1	2	3	4
P8. Affected your work or ability to work?	0	1	2	3	4
P9. Affected any other important part of your life such as parenting, or school or college work, or other important activities?	0	1	2	3	4

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ICD-11: International Trauma Questionnaire – complex symptoms

Below are problems that people who have had stressful or traumatic events sometimes experience. The questions refer to ways you typically feel, ways you typically think about yourself and ways you typically relate to others. Answer the following thinking about how true each statement is of you.

How true is this of you?	*Not at all*	*A little bit*	*Moderately*	*Quit a bit*	*Extremely*
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
In the past month, how the above problems in emotions, in beliefs about yourself and in relationships:					
C7. Created concern or distress about your relationships or social life?	0	1	2	3	4
C8. Affected your work or ability to work?	0	1	2	3	4
C9. Affected any other important parts of your life such as parenting, or school or college work, or other important activities?	0	1	2	3	4

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NICE: PTSD Treatment

Offer **individual trauma-focused CBT** for adults who have diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 1 month after TE

- Cognitive Processing Therapy
- Cognitive Therapy for PTSD
- Narrative Exposure Therapy (best for refugees with multiple traumas)
- Prolonged Exposure

OR

- EMDR if client prefers it but not for combat-related trauma

NICE National Institute for Health and Care Excellence

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NICE guidance for Complex PTSD

Treat as you would straightforward PTSD

But also:

- **Build in extra time to develop trust with the person, by increasing the duration or the number of therapy sessions according to the person's needs**
- **Take into account the safety and stability of the person's personal circumstances (for example their housing situation) and how this might affect engagement with and success of treatment**
- **Help the person manage any issues that might be a barrier to engaging with trauma-focused therapies, such as substance misuse, dissociation, emotional dysregulation, interpersonal difficulties or negative self-perception**
- **Work with the person to plan any ongoing support they will need after the end of treatment, for example to manage any residual PTSD symptoms or comorbidities**

NICE National Institute for Health and Care Excellence

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However…

- **Be aware that multiple traumas do not necessarily result in Complex PTSD**
- **Possible to have undergone many traumas which results in 'simple' PTSD or no PTSD or another diagnosis altogether.**
- **Equally, evidence is suggesting that a one of trauma can result in a Complex PTSD presentation**
- **Be led by whole picture of symptoms, not just number or nature of traumas to guide you**

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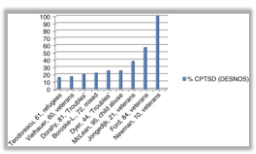
CPTSD rates by population

Treatment seeking population rates



General population rates:

- **USA** **3.4 % PTSD**
  3.8 % CPTSD [1]
- **Germany** **1.5 % PTSD**
  0.5 % CPTSD [2]

[1]- De Silva, U., Glover, N., & Katona, C. (2021). Prevalence of complex post-traumatic stress disorder in refugees and asylum seekers: Systematic review. *BJPsych Open*, *7*(6), E194. doi:10.1192/bjo.2021.1013
[2]- Maercker A, Hecker T, Augsburger M, Kliem S. ICD-11 Prevalence Rates of Posttraumatic Stress Disorder and Complex Posttraumatic Stress Disorder in a German Nationwide Sample. J Nerv Ment Dis. 2018 Apr;206(4):270-276. doi:

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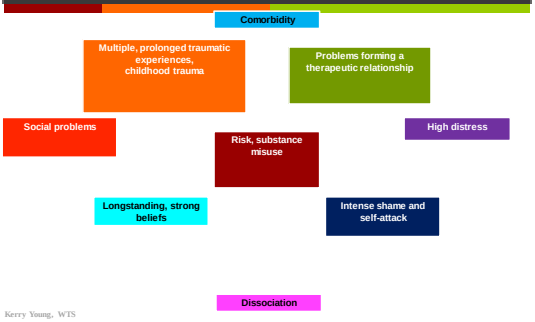
More helpful to consider aspects of complexity



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So how should we treat complicated and Comple PTSD?

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ISTSS Guidelines Position Paper on treatment of Complex PTSD in Adults

ISTSS International Society for Traumatic Stress Studies

- Looked at recent meta-analysis
- There were only two studies that included all symptoms clusters representative of CPTSD per ICD-11
- TF-CBT (and EMDR) yielded outcomes superior to waitlist or treatment as usual

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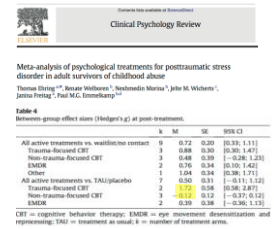
Meta-analysis of treatment for adult survivors with PTSD



Clinical Psychology Review

Meta-analysis of psychological treatments for posttraumatic stress disorder in adult survivors of childhood abuse

Thomas Ehring [a,*], Renate Welboren [b], Nashmedin Morina [b], John M. Wicherts [c], Jantina Freitag [a], Paul M.G. Emmelkamp [b,d]

Table 4
Between-group effect sizes (Hedges's g) at post-treatment.

	k	M	SE	95% CI
All active treatments vs. waitlist/no contact	9	0.72	0.20	[0.33; 1.11]
Trauma-focused CBT	3	0.88	0.30	[0.30; 1.47]
Non-trauma-focused CBT	3	0.48	0.39	[−0.28; 1.23]
EMDR	2	0.76	0.34	[0.10; 1.42]
Other	1	1.04	0.34	[0.38; 1.71]
All active treatments vs. TAU/placebo	7	0.50	0.31	[−0.11; 1.12]
Trauma-focused CBT	2	1.72	0.58	[0.58; 2.87]
Non-trauma-focused CBT	3	−0.12	0.12	[−0.37; 0.12]
EMDR	2	0.39	0.38	[−0.36; 1.13]

CBT = cognitive behavior therapy; EMDR = eye movement desensitization and reprocessing; TAU = treatment as usual; k = number of treatment arms.

- TF-therapies also reduced dissociation and depression
- No more drop-outs in TF-therapies vs. non
- Individual TF-therapy better than group

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Ehlers and Clark (2000)

People who are involved in traumatic events go on to develop PTSD if they process the trauma in a way that leads to a sense of CURRENT THREAT

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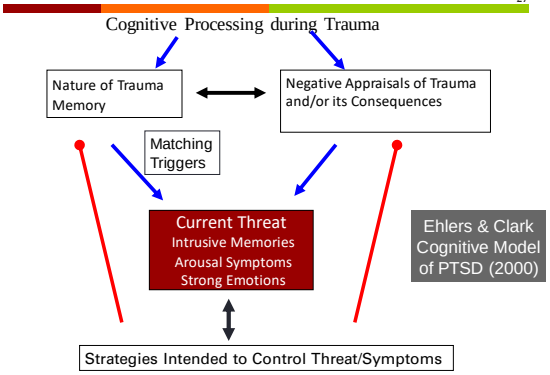

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How does this sense of current threat happen?

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Cognitive Model Ehlers & Clark (2000)

1. Negative appraisals of event and after effects
2. Nature of trauma memory
3. Ultimately unhelpful coping strategies

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Overview of Ehlers and Clark (2000) Treatment Plan

A. Normalize PTSD and explain
B. Reclaiming life work
C. Memory processing (re-living to identify hotspots)
D. Cognitive re-structuring
E. Identifying troublesome triggers for remaining intrusive symptoms
F. Stopping avoidance/safety behaviours (work on post-traumatic appraisals)
G. Revisiting site of trauma

MAY NOT NEED TO DO ALL BITS

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https://oxcadatresources.com

Guidance for remote working and short videos

Register and login for training videos and therapy materials

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Good way of thinking about Cognitive Model PTSD

- Multisensory recording is made of traumatic event (sound track, picture track, smell track, taste track, sensation track, emotion track, thought track)
- This recording essentially 'freezes in time' the traumatic event…with full force of emotions etc felt at the time e.g., "I'm going to die" (fear) "I caused this"(guilt) "I'm letting myself down' (shame)
- Because of how brain functions during extreme stress, this recording is not stored away in our normal memory stores (where we would be able to control when we think of it again)
- It pops into someone's mind every time something reminds them of the traumatic event

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Good way of thinking about Cognitive Model PTSD

- When it pops in, the person experiences again the full force of the traumatic event
- This is a natural part of the recovery process – as the memories come in, the person is able to 'chew them over' and update them ("I survived"/"It wasn't my fault" etc.) which:
  - Takes the sting out of the emotions
  - Places them in the past
  - Processes them so they are put away into normal memory stores (from which they don't pop unbidden any more)

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Good way of thinking about Cognitive Model PTSD

- For some people/some kinds of events/in some circumstances it is not possible to chew it over – it is too frightening/too painful/not a priority
- So memory stays frozen in time and popping into person's mind against their control
- Because it is frozen in time, they push it out as it is too awful - leading to an intrusion/avoidance cycle – which, over time, becomes PTSD

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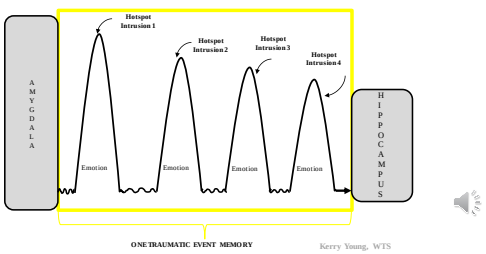
Single Event Trauma



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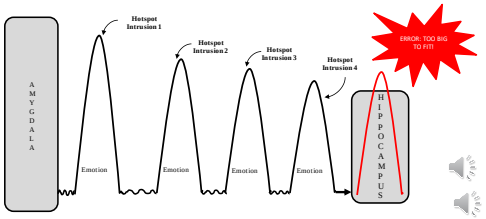
Single Event Trauma



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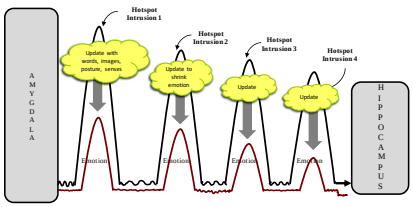
Treating Single Event Trauma - Updating



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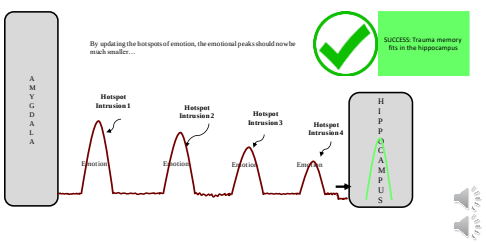
Single Event Trauma



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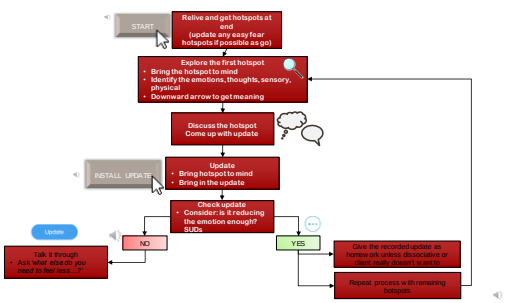

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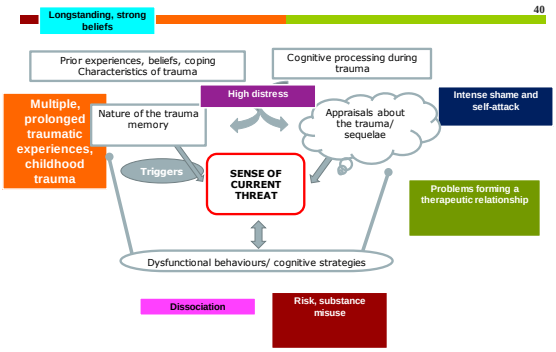
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Longstanding, strong beliefs
Prior experiences, beliefs, coping Characteristics of trauma
Cognitive processing during trauma
High distress
Intense shame and self-attack
Multiple, prolonged traumatic experiences, childhood trauma
Nature of the trauma memory
Appraisals about the trauma/ sequelae
Triggers
SENSE OF CURRENT THREAT
Problems forming a therapeutic relationship
Dysfunctional behaviours/ cognitive strategies
Dissociation
Risk, substance misuse
Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. Behaviour research and therapy, 38(4), 319-345.
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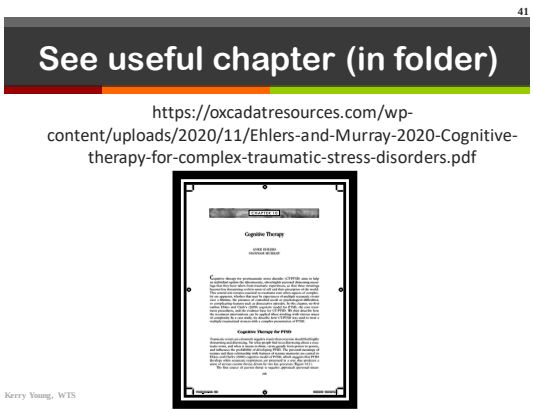
41
See useful chapter (in folder)
https://oxcadatresources.com/wp-content/uploads/2020/11/Ehlers-and-Murray-2020-Cognitive-therapy-for-complex-traumatic-stress-disorders.pdf
Cognitive Therapy
Cognitive Therapy for PTSD
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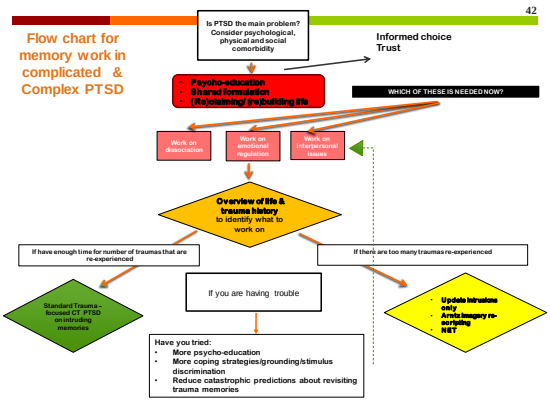
42
Flow chart for memory work in complicated & Complex PTSD
Is PTSD the main problem? Consider psychological, physical and social comorbidity
Informed choice
Trust
Psycho-education
Shared formulation
(Re)claiming/ (re)building life
WHICH OF THESE IS NEEDED NOW?
Work on dissociation
Work on emotional regulation
Work on interpersonal issues
Overview of life & trauma history to identify what to work on
If have enough time for number of traumas that are re-experienced
If there are too many traumas re-experienced
Standard Trauma – focused CT PTSD on intruding memories
If you are having trouble
Update intrusions only
Arm/a Imagery re-scripting
NET
Have you tried:
More psycho-education
More coping strategies/grounding/stimulus discrimination
Reduce catastrophic predictions about revisiting trauma memories

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CPTSD: Phased approach?

Judith Herman: Complex PTSD

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Clarify terms

- Psychological stabilization:
  - ensuring people have the skills to cope with the TFCBT
  - i.e. can calm themselves down in a (preferably non-self-harming) way
  - NB people with complicated PTSD are never going to be entirely without psychological distress/unhelpful coping
- Practical stabilization:
  - Goodenough housing, medical, legal, financial & family situations

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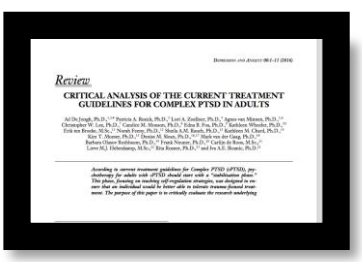
There is a bit of controversy here…



Review

CRITICAL ANALYSIS OF THE CURRENT TREATMENT GUIDELINES FOR COMPLEX PTSD IN ADULTS

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De Jong et al (2016) concluded for Complex PTSD

No support for:

1. View that phase-based approach is *necessary*
2. View that tf-therapy for Complex PTSD had unacceptable risks
3. There are significant gains in outcome of having stabilisation phase first

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De Jong et al, 2016

"In conclusion, the evidence does not currently support the recommendation for a stabilization phase prior to providing trauma-focused treatment in persons with cPTSD, or related severe or complicated presentations of PTSD. For patients with more cPTSD presentations, the recommendation for an initial stabilization phase has the potential to result in a delay or restriction of access to effective trauma-focused treatments. Delaying trauma-focused treatment could also be demoralizing to patients by inadvertently communicating to them that they are not capable of dealing with their traumatic memories…."

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Hmm what do we know:

- Effect sizes treatments for childhood trauma equal to those of adult trauma survivors (Ehring et al., 2014)
- Affect regulation improves following evidence-based treatment (PE) in those with and without a childhood abuse history (Jerud et al., 2014)
- Patients with psychosis or schizophrenia and PTSD respond 'normally' to EMDR or PE without prior stabilization: low drop out and less serious adverse events than TAU (van den Berg et al., 2014)
- Patients with/out history CSA do just as well at intensive (2 x 4 consecutive days) EMDR/PE (Wagenmans et al., 2018)

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Review:

CRITICAL ANALYSIS OF THE CURRENT TREATMENT GUIDELINES FOR COMPLEX PTSD IN ADULTS

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From UKPTS Guideline for CPTSD 2017

"It would appear proportionate, given current evidence, to conclude **that trauma-focused therapy should not be unnecessarily delayed or avoided by a stabilisation phase**: however, it is equally important that this is considered in light of the individual's presentation and recent risk behaviours. **Where there is recent self-harming or parasuicidal behaviour,** the clinician should err on the side of safety (and potential effectiveness) and **include a stabilisation and psychoeducation phase"**

Echoed by ISTSS (2012)

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To stabilize or not?

- tCT-PTSD is an integrated rather than a phase-based approach
- With complex cases, these interventions do precede memory work
- For some clients, they will be very brief (1-2 sessions)
- Other may require more time
- Our general rule is:
  - Don't delay memory work unnecessarily
  - Tailor your intervention to an individual's needs (e.g. not everyone will be dissociative/struggle with trust)
  - Address only what is needed to move on to memory work

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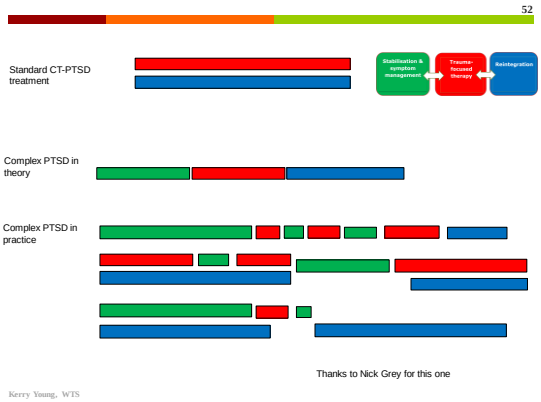

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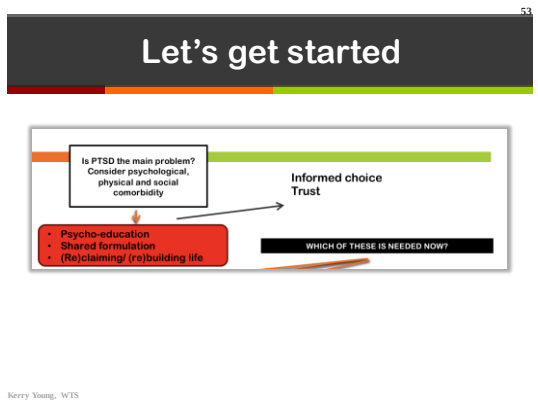

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Check on their ability to maintain a focus on psychological work for PTSD

Just ask:

"I know that you have serious problems with your:
- Accommodation
- Health
- Finances
- Relationships
- Family
- Legal case

It sounds as if we/you are doing as much as we/you can about that at the moment. Do you think that, despite this problem, you are able to focus on working with us to try and reduce these memories…..or is the other stuff all that you can think of at present?"

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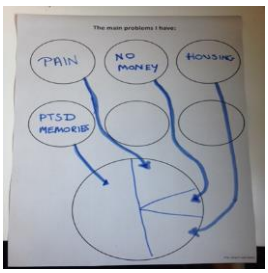
A good way to identify priorities



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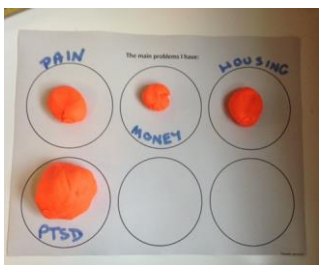
Or…



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DO NOT Assume

- No rules about this
- We know people can benefit from trauma-focused work when in danger and in unstable social circumstances
- It is *their* choice

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What about comorbidities?

- Formulate how are interlinked
- Most treatment research, tf-therapy improves PTSD *and* depression
- General rule of thumb is treat PTSD first then look at the other stuff. Estimates from Kerry's vast experience
  - 99% time treat PTSD first with comorbid depression
  - 100% time treat PTSD with substance misuse
  - 90% time treat PTSD first with panic

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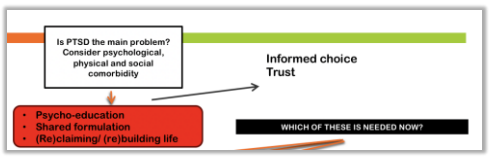
Informed choice



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Informed Choice

1. Important to ensure they understand why talking about trauma is a good idea

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Cupboard metaphor to explain PTSD

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Cupboard

Memory Store in Brain

Folded towels

Typical memories

Dirty duvet/blanket

Trauma memories

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Typical memories

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Intrusive trauma memories

Trauma memories

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Talking therapy

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Talking therapy

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Waste paper basket metaphor

Particularly good for multiple Traumatic events

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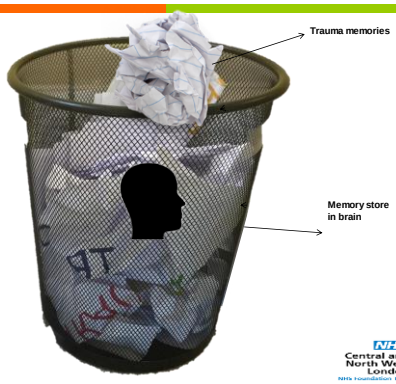

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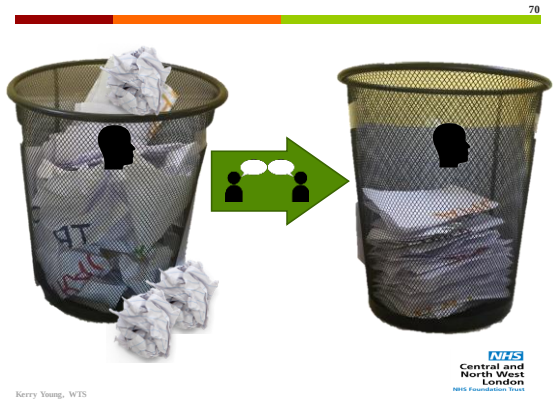
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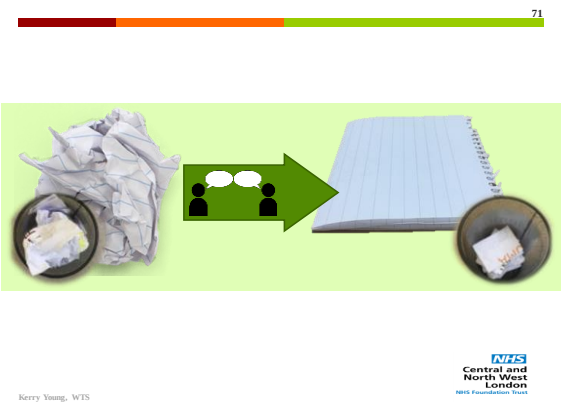
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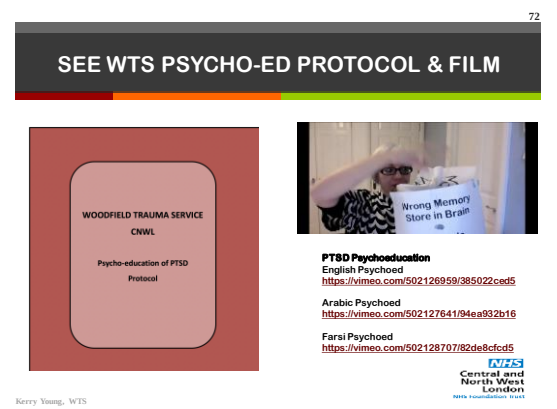
72
SEE WTS PSYCHO-ED PROTOCOL & FILM
WOODFIELD TRAUMA SERVICE
CNWL
Psycho-education of PTSD
Protocol
Wrong Memory
Store in Brain
PTSD Psychoeducation
English Psychoed
https://vimeo.com/502126959/385022ced5
Arabic Psychoed
https://vimeo.com/502127641/94ea932b16
Farsi Psychoed
https://vimeo.com/502128707/82de8cfcd5
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Informed Choice

1. Important to ensure they understand why talking about trauma is a good idea
2. Important to discuss evidence

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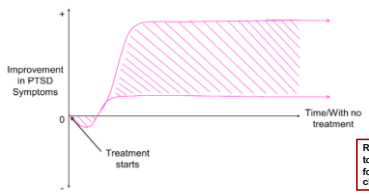
Typical recovery curve for multiple traumatic events



Shaded area shows typical range of improvement in PTSD symptoms after trauma-focused therapy for multiple traumatic events

Remember moderate to high effect sizes for adult survivors of childhood abuse

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Show more outcome studies if helpful

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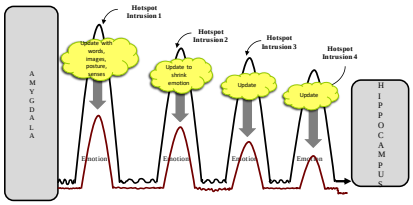
Show them this



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And this if helpful

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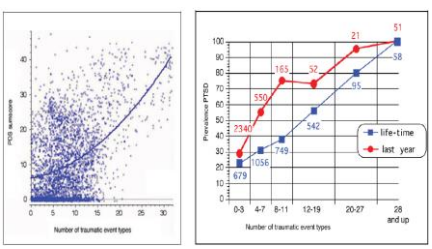
How are people affected by childhood trauma?

- Adverse Childhood Experiences (ACEs) and traumatic events have a dose effect



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Informed Choice

1. Important to ensure they understand why talking about trauma is a good idea
2. Important to discuss evidence
3. Important to discuss pros & cons of treatment
4. **Hand the decision to them**
5. Avoids being/feeling coercive

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Doing TF-CBT	NOT Doing TF-CBT
Pros (short- and long-term)	Cons (short- and long-term)

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Now hand decision to them…

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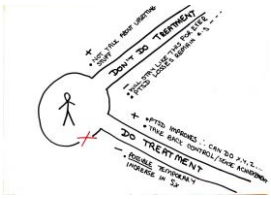
Informed Choice



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NOT A ONE-OFF OPPORTUNITY

- Can come back for treatment if now is not the right time
- Pros and cons of treatment
- Write it down on a colourful postcard and let them go away and think about it

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Informed Choice

1. Important to ensure they understand why talking about trauma is a good idea
2. Important to discuss evidence
3. Important to discuss pros & cons of treatment
4. **Hand the decision to them**
5. Avoids being/feeling coercive
6. NB THEY ARE TERRIFIED

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Questions about psycho-ed?

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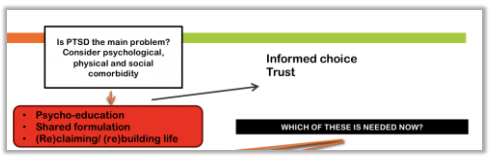
What's next? Trust



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The Therapeutic Relationship in PTSD

- Fear that the nature of memory-focused work in PTSD might affect the therapeutic relationship.
- Research shows that:
  - Strength therapeutic alliance in trauma-focused therapy for PTSD comparable to that in other therapies (Gilboa-Schechtman et al., 2010; Ormhaug et al., 2014; Capaldi et al., 2016)
  - Even those with severe PTSD can have strong therapeutic relationship (Callahan et al., 2003)
  - Presence multiple events and comorbidity does not weaken the alliance (McLaughlin et al., 2014)
  - No greater drop-out rate in Ehring meta-analysis with TF-therapies

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The Therapeutic Relationship in PTSD

- Key task of therapy in PTSD = reduce sense current threat
- Can reduce the threat with physical and with psychological environment

For more information, see Grey, N., Young, K. & House, J. (2018). The Therapeutic Relationship in PTSD. In Moorey and Lavender (Eds) *The Therapeutic Relationship in CBT*. SAGE

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The Therapeutic Relationship in PTSD – reducing the current threat early on

PHYSICAL FACTORS

- Longer sessions for memory work (90 minutes)
- Rooms that are easy to leave
- Rooms that minimize dissociation
- Gender of therapist/interpreter
- Continuity of therapist/interpreter

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The Therapeutic Relationship in PTSD – predicting/preventing threats to the alliance

THREATS FROM THE NATURE OF THE TRAUMA

- Rapid and timely normalizing of responses associated with shame or guilt
- Cognitive techniques to work with shame/guilt IF getting in way

THREATS FROM THE CLIENT

- Open discussion of issues with trust
- Confidentiality
- Making it clear therapist comfortable with discussing details of trauma
- Eliciting and 'challenging' catastrophic predictions about telling the story

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Trust

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Difficulty of establishing trust..

- May come from a sub-culture where cannot trust anyone/authority
- May come from a family where you could not trust (often likely for Complex PTSD)
- Abuse breaks trust

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Establishing trust

PUT IT ON THE TABLE:

- "Most people we see who have been through trauma find it difficult to trust us to begin with – it is unsurprising, given what has happened to them"
- "We have found that it helps to talk about what makes it easier or harder for you to trust me. So, with your permission, I would like to ask you about it at the end of every session, so I can do more of the things that make it easier to trust me and less of the things that make it harder. Is that OK?

- **TRY TO BE REALLY OPEN AND ALMOST MATTER-OF-FACT ABOUT IT** (so no one needs to feel embarrassed)
- **WATCH YOUR NON-VERBAL COMMUNICATION** (be open, non-threatening, soft)

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Establishing trust

USE VISUAL ANALOGUE SCALE OR THERMOMETER

- "What did I do today that increased my score…would you like me to do more of that?"
- "What did I do today that decreased my score…what would you like me to do instead next time?"
- "What do you think happened to reduce my score this week…what were you thinking about?"

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Be consistent

- These guys have had lots of boundary violations
- Be clear and consistent

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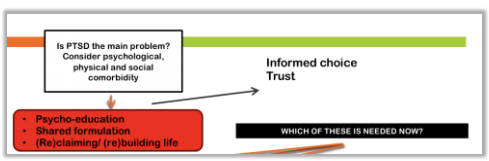
What's next? Rebuilding life



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(Re)building your life

- People with long trauma histories or significant life changes may not be easily able to 'reclaim' their life
- Instead we focus on '(re)building'
- This includes making plans for how they want to live their life in the future – maybe using values-based goals and possibly future imagery

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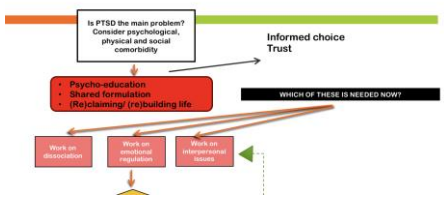
What's next? Formulate



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Can we go to the memory work or do I need to do something else first?

- Emotional regulation skills needed now?
- Interpersonal issues need addressing now?
- Dissociation management needed?

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Assessing if need to teach some emotion regulation skills

Assess by asking:

- How do you cope when upset/worried/angry/sad?
- What can you do to make yourself feel better in each case?
- When you were little, how did your parents react when you were upset/worried/angry/sad? What did they do to help you feel better?
- When you get upset/worried/angry/sad, what (if anything) do you fear will happen?

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Teaching coping skills

- If it sounds sensible enough – **MOVE ON**
- If no adaptive coping strategies then teach
- Helpful to match soothing strategy to modality of unhelpful strategy
  - Arousal (self-harm/violence/aggression) is **physiological** (so try e.g. breathing, PMR, exercise, self-hypnosis, general alternatives to DSH, warm baths etc.)
  - Binging/drinking/isolation are **behavioural** (so try e.g. time out, replacement behaviours, social support)

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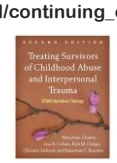
Skills Training in Affective and Interpersonal Regulation (STAIR)

- All of the materials and training videos are available online - manualized and easy to use
- 8 sessions on emotional regulation and relationship difficulties
- www.ptsd.va.gov/professional/continuing_ed/stair_online_training.asp



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STAIR App

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Skills Training in Affective and Interpersonal Regulation (STAIR)

- Cloitre suggests you use in modular form i.e. what does the patient need to work on and when?

Modular therapy for CPTSD: A person centered approach

1. A thorough assessment of the patient's presenting problems resulting in a case formulation about the underlying causes.
2. Therapist and patient decide on specific CPTSD clusters to target based on preference, readiness and severity using appropriate evidence based interventions.
3. At the end of delivery of this module, an assessment is conducted and the next therapeutic target is selected.

Karatzias & Cloitre (2019). Journal of Traumatic Stress. In press.

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Skills Training in Affective and Interpersonal Regulation (STAIR)

- Emotional regulation
  - Breathing, emotional awareness, self-soothing, positive activities
- Interpersonal difficulties
  - Communication skills, expectations, basic rights, assertiveness, boundaries

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Emotional regulation stuff

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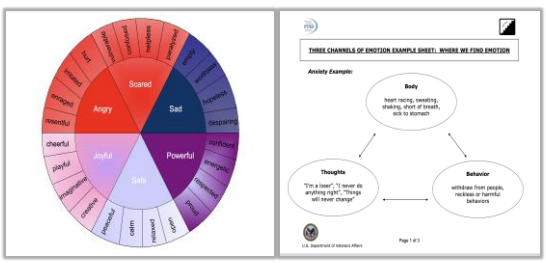
STAIR – emotional awareness



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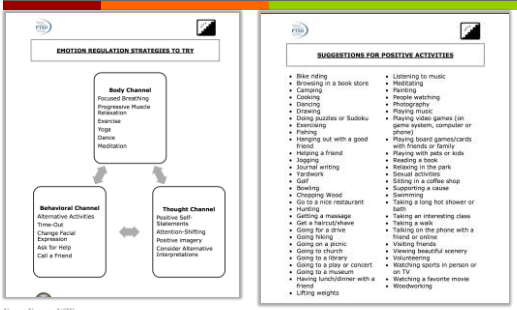
STAIR – emotional regulation



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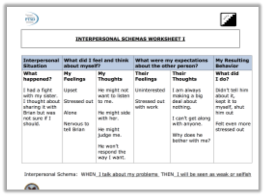
STAIR – Interpersonal stuff



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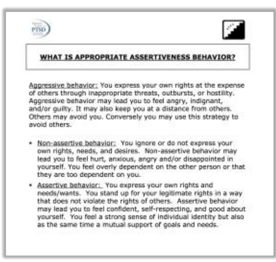
STAIR - interpersonal



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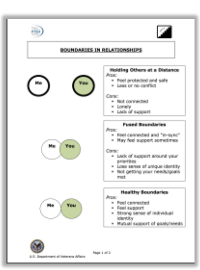
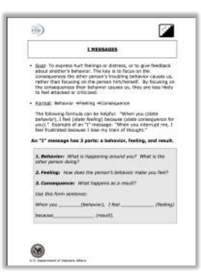
STAIR - interpersonal





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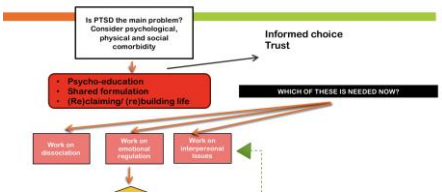
What's next? Dissociation



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FREEDOM FROM TORTURE

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LONDON CBT TRAINING CENTRE

Training to meet the needs of refugees and asylum seekers in IAPT 2021-2023

Kerry Young and Sameena Akbar

Woodfield Trauma Service

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Dissociation and Grounding

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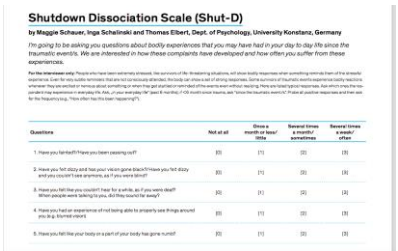
Measuring Dissociation
Shutdown Dissociation Scale (Shut-D)
In folder



Shutdown Dissociation Scale (Shut-D)

by Maggie Schauer, Inga Schalinski and Thomas Elbert, Dept. of Psychology, University Konstanz, Germany

I'm going to be asking you questions about bodily experiences that you may have had in your day to day life since the traumatic event/s. We are interested in how these complaints have developed and how often you suffer from these experiences.

Questions	Not at all	Once a month or less/ little	Several times a month/ sometimes	Several times a week/ often
1. Have you fainted? Have you been passing out?	(0)	(1)	(2)	(3)
2. Have you felt dizzy and has your vision gone black? Have you felt dizzy and you couldn't see anymore, as if you were blind?	(0)	(1)	(2)	(3)
3. Have you felt like you couldn't hear for a while, as if you were deaf? When people were talking to you, did they sound far away?	(0)	(1)	(2)	(3)
4. Have you had an experience of not being able to properly see things around you (e.g. blurred vision)	(0)	(1)	(2)	(3)
5. Have you felt like your body or a part of your body has gone numb?	(0)	(1)	(2)	(3)

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Shut-down dissociation

- A normalising model which can be used as psychoeducation is Schauer & Elbert (2010)
- Argues that dissociation is an evolutionarily-developed strategy which is adaptive if:
  - Victim is in direct contact with perpetrator
  - In the presence of bodily fluids (with danger of contamination/impregnation)
  - When body already 'punctured' (e.g. with knife/penetration)

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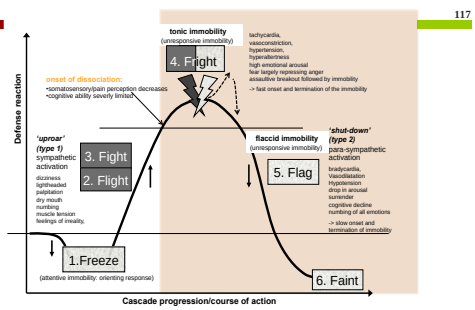

See: Schalinski, I., Schauer, M., & Elbert, T. (2015). The Shutdown Dissociation Scale (Shut-D). *European journal of psychotraumatology*, *6*. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4407127/bin/EJPT-6-26596-s001.pdf

Defence Cascade

from: Schauer & Elbert (2010). Dissociation following traumatic stress: etiology and treatment. *Journal of Psychology*, Vol. 218(2):109–127.

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Key messages

- Evolutionary adaptive response
- Makes sense
- Can manage it if you understand WHY it is happening and clients can learn to manage it
- So you can proceed with trauma-focused therapy

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So how do we help?

- For **all forms** of dissociation, there is a process like an 'arm wrestle' between the past and the present
- Using reminders of the here and now can help the present to win

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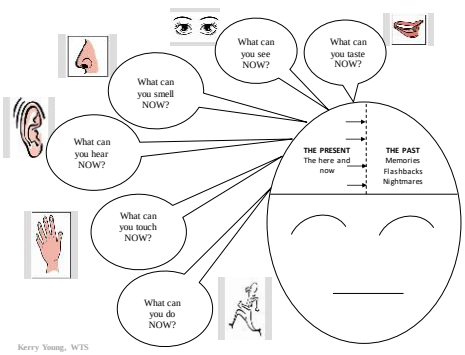

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Smell

- Peppermint, clove, eucalyptus, chili, garlic or peppermint oils, as well as wasabi root, horseradish and fresh ginger are all particularly effective as they stimulate trigeminal nerve (alerts you to your present surroundings)
- Smelling salts
- Decongestant sprays/sticks
- Essential oils/olbas oil on pillowcases
- Air fresheners
- Citrus fruits
- Perfume

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Taste




- Peppermint & ginger
- Strong mints
- Chilli gum/Airwaves
- Wasabi peas
- Cough sweets
- Breath sweets
- Sour sherbet
- 'Popping candy'
- Fruity sweets

- IDEALLY **COMBINE** TASTE & SMELL USING PEPPERMINT/ GINGER

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Sight





- "Open your eyes"
- Set up environment to re-focus on present and notice what you can see
- Notices stating location, year etc
- Decoration/lighting that discriminates between current location and traumatic event e.g. current photographs, calendars, contemporary pictures
- Night-lights to ensure clients can see these materials if they dissociate at night
- Messages/photos on phone

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Touch

- Stress balls
- Beaded bracelets
- Interesting textures eg play dough, Mohdoh, silly putty, marbles, velvet, feathers, astroturf, pebbles/shells
- Hot or cold compresses
- Elastic bands on wrists
- Pop bubble wrap
- Vibrating massagers or TENS machine
- Being in postures that were not possible in the traumatic event
- Applied tension
- Piece of taut cloth

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Sound

- Music/noises that distinguish the current situation from traumatic event eg white noise/wave sounds/bird song/forest sounds
- A loud ticking clock to focus on
- Radio with contemporary music/voices
- "I am safe, it is 2021 and I am in…"
- Recordable motion sensors
- First names/pet names

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How should you use this stuff?

- Explain 6F's to all your clients (and carers if appropriate)
- Transmit message that it is entirely normal, biological and outside of their conscious control
- Scaffold with WTS films for clients

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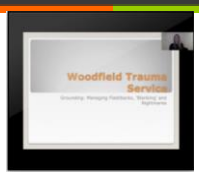
Further Resources



Grounding English
https://vimeo.com/441597178/b54b9ea87f

Grounding Arabic
https://vimeo.com/449426390/96463934ab

Grounding Farsi
https://vimeo.com/640886334/b2b483af24

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How should you use this stuff?

- Try out various grounding strategies with your client ….match sense of flashback to sense of grounding strategy if possible
- Will probably have to buy this stuff for low income clients
- Find a combination of things they want to try at home in day and at night
- Keep collecting feedback and tweaking

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Further Resources


A protocol for managing dissociative symptoms in refugee populations

Adaptations for people who dissociate

Dissociation 1 – Introduction to dissociation

Dissociation part 2 – Skills to manage dissociation

Dissociation part 3 – Managing dissociation during a session

Dissociation part 4- Adapting memory work for patients who dissociate

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How to use in sessions

- Ensure patient has eaten/drunk well (500ml water if possible)
- Prepare grounding strategies and use from the beginning
- Good lighting
- If you are working remotely – ask them to show them to you AND make sure sitting somewhere soft if they might faint

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How to use in sessions (cont.)

- If grounding not working, have a chat, agree what else to try
  1. stronger grounders
  2. use incompatible postures
  3. lower anxiety at beginning of session (Soothing Rhythm Breathing)
  4. temporarily raise blood pressure (e.g. physical exercise – jump on spot/balance board/squats/cycling/steps) to counteract dissociation
  5. if necessary, one sentence past followed by one sentence here and now -"Peep and creep"
  6. encourage/invite previously suppressed anger
  7. a third person/on video or pet
  8. do lying down if necessary

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Films

Managing dissociation in reliving

https://vimeo.com/293361180/773cdbee87

Managing Dissociation in ImRs

https://vimeo.com/461359375/4d7c5eb242

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Dissociation does NOT mean you should not do memory work

All studies find reliving/trauma-focused work is still very effective when people dissociate (e.g., Hoeboer, et al., 2020)

Client not as disturbed by dissociation as you are – it happens all of the time!

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Dissociation does NOT mean you should not do memory work

Ehlers & Clark say you can use alternative memory-focused techniques if the patient is struggling – narrative writing, 'bird's eye view' reliving etc

Adaptations for people who dissociate

Dissociation 1 – Introduction to dissociation

Dissociation part 2 – Skills to manage dissociation

Dissociation part 3 – Managing dissociation during a session

Dissociation part 4- Adapting memory work for patients who dissociate

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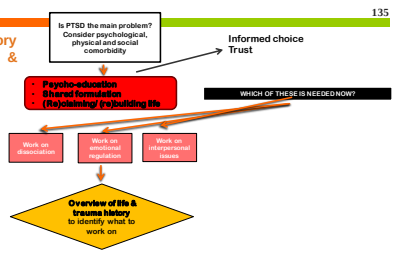
Flow chart for memory work in complicated & Complex PTSD



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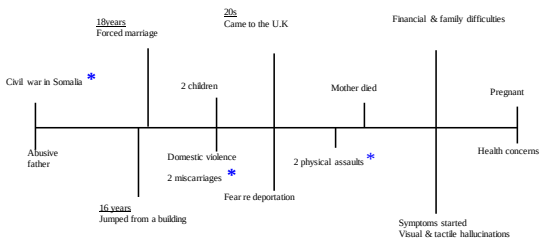
Example drawn life line



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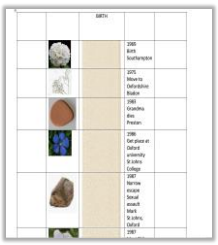
Lifeline- guide in resources

Asterisk the "Ones that come back to you now, as flashbacks and nightmares"



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Intrusion diaries

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Intrusive memories diary

How to fill in this diary

- If you have any **intrusive memories/flashbacks of traumatic events** during the next week, please note them in this diary.
- **What are intrusive memories/flashbacks?**

  Intrusive memories/flashbacks are vivid, emotional memories of traumatic events that pop into your mind without warning. They often take the form of **visual pictures in your mind's eye** e.g. like a photograph, or film clip. They can also include other senses e.g. sounds and smells. They may or may not be triggered by something you are aware of e.g. telling someone about the event, or watching the news. **Intrusive memories/flashbacks of the traumatic events can be very short, fleeting and broken up.** They can also come to mind when you are asleep (a nightmare). We would still like to know about them in the diary!
- **What does not count as an intrusive memory/flashback?**
  - Voluntarily/intentionally thinking or ruminating about traumatic events
  - General thoughts about traumatic events **without images**, e.g. "I was a prisoner".
- **What to do when you have an intrusive memory/flashback:**
- For every intrusive memory/flashback, please note the label of that intrusion in the correct small box in the table at the right time of the day (morning, afternoon, evening, night). **The labels are written on the worksheet you did with your therapist**
- **If you did not experience any intrusions at a given time of day, please fill in "0" in that box** (see example).

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Hamid's List of Intrusions

A. Footsteps
B. Screaming of others
C. Smell of blood
D. When they threatened to shoot me
E. When they cut my ear
F. When they shot my friend
G. Bomb in main street – 2009
H. Helicopter crash

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Insert the label for the intrusion you experienced or 0 if no intrusions at that time of day

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Day 1							
Morning	B	B					
Afternoon	E	A	A	B	B		
Evening	F	G	G	E			
Night	H	B	B	B	B	B	

Date of day 1: _____

Day 2							
Morning	H	H	A				
Afternoon	0						
Evening	A	H	G	G	D	E	
Night	E	B	E	E			

Day 3							
Morning							
Afternoon							
Evening							
Night							

Day 4							
Morning							
Afternoon							
Evening							
Night							

Day 5							
Morning							
Afternoon							
Evening							
Night							

Day 6							
Morning							
Afternoon							
Evening							
Night							

Day 7							
Morning							
Afternoon							
Evening							
Night							

Day 8							
Morning							
Afternoon							
Evening							
Night							

4 5

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Working with multiple trauma memories

Deciding where to start

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Flow chart for memory work in complicated & Complex PTSD

Is PTSD the main problem? Consider psychological, physical and social comorbidity

Informed choice
Trust

- Psycho-education
- Shared formulation
- (Re)claiming/ (re)building life

WHICH OF THESE IS NEEDED NOW?

Work on dissociation

Work on emotional regulation

Work on interpersonal issues

Overview of life & trauma history to identify what to work on

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Why chronological?

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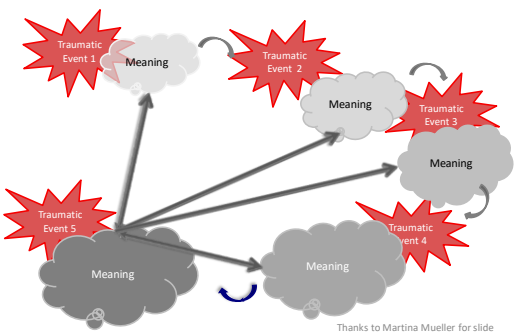
Meaning is built up over time - recollections of any of these traumatic events become infused with the cumulative meaning, not the one the event held on its own. 146



Thanks to Martina Mueller for slide

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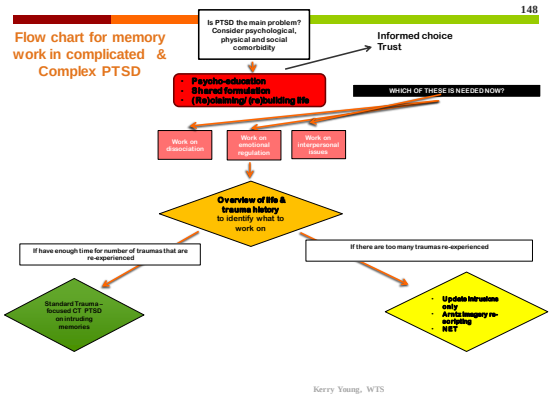

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If have enough time for number of traumas that are re-experienced

- Do standard TF-CT for each event **RE-EXPERIENCED**
- Preferably in chronological order if you can
- May need to use more imagery than usual to update hotspots …see later
- Often there are more sensory elements that need sensory updating
- Get efficiency over time

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Updating hotspots with strong sensory elements

- If hotspots feature a very strong smell e.g. burning, sweat, semen, death
  - consider updating with words but also a nice smell
  - e.g. oils, perfume, peppermint, ginger

- If hotspots feature a loud noise e.g. screaming, sirens, verbal abuse
  - consider updating with words but also with direction to notice there is no noise now/nicer noise
  - e.g. radio, music, ticking clock, bird song, waves

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Updating hotspots with strong sensory elements

- If hotspots feature a strong taste e.g. blood,semen, smoke, dead bodies
  - consider updating with words but also a nice, strong alternative taste
  - e.g. mints, cough sweets, sweets, citrus fruit

- If hotspots feature a strong physical sensation e.g. pain, heat, impact
  - consider updating with words but also with
    - direction to notice there is nothing there now
    - or alternative, nice/incompatible physical sensation
    - e.g. velvet, ice pack, heat pack, soft blanket, massager, feather, silk scarf, soft toy, incompatible posture

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Why use imagery to enhance updates ?

- Significant proportion of hotspots are images (c. 40% in Grenfell audit, especially around own/other's death)
- You need an image to update an image
- Imagery also useful for updating when:
  - what person feared actually happened e.g. murder, death, rape, sexual abuse
  - working with feelings of powerlessness, shame, guilt, anger, contamination
  - head – heart lag in general (often way with guilt)
  - simply to enhance a verbal update ("I survived" plus image of self alive and well)

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Let's take an example - Leila

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Leila

- Mid 40s, highly educated journalist from the Middle East
- Very happy early family life
- Married, domestic violence from husband and repeated arrests and torture by security services
- Has a daughter who is now in her late teens

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Leila

- Escaped to the UK in 10 years ago with daughter
- Ongoing phone threats from security services
- One serious suicide attempt but managing to work a bit
  - Very high level of depression
  - Hopeless
  - 'This treatment is my last chance. I can't fight anymore'.

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Leila

- Issues around trust
- Severe PTSD; dissociative +++ (screaming and fainting), flashbacks and nightmares, avoidance, hyperarousal
- Housing problems

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Leila

- Used assessment circles to identify priorities – PTSD main one
- BUT – housing a significant preoccupation so some practical stabilization needed
  - Refer to support worker
  - Write support letter
- Psychological stabilization minimal – psycho-ed, grounding and coping to decrease arousal (Soothing Rhythm Breathing) - does not take up more than 3 sessions
- Trust – actively identify trust as an issue and work on it
- Suicidal ideation: not active and no recent history of harm. Client has a crisis plan but suicidal thoughts driven by PTSD so we must tackle that

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Case Example –Leila

- Treatment plan is 15 sessions of TF-therapy
- So, multiple traumas + dissociation + housing issues + trust + risk still required low levels of practical and psychological stabilization

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Leila

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What intruding from Lifeline

A. Husband hit me on street
B. Forced to watch prisoners being hanged
C. My child seeing my husband beat me

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Treatment

1. In chronological order
2. Relive, identify hotspots, elaborate and update hotspots:
   1. Husband hit me on street
   2. Forced to watch prisoners being hanged
   3. My child seeing my husband beat me

3. Mix of verbal and imagery updates

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Example updates – watching others being hanged

Hotspot	Sensations	Emotions	Thoughts	Update
Hearing the sound of people being whipped as walk up stairs	• Sick • Can't breathe • Hands hurting behind back • Sound of screaming	Terror	I will be next	• They didn't whip me on that day • I am safe and well in London • I can move my hands around • I can hear Vaughan Williams music, there is no screaming
Seeing others being hanged	• Blackness • Fainted	• Terror • Loss	• They will hang me now • My daughter will be alone (no image)	• Raise blood pressure with jumping on spot • Imagery re-script of the whole thing being a play, actors leave, curtain comes across • Nice smell • Look around, see UK stuff

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Piglet time

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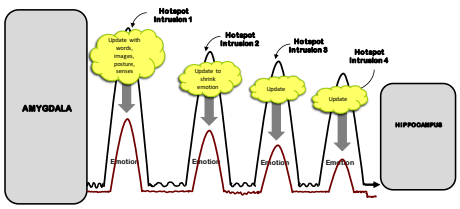
Treating Multiple Event Trauma - Updating



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For times when the feared thing did happen….

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Why is imagery so helpful

It has a great effort : results ratio!

Plus..it is so interesting..

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Seeing in the mind's eye: mental imagery

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Mental imagery

"**Mental Imagery** occurs when perceptual information is accessed from memory, giving rise to the experience of 'seeing with the mind's eye', 'hearing with the mind's ear' and so on.

By contrast, perception occurs when information is directly registered from the senses.

Mental images need not result simply from the recall of previously perceived objects or events; they can also be created by combining and modifying stored perceptual information in novel ways."

Kosslyn et al. (2001)

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Mental Imagery

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Mental imagery in cognitive therapy

- People often say imagery has more powerful impact on emotion than verbal cognition
- But does it?

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Mental imagery in cognitive therapy

Experimental evidence to show that imagery is important in CT because:

1. more powerful impact on emotion than verbal cognition
2. perceptual equivalence with real experience
3. impacts on learning and behaviour

Holmes & Mathews, *Emotion* 2005

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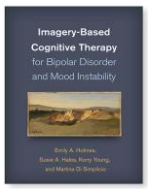
Marvellous new book: clinical manual



Guilford Press, May 2019

Forwards by Guy Goodwin and Gillian Butler

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Also, WTS explaining imagery 'science' handout

AND

Vimeo link:

Explaining science of imagery

https://vimeo.com/367231988/6aba6ecfa5

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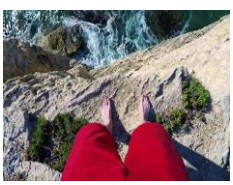
Which one has more of an effect on you? The picture or words?



I AM STANDING AT THE EDGE OF A CLIFF

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Verbal instructions

"Make a sentence to combine the next picture and word"

view

Imagery instructions

"Imagine the combination of the next picture and word"

view

Verbal instructions

"Make a sentence to combine the next picture and word"

jump

Imagery instructions

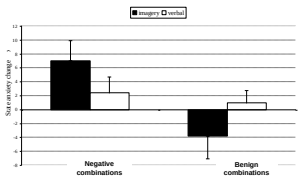
"Imagine the combination of the next picture and word"

jump

When combining the pictures and words, do **imagery** rather than **verbal** instructions have a greater impact on emotion?

State anxiety change (STAI)

Imagery → more powerful for both negative & positive material



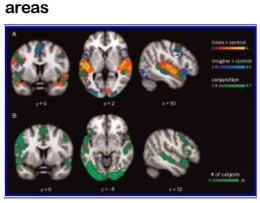
Holmes et al, *Emotion* 2008

Summary:

Imagining events is more emotionally powerful than thinking about them verbally

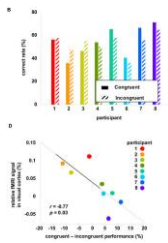
2. Images are perceptually equivalent to real experience

Imagery and perception activate largely overlapping brain areas



2. Images are perceptually equivalent to real experience

- Found for faces, scenes, shapes, music, motor tasks.
- Explains why mental practice of e.g. piano improves performance - and is reflected in corresponding changes in motor cortex (Pascual-Leone et al., 1995; Sirigu & Duhamed, 2001).
- Early visual cortex (V1) activated during visual imagery & **pattern of activation mirrors perception**.
  - Fusiform face area for faces seen/imagined
  - Parahippocampal place area for places seen/imagined
  - **If imagine increasingly bright lights, pupil contracts accordingly**
  - Patients with unilateral visual neglect showed the neglect even when imagining novel visual scenes (Bisiach & Luzzatti, 1978)
- *See Pearson et al., (2015) for good review*



32 ms
Same-colour interference

Vividness of imagery is correlated to greater brain activity in primary visual cortex and to worse performance on a colour-naming task

Cui et al, *Vision Res* 2008

In summary 1…

- So for example…
- If you have a frightening image the same bits of your brain 'light up' as when you are genuinely under threat
- Suggests the emotions are very similar in reality and in imagery

In summary 2…

- Plus..
- The more vivid/frightening you think the image is, so too does your brain
- The image will get in the way of doing other things

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In summary 3…

- Plus….
- Not only will images make you feel more afraid than just thinking about something
- They will make you behave in a more fearful way e.g. your heart will race, you may freeze/hide/jump….

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In summary 4…

- Imagery engages the neural structures involved in perception and those neural structures will affect the body
- It's all inclusive – like REALITY!

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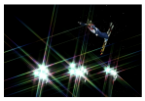
Not just a bad thing

- Sexual fantasy

- Mental practice e.g., sports psychology



Emily Cook, a U.S. freestyle aerials Olympian, goes beyond "visualization" in her training. "You have to smell it," she said. "You have to hear it. You have to feel it, everything."

"I would say into the recorder: 'I'm standing on the top of the hill. I can feel the wind on the back of my neck. I can hear the crowd,' " Cook said. "Kind of going through all those different senses and then actually going through what I wanted to do for the perfect jump. I turn down the in-run. I stand up. I engage my core. I look at the top of the jump.

"I was going through every little step of how I wanted that jump to turn out."

Cook then played the recording back as she relaxed, eyes closed, feeling her muscles firing in response. She said that such mental work helped her return to the sport a better jumper and that she also had used imagery to break the cycle of negativity. Whenever fear surfaced, she would picture herself pricking a big red balloon with a pin.

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In summary 1…

- So for example…
- If you have an image of yourself as safe/powerful, the same bits of your brain 'light up' as when you are genuinely safe/powerful
- Suggests the emotions are very similar in reality and in imagery

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In summary 2…

- Plus..
- The more vivid you think the image is, so too does your brain
- The image will get in the way of doing other things

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In summary 3…

- Plus….
- Not only will images make you feel more safe/powerful than just thinking about something
- They will make you behave in a more safe/powerful way e.g. heart rate slow, muscles relax/feel energized, strong posture, feel strong….

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In summary 4…

- Imagery engages the neural structures involved in perception and those neural structures will affect the body
- It's all inclusive – like REALITY!

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Can use imagery to update hotspots

- Can do 'on the hoof' in the hotspots
- Or prepare a bit outside of hotspot
- Or a bit of both

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How To Update A Hotspot With Imagery 'on the hoof'

Patient watching his brother being mock executed

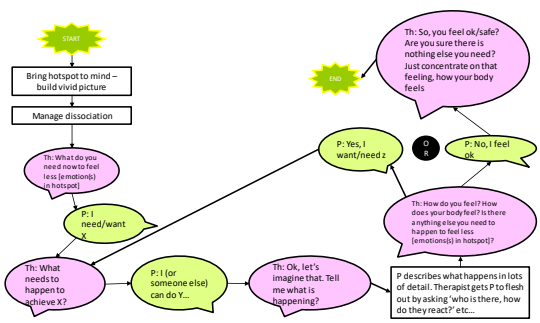
https://vimeo.com/560362805/a457069bf7

2nd hotspot:

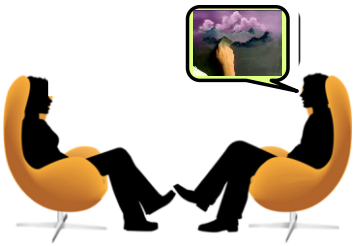
Taken out of cell, into room, bring in his brother, put rope around brother's neck

9:55 – 21:00

Baby sloth time



Start by helping the patient to bring a hotspot to mind. Build a vivid picture of the events



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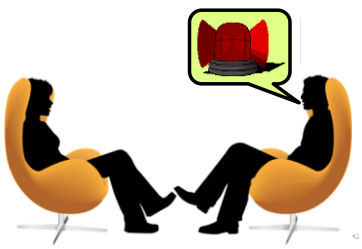
Help the patient to manage dissociation. "Try to stop it there, don't let it run on. " Get it clear but not overwhelming.



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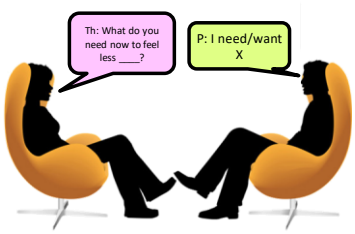
Therapist asks the patient questions about what they need to happen now to feel less [emotion(s) in hotspot]



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The therapist helps the patient to consider how this might happen

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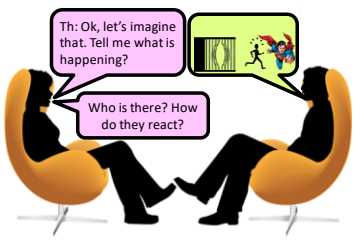
Patient then describes what happens in lots of detail. The therapist gets the patient to flesh out the narrative by asking questions.



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The therapist then asks the patient how they are feeling. If the patient feels ok then they can finish

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BUT It might be that the patient feels that something else still needs to happen…

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If this is the case, the therapist takes the patient back and they work through the cycle again until the patient feels like nothing more needs to happen

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How to explain this to clients

1. **Use pulse diagram and discuss need to shrink emotion**

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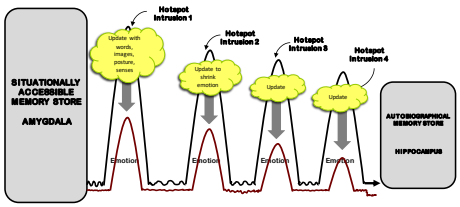
Treating Multiple Event Trauma - Updating



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How to explain this to clients 1

1. Use pulse diagram and discuss need to shrink emotion
2. Then take them through an explanation along these lines....
3. We can't change what happened - it was so awful – although we would like to- but we can change how you feel when you remember it
4. We can change how you feel by talking and reasoning, but we know from research that sometimes it is much more effective to use imagery to change these meanings, particularly with traumatic events like yours, that were so awful

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How to explain this to clients 2

1. Brain research shows that the brain responds in almost the same way to imagined events as to real events, even when the person knows that the event is imagined. This means that we can have a much stronger impact on the brain when we imagine things than when we just talk about them.
2. So, if we want to shrink the emotion in your hotspots, using mental imagery might be the best way
3. (Can talk more here about science of imagery for some patients if interested)
4. I will ask you to bring to mind the worst moment/hotspot. When it is clear in your mind, I will ask you to pause and think about your needs. By this I mean physical needs (like food, heat, water) but also your emotional needs (safety, freedom to express your feelings, connection to others, reassurance, justice, comfort, survival etc)... so..for example, if you are afraid, you might need comfort; if you think you are going to die, you might need to find a way to survive.

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How to explain this to clients 3

1. Then we will imagine that and see how that makes you feel and what else you need, and we will keep going until it feels better for you/until you don't need anything else
2. Using imagery also gives you the possibility to express your feelings, needs and actions that you had to suppress at the time. For instance, if somebody is attacked, he or she might feel the inclination to fight back. But, if it is very dangerous to fight back, people (often automatically) suppress this inclination. Although this can be a very sensible thing to do when you are powerless (the consequences of fighting back might have been disastrous), in the longer term, people can feel very bad about how they reacted at the time.
3. Similarly, if at the time you needed to escape or to make something stop, but you couldn't, using imagery we can try in imagination what you were prevented from doing back then, and see if it helps you to feel better as you remember it with me.

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How to explain this to clients 4

- Because this is in our imagination, you can be totally in control of what happens and what you do doesn't have to be real or possible. Some people use magical powers, some people use guns or special weapons they didn't have at the time, some people get God to help, some people imagine themselves/others intervening in the trauma…when we get to that part, something will occur to you and we can try it out and see if it makes you feel better. If it doesn't, we can rewind the image and try something else….we will get there in the end

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NB

- You should use a few ideas as possible that come from you… and as many as possible that come from them
- Your idea of safety might be their idea of Hell and vice versa
- With some clients, you may need to discuss the Rs and half plan before you update..eg with guilt and death

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Examples of how can we use this to deal with:

- Fear – Leila
- Guilt - Amir
- Shame - Maria
- Contamination – Asifa
- Loss - Nura

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Guilt

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How to use this to shrink guilt

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Amir – Background information

Clinical work carried out by Dr Zoe Chessell

- Male, early 60s, from Middle East
- Happy childhood
- Multiple careers, including a successful journalist
- **Imprisoned for three months and then later for two days**
- **Learnt that his wife had been murdered due to his career**
- Moved to the UK in 2016, now has Refugee Status

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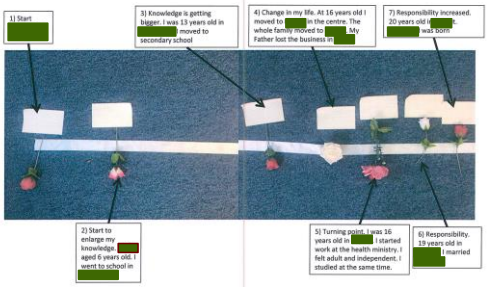
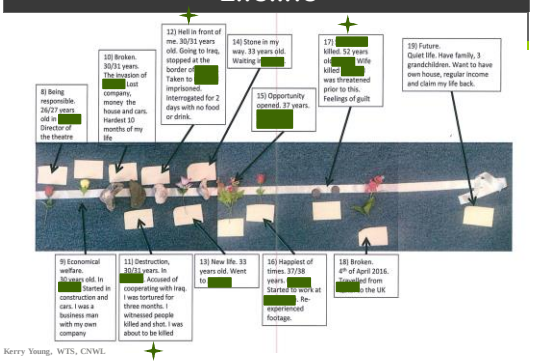
Lifeline



Kerry Young, WTS, CNWL

221

Lifeline



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Amir

Hotspot	Emotions	Appraisals	Meaning
Image of my wife falling to the floor after being shot She is bleeding There is no one there to help her	Guilt (felt physically like a heavy pressure on chest) Sadness	It is my fault she is dying If I did not work for them this would not have happened She will blame me for this If I had been there and she had got to the hospital she would be alive I cannot help her and she is going to die	It is my fault she is dying I am a bad person

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2 2 4

Why Guilt in PTSD

- Unpleasant feeling accompanied by a belief that one should have thought, felt, or acted differently in a negative event (personally controllable)
  - Responsibility for causing the event because:
    1. not **sharing responsibility** fairly
    2. should have known/did know **(hindsight bias)**
    3. **memory gaps** so assume responsibility
    4. minimize **own shock symptoms**/terror
    5. blame self for impossible choices/**Hobson's choices**
  - e.g. 'I caused this', 'I should be helping someone else', 'I knew this would happen…I shouldn't have done x'

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Working with guilt

- You can sometimes work on post-traumatic guilt later on in the protocol
- BUT mostly, guilt work is used to update hotspots
  - If guilt first felt peri-traumatically
  - If guilt felt shortly after trauma and seems to have 'backwashed' the trauma memory

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Useful paper with film links


A cognitive behavioural therapy (CBT) approach for working with strong feelings of guilt after traumatic events

Abstract

This article outlines a cognitive behavioural therapy (CBT) approach to treating feelings of guilt and aims to be a practical 'how to' guide for therapists. The therapeutic techniques were developed in the context of working with clients with a diagnosis of post-traumatic stress disorder (PTSD); however, the ideas can also be used when working with clients who do not meet a diagnosis of PTSD but have experienced trauma or adversity and feel guilty. The techniques in this article are therefore widely applicable to veterans, refugees, survivors of abuse, the bereaved, and healthcare professionals affected by COVID-19, amongst others. We consider how to assess and formulate feelings of guilt and suggest multiple cognitive and imagery strategies which can be used to reduce feelings of guilt. When working with clients with a diagnosis of PTSD, it is important to establish whether the guilt was first experienced during the traumatic event (peri-traumatically) or after the traumatic event (post-traumatically). If the guilt is peri-traumatic, following cognitive work, this new information may then need to be integrated into the traumatic memory during reliving.

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Working with Guilt in PTSD

1. Clear statement of what feel responsible for and why
2. "In my experience of working with people with PTSD, they can often overestimate their level of responsibility for what happened. Now, I don't know if that is the case for you, but would you be willing to explore it a bit with me? As I said, I do not know if you are or are not overestimating your responsibility, but it is worth having a look because the guilt can keep PTSD going and, as we know, having PTSD is causing x, y, z losses in your life…"
3. If they give permission, start with dominoes

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Guilt in PTSD

- Play clip of guilt pie chart video
- WARNING RE CONTENT AND case summary

https://vimeo.com/517267847/3e6555ef34

0:00 – 8:00 then ffwd to 32:00

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Treating guilt moments
For sharing responsibility fairly…

- Dominoes then:
  - Pie charts
  - Matches
  - Clay
  - Lentils
  - Shreddies!
  - Surveys to ask others

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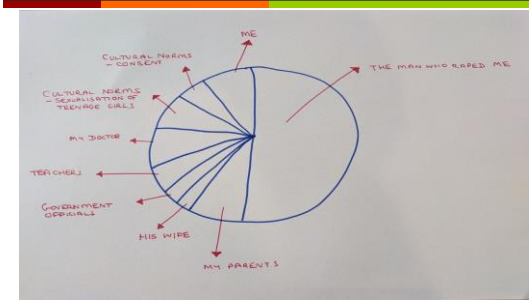
Responsibility Pie Chart



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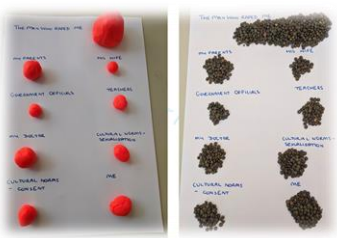
Guilt pie charts



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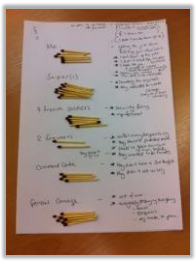
Guilt pie charts - matches –

c/o Phil Lurie



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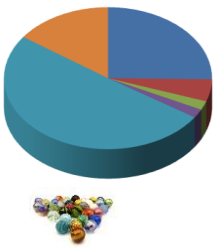
Amir Responsibility pie chart

"It is my fault she was killed" (strength of belief = 100%)

But is there anyone else who could be responsible?

1) Miltia group (25%)
2) The person who gave the order (5%)
3) The "gang" of the Middle East (15%)
4) The men who killed her (5%)
5) The job (2%)
6) Qais (50%)
7) Me (0%)



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Treating guilt moments
For hindsight bias…

- Socratic dialogue
- Guest and iron

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See knowledge and blame film

https://vimeo.com/517264352/09068b8df5

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Treating guilt moments

- For memory gaps
  - Reliving may fill in
  - Or create likely story
- For minimizing own responses
  - psycho-education re dissociation or fight/flight

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Treating guilt moments
For Hobson's choices…

End of the tunnel drawing
See film in paper

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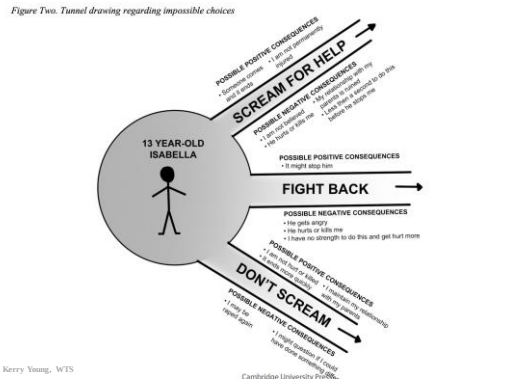

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Cambridge University Press...

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Using imagery in guilt updates

- Can use imagery to encapsulate/strengthen cognitive work for updates
- Do the cognitive work first and give client choice of trying words alone or words-plus-image as update

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Using imagery in guilt updates

- If they choose words-plus-image update, to generate image:
  - Get the patient to close their eyes while you/they say out loud the summary of the cognitive work
  - Tell them to relax and just notice what images pass through their mind
  - Encourage them to continue for a few minutes until one image seems better/stronger than the rest
  - If no one is better than the others, just pick the first one that came to mind..and try this first
  - Elaborate this image with them in the session, check it generates the desired emotions strongly i.e not guilty
  - If a bit weak, ask them what else they need in the image to feel less responsible……as in ImRs

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Amir

- Relived the trauma memory
- Identified hotspots
- Guilt hotspot – tried verbal updates, agreed with in head but still *feel* guilty
- Discussed how to use cognitive work on guilt within an image – to move what know 'from head to heart'
- Relived the beginning of the hotspot and introduced the image at agreed point and checked it reduced guilt

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Image	Rs image
My wife falls to the floor after being shot She is bleeding There is no one there to help her	My wife and my therapist lift the heavy rock of guilt from my chest and throw it off a mountain I say sorry to my wife and my wife tells me it is not my fault My wife touches me on my face gently and forgives me

Dr Zoe Chessell, BABCP 2019

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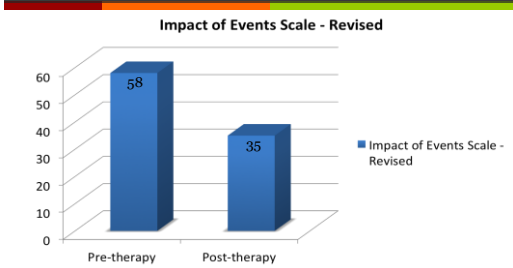
Outcome PTSD



This decrease remained six months later

Dr Zoe Chessell, BABCP 2019

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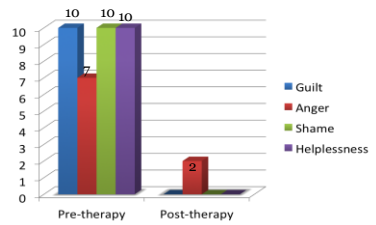
Outcome - feelings



This decrease remained six months later

Dr Zoe Chessell, BABCP 2019

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Amir's thoughts

Before the imagery work I felt responsible and guilty for my wife's death and I felt that if I was not her husband she would still be alive

After the imagery work I do not have flashbacks and nightmares to my wife's death. When she does come in dreams it is the image of you (Zoe) and my wife telling me I am not guilty

I am convinced I am not responsible and guilty now. However if I ever do feel this I think of your words and the image and it goes instantly

I would encourage anyone to do the imagery treatment. It was really excellent. I am like a locked box opened…

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Hedgehog time

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OxCADAT Guilt RESOURCES

Timestamps:

00:43 – Section 1: Appraisals that link to guilt and self-blame (Roleplay 02:20)
03:59 – Section 2: Spotting cognitive biases
05:47 – Section 3: The aims of cognitive restructuring
06:26 – Section 4: Helpful questions to ask
07:21 – Section 5: Working with hindsight bias (Roleplay 08:16)
10:38 – Section 6: Responsibility pie charts (Roleplay 11:56; Patient Testimony 16:55)
20:58 – Section 7: Surveys
21:42 – Section 8: Exploring other actions
22:40 – Section 9: Addressing maintaining behaviours and cognitive strategies
23:51 – Section 10: Letting go of guilt
25:15 – Section 11: Helping people who are responsible
27:45 – Section 12: Summary of key interventions

Examples of how can we use this to deal with:

- Fear – Leila
- Guilt - Amir
- Shame - Maria
- Contamination – Asifa
- Loss - Nura

Shame

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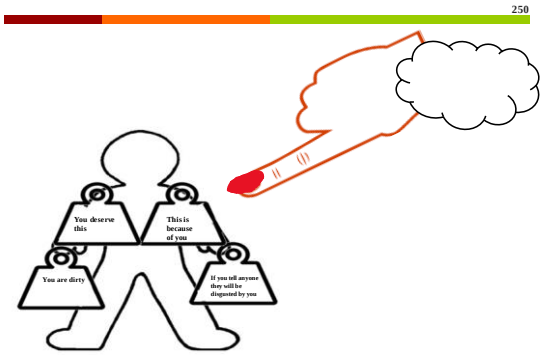

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Using imagery to update shame

- Aim is to move the red shiny fingernail off you and onto the people who deserve it:
  - seeing faces of abusers/assailants ashamed as they are reprimanded for their actions
  - punishing them
  - educating them

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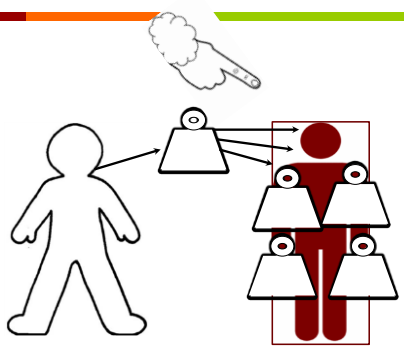

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Updating shame

- Aim is to move the red shiny fingernail off you and onto the people who deserve it:
  - With words – discussions to get to "It is they who should be ashamed"
  - With imagery:
    - seeing faces of abusers/assailants ashamed as they are reprimanded for their actions
    - punishing them
    - educating them
- OR point at all of us
  - Psycho-ed about dissociation or involuntary sexual arousal/lubrication during rape or wetting/soiling self during torture
  - depersonalizing methods of abusers/assailants/torturers

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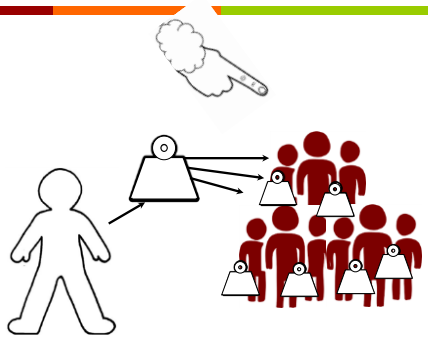

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Pointing at all of us

- Involuntary erection very common in men during rape or forced sexual activity
  - 88% reported erection during forced sexual activity
  - Struckman-Johnson C, Struckman-Johnson D. Men pressured and forced into sexual experience. Arch Sex Behav 1994;23:93–114
- Involuntary orgasm common in men & women during rape
  - 5-20% rates in literature
  - Levin & van Berlo (2004) doi:10.1016/j.jcfm.2003.10.008
- Involuntary lubrication, engorgement etc in women during rape – it is protective and automatic
  - Kime ZR. Aberrant sexual behaviour, violence and reproduction. J Sex Ed Ther 1993;18:231–32
- Wetting/soiling self when very afraid very common and caused by fight or flight response

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Pointing at all of us

- Dissociation during rape more or less inevitable
- Kerry has never seen someone with PTSD to rape who didn't dissociate peri-traumatically
- It is automatic and part of the Defence Cascade – to keep you safe
- Big strong men, big strong women, everyone does it

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Depersonalizing abusers/assailants Examples…..

- Helpful to discuss how grooming works, how abuser will make child feel special and only very slowly start to do harm
- So child may enjoy being with this person at times
- Children are taught to obey adults, so abuser will use that
- Abusers commonly threaten others/disbelief/punishment if tell
- Child does not know something is inappropriate or, if suspect, abuser will contradict
- Abuser acting really normally afterwards implies nothing untoward has happened eg make breakfast after rape, say "Did you enjoy that?," suggest another date

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Updating shame

- Aim is to move the red shiny fingernail off you and onto the people who deserve it:
  - With words – discussions to get to "It is they who should be ashamed"
  - With imagery:
    - seeing faces of abusers/assailants ashamed as they are reprimanded for their actions
    - punishing them
    - educating them
- OR point at all of us
  - Psycho-ed about dissociation or involuntary sexual arousal/lubrication during rape or wetting/soiling self during torture
  - depersonalizing methods of abusers/assailants/torturers

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Updating shame

- OR soothe away the shame:
  - compassionate imagery
  - cleaned up/covered up

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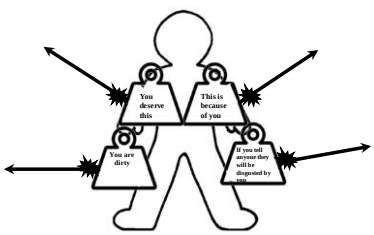

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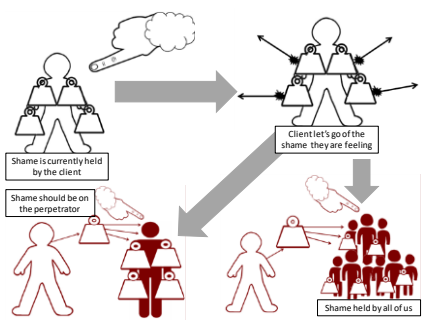

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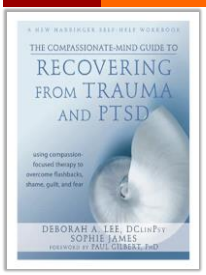
Useful for shame and self-blame



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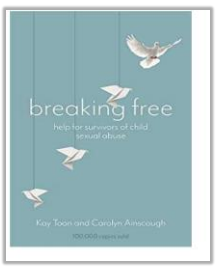
Useful for shame and self-blame re childhood abuse



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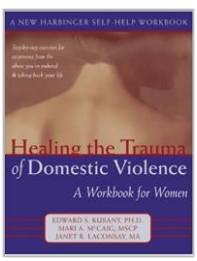
Useful for shame and self-blame re domestic abuse



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- Working with different cognitive themes and emotions in PTSD
  - Working with an overgeneralised sense of danger
  - Working with guilt
  - Working with shame
  - Working with anger
  - Working with rumination
  - Working with degradation, mental defeat, and low self-worth
  - Working with disgust and mental contamination
  - Working with patients who are traumatically bereaved
  - Working with patients with permanent physical injury

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Case example: Maria

- 53 year old woman originally from Africa
- 47 year history of abuse and rape
- 3 x fled from one country to another
- Living in UK without recourse to public funds- asylum claim refused
- Homeless

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Maria : Example of ImRs: (first time raped by teacher at 13 yrs)

from Reem Shafiq and Kerry Young BABCP symposium 2017

Hotspot	Update RS
Raped for 1st time by teacher in his home (13 yrs) **Feels dirty, ashamed, frightened**	**Imagines hurting the teacher - grabs 'chairs and all the tables' and throws them at him. He tries to run away but chases after him, grabs him, 'throws him away'. Shouts at him 'look at what you've done to me you dirty man!'** **She calls the police from the phone in reception and tells them, 'Come and get him!' 'He raped me! Come and get him, he's standing here now!' She imagines 'he can't run away' as other people are here surrounding him. They think he's done wrong'. 'If he wants to run away they won't let him go.'** **Police come and take him away, 'they lock him up.' She gives statement to police. He is prosecuted.**

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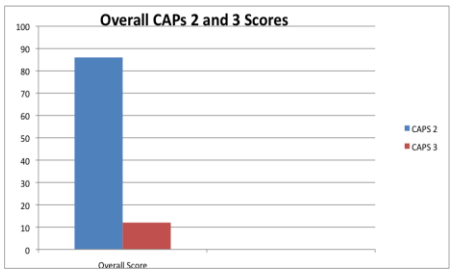
Maria Outcomes - PTSD



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Examples of how can we use this to deal with:

- Fear – Leila
- Guilt - Amir
- Shame - Maria
- Contamination – Asifa
- Loss - Nura

IAPT RAS training 2021-2023, Kerry Young & Sameena Akbar, WTS

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Contamination

- 30-40% of WTS patients report pervasive feelings of contamination years later
- Mainly sexual fluids but also smells of burning, dirty prison cells/rooms, sweat, urine, smoke, gunpowder, dead bodies
- Often think others can see or smell it too
  - "I have the idea that body fluids from the perpetrator are in my blood, flowing through my body"
  - "I smell their sweat and body fluids and others smell it if I sit next to them"
- Imagery particularly useful here…..you can't update a smell or taste with words

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Cognitive Re-scripting and Imagery Modification (CRIM) for reducing the FBC
The RCT (Jung & Steil, 2013) (IN FOLDER)

- Two session standalone intervention for FBC in adult survivors of CSA with chronic PTSD
- In addition to eliminating FBC, remission from PTSD in 35.7% of the patients in the treatment group compared to 7.1% in the wait list condition

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How to use CRIM to update a hotspot

1. Explore the contamination – smell, taste, sensation, what does it look like?
2. Draw on outline….

Thanks to Regina Steil

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Outline

Thanks to Regina Steil

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How to use CRIM to update a hotspot

1. Explore the contamination – smell, taste, sensation, what does it look like?
2. Draw on outline
3. Give dry feet explanation about cell renewal
4. Find out scientific information regarding the frequency of renewal of the human skin/internal body cells they feel are contaminated

Thanks to Regina Steil

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Cell Regeneration Information

Small intestine	4 days -	Dead cells leave body as feces
Cervix menstrual/vaginal	6 days -	Dead cells leave body in discharge
Sperm (inside another body) menstrual/vaginal	7 days -	Dead cells leave body in discharge or as feces
Stomach	9 days -	Dead cells leave body as feces
Mouth	10 days -	Dead cells leave body as feces
Skin	30 days -	Dead cells fall off body
Vagina and vulva vaginal	30 days -	Dead cells leave body in menstrual/ discharge
Blood cells	4 months -	Dead cells leave body as feces
Nose	10 days-	Dead cells leave the body in snot and as feces

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Good resources on cell renewal

- Skin renewal:

  https://www.youtube.com/watch?v=kT88G56YWKE - this is from an advert for skin care products but it has a good animation of dead skin cells falling off

  https://www.youtube.com/watch?v=47CuzkUDkm8 - this is an animation following one skin cell from the lower levels of the skin until it falls off. It has a day counter so you can visually see the 28 day cycle

- Full body cell renewal: https://www.youtube.com/watch?v=Nwfg157hejM - this is from a talk show discussing 'how old your body really is' but it highlights different parts of the body (stomach, skin, red blood cells) and their different cell lifespans. I'm not sure how useful the whole video is but clips might be good.

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How to use CRIM to update a hotspot

1. Explore the contamination – smell, taste, sensation, what does it look like?
2. Draw on outline
3. Give dry feet explanation about cell renewal
4. Find out scientific information regarding the frequency of renewal of the human skin/internal body cells they feel are contaminated
5. Calculate how often the patient's cells have been renewed since the last contact with the contaminant
6. **Construct mental image of new information about cell renewal** (repeat information and notice what images spring to mind, pick one and work it up)
7. **(Listen to recording at least once daily for a week/practise without recording)**
8. **Insert, to update the hotspot, check working…if not, what else do they need to feel cleaner/less contaminated?**

Thanks to Regina Steil

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Examples of "clean" images

- A magical laser cleans the skin
- Get out of old skin like out of a wetsuit, burn it
- Clean with the help of a high-pressure cleaner
- Dirty feeling taken out and buried in ground, never to come up again
- Magical cleansing shower, feeling of being clean, clean teeth and minty breath

- Bathing in a holy pool of water, with roses and lilies floating in it, watching the dirt float away, coming out and being wrapped In clean, white towel
- On a beach, walk slowly to the sea and lay in shallow water, the waves crash over them and clean them
- Picturing skin renewing hundreds of times, like a snake shedding its skin
- Winding like a snake in the desert in the sand, while external skin cells are replaced

Thanks to Regina Steil

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Case example: Asifa

- Multiple rapes in prison
- Feeling of semen on thighs, smell of urine
- Won't sit near therapist because she fears therapist can smell rapist's bodily fluids on her

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Imagery for contamination

- Used Jung and Steil protocol
- Researched how often cells in body turn over both inside and out
- Asifa creates very vivid image of her descending into a beautiful orange-scented pool. Hears birds, feels fresh air
- Then 'clean' image used to update hotspot

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What do clients say?

Before I used to put my head down on the street. Now I will raise my head today and the first time I feel that I am strong and I am a new person

I feel active, I feel comfortable. I went to psychotherapy for a year but this is the first time I have seen change. Even my mother noticed the change in me. Before when we had guests my mother told me to bring out tea and water but I felt shy and ashamed. Now I don't feel that. I can communicate with others and go to the shop.

Sam Akbar & Kerry Young, CNWL, UK

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See CRIM film links

Characterise the FBC and do research for clean image

https://vimeo.com/559650949/10c5670236

Generate clean image

https://vimeo.com/559653045/938c041f17

Swap in clean image

https://vimeo.com/559649927/acdb5a0ad9

Thanks to Regina Steil

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Cute baby time

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Examples of how can we use this to deal with:

- Fear – Leila
- Guilt - Amir
- Shame - Maria
- Contamination – Asifa
- Loss - Nura

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Traumatic death

- If there is traumatic death in a hotspot, they will keep re-experiencing the moment of death
- If you keep re-experiencing the moment of death, the death isn't over yet
- If the death isn't over yet, you cannot grieve and adjust

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Traumatic death

- To help someone grieve, need to reduce re-experiencing of death
- To reduce re-experiencing of death, need to process trauma memory
- To process trauma memory, need to reduce emotion in moment-of-death hotspot
- What is not real/imagined may be best way to reduce emotion
- Not invalidating death, simply trying to stop it repeating for ever, allowing person to mourn

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When the dreadful thing does happen...traumatic grief

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Options

- **Prevent it**
- Try getting the person to update by imagining what they would have liked to have done but couldn't e.g. cover a dead person with a blanket or say goodbye or wash the blood from a dead person or carry someone home.
- Can also help to imagine that person is at peace, and isn't suffering anymore e.g. in Heaven or a peaceful place
- **Bury with cultural burial rites**
- **Conversations with dead person**
- **Terrible revenge!**
- **Very specific ones e.g. Eminem/George Michael/Dwayne The Rock**

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Case Overview: Nura

work carried out by Millay Vann

- 27 year old female refugee from North Africa
- At age 16 witnessed the murder of her family and was raped by soldiers

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Nura
From Presentation by Millay Vann and Kerry Young, BABCP Conference 2014

Hotspot	Thoughts	Sensations	Emotions	Rs
Seeing dad's face covered in blood; my hands on his face covered in blood	They have killed him I have to help him	Sight of blood on my hands Feeling of sticky warm blood on my hands	Shock Fear	He opens his eyes and we say goodbye. I lovingly clean the blood off of his face and body; I kiss and hug him and put a white blanket over him. There is no blood on me now – use feather on hands

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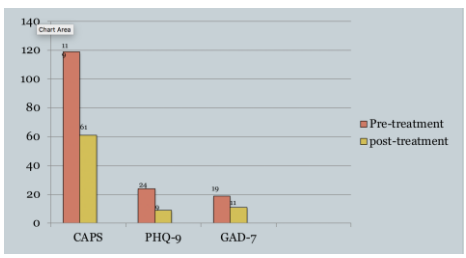
Nura Outcomes



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Nura Outcomes

Measures (2 week period)	Pre-treatment	Post-treatment
Hours of leisure, social, occupational or housework activities	6	41
Number of GP visits	2	0

By the end of treatment, Nura was:

- Attending weekly women's swimming classes
- Attending weekly maths classes as a community college
- Going out daily for food shopping or walks
- Enrolled in a befriending scheme and waiting for a mentor
- Living in her first independent flat

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Remember……

- Doesn't matter if it isn't real
- Just trying to shrink the emotion enough

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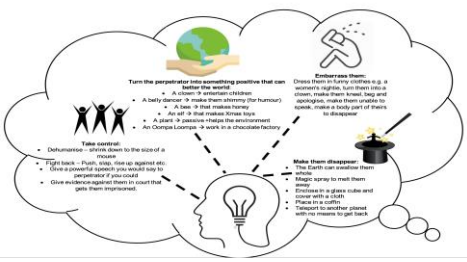
List of Imagery update ideas from WTS patients over last 5 years



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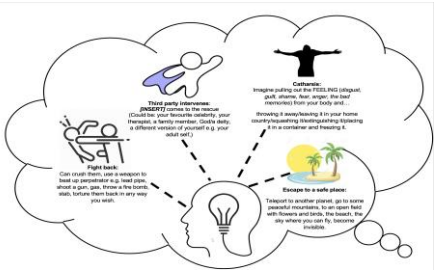
List of Imagery updates ideas from WTS



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Questions about use of imagery?

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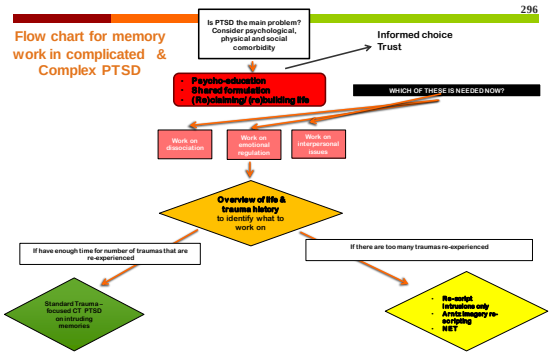

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Other arm example

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Zara

- Zara, 45
- Referred by primary care
- Actively self-harming
- History of CSA, domestic violence and rape
- Working part-time
- Lives alone
- Has a boyfriend but difficult relationship
- Not many friends
- One daughter aged 23, sees quite regularly
- History of alcohol abuse

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Trauma Account

- Sexually abused by mother's boyfriend between 11-13
- Told mother who told her to 'stop lying'
- Emotional and verbal abuse by mother
- Heavy use of alcohol and drugs during teens
- Self-harm started age 14 - cutting
- Left home aged 16 - things better
- Aged 20 got married
- Domestic violence and two instances of rape
- Became very isolated
- Increase in self-harm, more frequent
- Daughter born
- Separated from husband soon after

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Psychological Presentation

- Having flashbacks and intrusions to childhood abuse and rape as an adult
- Nightmares to a number of DV incidents - afraid to go to sleep
- Dissociation
- Distress around men resembling ex-partner
- Drinking heavily
- Self-harming
- Isolating herself
- Preoccupied with housing situation - problems with tenancy
- Blaming herself for 'letting this happen', shame about symptoms and traumas

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Treatment

- Circles established could focus on PTSD (and wanted to)
- Trust discussed
- Alternatives to DSH agreed, no drinking before sessions
- Friend to support identified
- Psycho-ed re PTSD and dissociation
- Try out grounding materials
- **3 sessions**

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Zara's List of Intrusions

A. Nightmare of time husband beat me with baby in arms
B. Nightmare of husband trying to strangle me when pregnant
C. Nightmare of husband chasing me down the road
D. First time raped by John - flashback
E. Smell of semen - flashback
F. Forced oral sex John - flashback
G. First rape by husband -flashback
H. Standing in bathroom ashamed age 11 – flashback
I. John's twisted angry face – threatening - flashback

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Too many traumatic events re-experienced for tCT-PTSD

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Treatment

- Made list of intrusions and kept diary over week
- Agreed order to address – chronological
  1. Forced oral sex John
  2. Standing in bathroom ashamed age 11 –
  3. First time raped by John
  4. Smell of semen
  5. John's twisted angry face – threatening
  6. Husband trying to strangle me when pregnant
  7. Husband beat me with baby in arms
  8. First rape by husband -flashback
  9. Husband chasing me down the road
- Relived the beginning of the intrusion until the worst part and then asked what need now….
- One re-scripted per week – 8 sessions
- Rape re-scripts required jumping on the spot to manage dissociation

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Intrusion	Rs
• Forced oral sex John	Therapist and Shami Chakrabarti protect child, shame John, posters on lamp posts
• Standing in bathroom ashamed age 11	Cleansing guardian angel, "This is not your shame".. John dissolved into crumbs, flushed down loo
• First time raped by John	Adult self plus baseball bat and Shami
• Smell of semen	CRIM image of lemon shower
• John's twisted angry face – threatening	Adult self, "You're a paedophile" police arrive
• Husband trying to strangle me when pregnant	Guardian angel zaps away then patient yells at husband, he runs away
• Husband beat me with baby in arms	Wall of protectors around Zara and child, police arrive
• First rape by husband	Baseball bat, he runs away
• Husband chasing me down the road	No need

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Treatment

- 3 sessions on stimulus discrimination re people who look similar to ex-husband

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Video: Trigger Discrimination

https://oxcadatresources.com/covid-19-resources/

In the next therapy clip, the therapist and patient are using Then vs Now to work on an audio trigger of the trauma memory – the sound of screeching brakes.

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Treatment

- 3 sessions on stimulus discrimination re people who look similar to ex-husband
- DSH stable then eases after ImRs session 5
- Drinking stable during tx then plan to reduce afterwards
- VAS shame, fear and guilt all reduce
- Intrusions reduce steadily

Kerry Young, WTS

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Duckling time

Kerry Young, WTS

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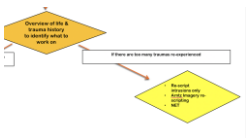
This other arm



- Re-scripting of intrusions very similar to Arntz method
- Arntz method- Client chooses what to work on, might not be just intrusions, could be meaning-related, stuff that has impacted on view of self etc

Kerry Young, WTS

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So now Arntz uses ImRs to re-script child and adult traumas

ADULT TRAUMA

- Imagine beginning
- Imagine somebody (yourself, another person, a fantasy figure) intervenes and changes the outcome:
  - Realize and meet needs
  - Express inhibited responses
  - Change the meaning you have taken from the memory

CHILD TRAUMA

- Imagine beginning (child perspective)
- First half of the total number of sessions: Therapist intervenes to change outcome for child (therapist directs action and then hands over to child)
- Second half of the total number of sessions: Patient's adult self intervenes to help the child (adult self perspective) then patient goes back to child perspective as their adult self intervenes

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Arntz method: Therapist leads re-script childhood abuse

- Patient describes trauma from child-self perspective, reliving in detail up to agreed pause point (therapist asks questions as per normal reliving)
- Therapist says "Now stop it there, don't let it run on, I want you to imagine that I have entered the scene (I am big and powerful), can you see me there? What am I wearing? How do I look?"
- Therapist then says tells patient that they re placing themselves between the perpetrator and the child, to keep the child safe, check patient can see/imagine that
- Therapist then admonishes the perpetrator and sends him away (e.g. "You should be ashamed of yourself hurting a little girl/boy like that. It is a terrible thing to do. It is against the law in every country in the World. I will not let you hurt x again. Now go."

Kerry Young, WTS, CNWL

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Arntz method: Therapist leads re-script childhood abus

- If perpetrator is a relative, try and avoid characterological admonishment and favour behavioural (as may be too much for the 'child')
- Therapist then turns to the child once the perpetrator has gone and asks them what they need (remind, doesn't need to be real or possible, can imagine anything they want)
- Try and hand over to the patient at this point, going round the need-imagine-feel-need cycle as for adult traumas.

Kerry Young, WTS, CNWL

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Arntz method Patient leads re-script childhood abuse

- Patient describes trauma from child-self perspective, reliving in detail up to agreed pause point
- Therapist says "Now stop it there, don't let it run on, I want you to imagine that your adult self/yourself as you are now has entered the scene. Can you imagine that? Are you there? Tell me what you see"
- Therapist then says "What do you need to happen now? "
- Go round the cycle until the patient in their adult self doesn't need anything else
- Therapist then says "I want you now to see things from the perspective of your child self – can you imagine yourself back inside their body? What do you need to happen now? "
- Go round the cycle until the patient in their child self doesn't need anything else

Kerry Young, WTS, CNWL

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Film of ImRs to childhood trauma

Childhood Abuse - Therapist Rescripts:

https://vimeo.com/454087987/1b7841cdb9

Childhood Abuse - Patient Rescripts:

https://vimeo.com/454086724/cba6a7e19d

Kerry Young, WTS

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Meta-analysis of ImRs

Imagery rescripting as a clinical intervention for aversive memories: A meta-analysis

Neshmedin Morina [a, *], Jaap Lancee [b], Arnoud Arntz [b]

Journal of Behavior Therapy and Experimental Psychiatry

Woodfield Trauma Service, London UK

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Meta-analysis of ImRs (2017)

- 19 trials (7 RCTs)
- Most PTSD/SAD also BDD, BN, MDD, OCD
- 8 PTSD trials (including 5 to childhood abuse/multiple TE)
- Range number sessions 2-16, mean <7
- Effect sizes (Hedges's g) 0.997 (large) – 2.499 (gigantic!!)
- Average pre-post Effect Size = 1.48
- Preferred by therapists
- As well as Sx reduction, get reduction in vividness/distress associated with images
- NB few RCTs (3) and then fewer active control conditions (2).

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Recent new directions for Arntz method – adult trauma, psychosis, refugees

Imagery rescripting for the treatment of trauma in voice hearers: a case series

Behaviour Research and Therapy

Imagery Rescripting as treatment for complicated PTSD in refugees: A multiple baseline case series study

Arnoud Arntz, Dana Sofi, Gerard van Breukelen

Woodfield Trauma Service, London UK

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Recent new directions for Arntz method – adult trauma, psychosis, refugees

European Journal of Psychotraumatology

Brief imagery rescripting vs. usual care and treatment advice in refugees with posttraumatic stress disorder: study protocol for a multi-center randomized-controlled trial

Regina Steil , Franziska Lechner-Meichsner , Johannes Johow , Antje Krüger-Gottschalk , Ricarda Mewes , Jana-Peter Reese , Hannah Schumm , Cornelia Weise , Neshmedin Morina & Thomas Ehring

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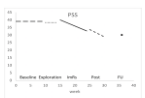
WOODFIELD TRAUMA SERVICE

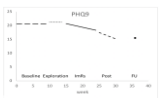
ImRs case series preliminary results

PTSD

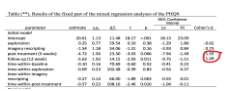


Estimated fixed means for the PSS from the final mixed regression model.

Depression



Estimated fixed means for the PHQ9 from the final mixed regression model.



Steel et al. in prep

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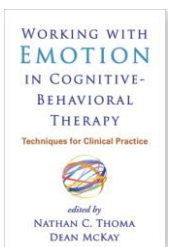
For adult survivors of childhood trauma



- ISBN 9781462517749
- 2014
- Chapter by Arntz

Woodfield Trauma Service, London UK

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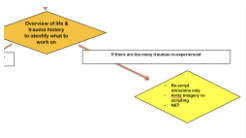
This other arm

- Narrative Exposure Therapy (NET)…



Kerry Young, WTS

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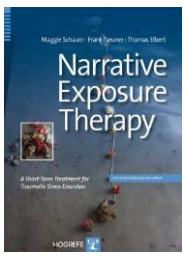
Narrative Exposure Therapy (NET)



- Schauer, Neuner, & Elbert (2005)
- For survivors of multiple, repeated or prolonged traumatic events
- Developed initially for use in refugee camps
- Overarching aim of therapy is to embed traumatic experiences within the autobiographical context of the individual's life and to process painful emotions
- KIDNET for children and FORNET for combatants and offenders
- Most evidence within refugee and asylum seeker populations
- 10-12 sessions

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Evidence for NET

- 56 studies NET, KIDNET, FORNET
- 30 countries
- Comparing 1370 participants treated with NET vs. 1055 controls
- Analysis studies with active controls:
  - small to medium effect sizes at end tx
  - large effect sizes after 6 months

Introduction to NET, Kerry Young, WTS, CNWL

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Introduction to NET, Kerry Young, WTS, CNWL

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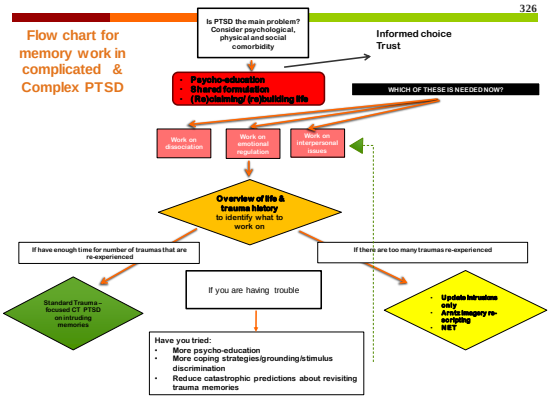

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Catastrophic predictions

- What exactly do they fear? What is the very, very good reason they are not taking your marvellous advice? Go mad? Overwhelm therapist? Disgust therapist? Worse for years and years? Then wife leave? Heart attack? Death?
- Go right to the end of prediction – can't argue against something if don't know what it is
- Then reassure - already re-experience the worst bits and cope….this is just 'joining up the dots' between the worst bits
- Coped with it then, can definitely cope with retelling it with a lovely therapist while being safe
- Kerry has supervised about 1000 cases of PTSD in refugees – with all sorts of therapists- and no one has ever gone mad/fallen apart/been hospitalized/died

IAPT RAS training 2021-2023,Kerry Young & Sameena Akhtar, WTS

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Catastrophic predictions

- Do we need to revisit coping strategies or plans for what will do after sessions?

Looking after ourselves

The Therapeutic Relationship in PTSD – predicting/preventing threats to the alliance

THERAPIST/SERVICE FACTORS

- Exposure techniques are underutilised in treatment of PTSD, despite well-established efficacy (van Minnen et al., 2010)
- Due to therapists' concerns about:
  - client drop-out
  - re-victimisation/exacerbation of symptoms
  - exposure might damage to the therapeutic alliance (e.g. Cahill et al., 2006).
- Therapists may also doubt their own ability to cope with hearing the content of trauma narratives
- Therapists remind themselves trauma-focused approach is evidence based
- Using evidence-based treatments for PTSD is associated with greater compassion and satisfaction and less burnout in therapists (Craig and Sprang, 2010)
- Crucial to use supervision to manage reactions to the stories
- Ensure session limits are used wisely to maximise space for completion of memory-based work

Tips for therapists

1. Remind yourself of the evidence for trauma focused therapy and the underlying memory theory
2. Remind yourself of how happily trauma therapists endorse this research
3. Remind yourself that all rapes/torture involve a great deal of dissociation so there is likely to be little detail of the worst bits

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Tips for therapists

4. Remind yourself that torture/rape/abuse is a crime/war crime. It works because the abuser's/torturer's/rapist's intention is that the person will never be able to discuss it, so s/he will suffer for the rest of their life.
5. As you and your client discuss it, you defy the abuser/torturer/rapist and help the patient defy him/her
6. Roll all of this into a feminist/human rights armour and put it on you to protect you as you talk it through

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Tips for therapists

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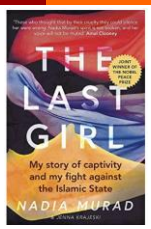
The Last Girl: My Story of Captivity, and My Fight Against the Islamic State



"Every time I tell my story, I feel that I am taking some power away from the terrorists."

Nadia Murad

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The best favour you can do someone who has been raped/tortured/abused and has PTSD is…

Do trauma-focused therapy so they can stop re-living it every day

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From recent patient..

"If you treat me as fragile, I will stay fragile for ever and not be able to adjust to my new life in the UK, or be a good father, or be a good friend…please don't treat me as fragile."

" I think that therapists should be more realistic and don't let emotions cloud their judgement about what is good for their patients."

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Emotion in sessions

- It is inevitable that you will feel like crying in some sessions
- It is inevitable that you will feel overwhelmed in some sessions
- SO. YOU. SHOULD
- It is terrible what has happened to these people
- They are not expecting you to be stony faced – they will think it strange…their abusers/torturers/rapists were stony faced
- It is OK to show that you are moved by what they say, to tear up even
- Say what you feel, be authentic, "That is so sad, I am so sorry that that happened to you"

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Emotion in sessions

- Occasionally, patients tell you they are worried that you won't be able to cope with what they tell you
- If then you cry a little in session, make sure you say something like:

"It is so sad to hear this and you can see that it is affecting me but I am so glad that you have been able to share it with me, trust me with this story. I know that your sharing it with me is the start of me helping you to stop reliving this event as flashbacks/nightmares"

- Look out for each other in the team too – letting out your feelings prevents burnout

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Crying is ok

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Do whatever works for you – this is what works for Kerry

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Plan

- Introduction to complicated/Complex PTSD presentations.
- Clinical pathway to follow:
  - How to assess and formulate more complicated/Complex PTSD
  - What to consider and what to do about difficulties with engagement
  - What to consider and what to do about difficulties with emotional regulation
  - How to understand and manage dissociation in this group
  - How to treat complicated/Complex PTSD using Ehlers et al's tCT-PTSD as a guiding framework
  - How to work with some of the themes common in complicated/Complex PTSD e.g. shame, guilt, loss, contamination

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So what is different for more complex cases?

Really important message:

- To treat more complex PTSD cases DO NOT THROW THE BABY OUT WITH THE BATH WATER
- Use the same model and flex it
- The same techniques are required for PTSD and CPTSD
- Get to the memory work asap – end of!

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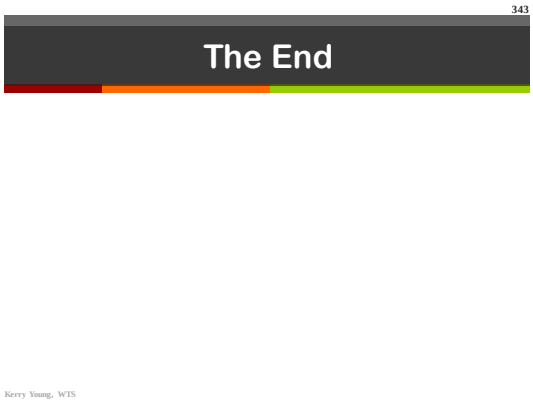

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