INTERSECTIONS BETWEEN TREATMENT FOR CPTSD AND EUPD/BPD:

THE *PRISM* PRINCIPLES AND OTHER RECOMMENDED TREATMENTS

4TH INTERNATIONAL TRAUMA INFORMED CARE ONLINE CONFERENCE
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AGENDA

- I. Naming: shift in orientation
- II. PRISM Principles
- III. Treatment Guidelines
  - Recommendations
  - Sequencing?
  - Intersections/overlaps and customization

NAMING

- What's in a name?
- A lot!
- Especially when it is Borderline Personality Disorder and what it connotes!!!!

GUIDING PRINCIPLE OF TIC

First, Do No ***More*** Harm!!!

"Complex and ongoing developmental traumas not unnaturally produce psychological conditions that likewise are complex and ongoing. Yet throughout the history of psychiatry, it is both fascinating and alarming that individuals with such conditions have been prominently subjected to invalidating or incorrect diagnoses."

(Middleton, Australian ASCA Guidelines, 2012, p. xi)

NAMING, BLAMING, SHAMING

- Not only that:
- Historically, sexism and sex stereotyping have played a large role in naming
  - BPD applied particularly to women and their range of symptoms (formerly known as hysteria)
  - Insult to injury
- BPD has been a diagnosis that connotes relational and emotional instability, impulsivity, danger to self and others, major headaches for the treating therapist, and pessimism about recovery.
  - Knee jerk reactions on the part of therapists are common: judgment, dislike, stigma, hopelessness
  - These reactions may be shared by others and become internalized by the client who equates their symptoms with their identity and self-worth and whose identity is shame-based.
  - NOTE: TIC movement developed by disgruntled and hurt clients

NAMING

- Herman (1992) suggested that when trauma occurs repeatedly over the course of childhood especially (but in other developmental epochs as well), it enters and impacts personality development. She called it Complex PTSD

- Other writers (Classen et al., 2006) suggested Post-traumatic Personality Disorder to emphasize the impact on personality development

- *DSM* did not go in this direction, except to keep the BPD nomenclature

NAMING

- **Some similarities between CPTSD and BPD/EUPD**
  - Both are developmental trauma disorders when they originate in childhood attachment difficulties and abuse by parents/caregivers who are impaired or incapable
    - Lack of attention, lack of mirroring, non-response, and non-protection
    - All forms of child abuse, major separations and losses (adverse childhood experiences that result in toxic stress)
    - Emotional abuse involving invalidation, animosity, bullying
  - Overlap between the two in terms of major characteristics

NAMING

- **Some differences between CPTSD and BPD/EUPD**
  - BPD: emotional regulation difficulties, esp anger; frantic efforts to avoid abandonment, unstable sense of self, unstable and intense interpersonal relationships, impulsivity, self-injury and suicidality
  - CPTSD: emotional regulation difficulties, identity issues including negative self-concept and cognitions, relational avoidance, self-injury/suicidality in some
    - Not all forms of CPTSD are the same (Elklit et al, 2014): spectrum disorder, some with more PTSD and others with less
      - CPTSD associated with more depression, anxiety, dissociation, sleep disturbances, somatization, interpersonal sensitivity, and aggression

SHIFT IN ORIENTATION

Naming VS Labeling

What *happened to you* versus what's *wrong with you*? (Bloom)

It's *not you*, it's *what happened to you* (Courtois)

Is it even a disorder? Or should we call it an injury?

RE-ASSESS CLIENTS AND EDUCATE AS NECESSARY

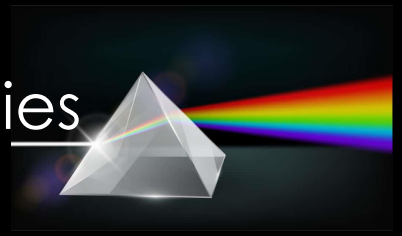
- Those with:
  - History of complex trauma and childhood adversity
- Diagnosis of:
  - BPD/EUPD
  - Schizophrenia
  - Bi-polar
  - ADHD
- May be accurate or not or may be dual diagnosis

TWO CASE EXAMPLES

- One of my clients: “I am a Borderline!!!!!”
- Stephanie Foo: I finally got my diagnosis and it made me overwhelmed and depressed. How can I ever get better?
- Recognition of resilience, creativity, strength, and “superpowers” can create hope and a resolution to heal.

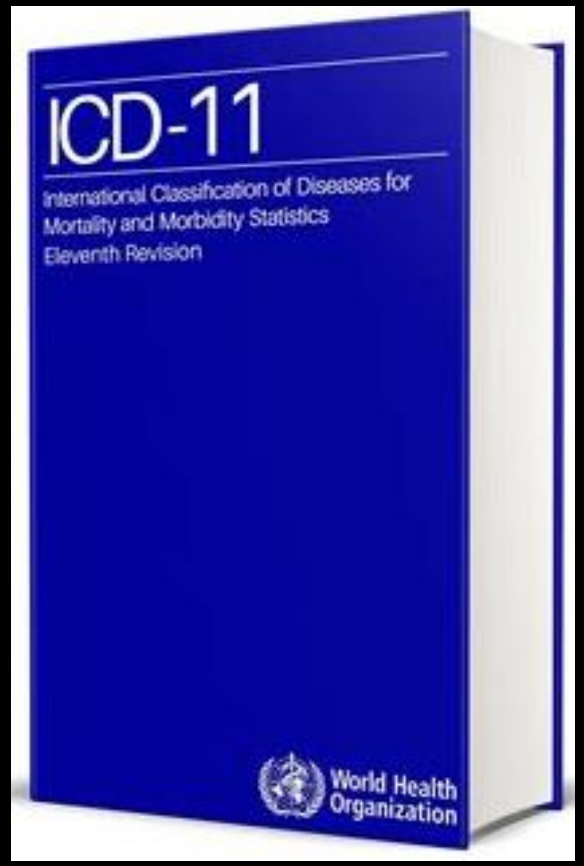
26 YEARS AFTER HERMAN'S ORIGINAL PROPOSAL…

- In June 2018 WHO ICD-11 included Complex PTSD and in May 2019 all member states adopted it
- Recognition of diagnosis:
  - gives a "diagnostic home" that is less stigmatizing (but still controversial)
  - supports insurance reimbursement
  - supports research funding
  - facilitates development of more effective treatment
  - provides better science for supporting more effective therapies



(Cloitre, 2017)

ICD-11 PTSD AND COMPLEX PTSD



"Gate" Criterion: Traumatic Stressor	
PTSD	**Complex PTSD/"PTSD plus" DSOs**
Re-experiencing	Re-experiencing
Avoidance	Avoidance
Sense of Threat	Sense of Threat
	Affect Dysregulation
	Negative Self Concept
	Disturbed Relationships
Functional Impairment	Functional Impairment

World Health Organization

"VICTIM TO PATIENT PROCESS"

REACTIONS, ADAPTATIONS, SYMPTOMS, DIAGNOSES

EXPRESSION:

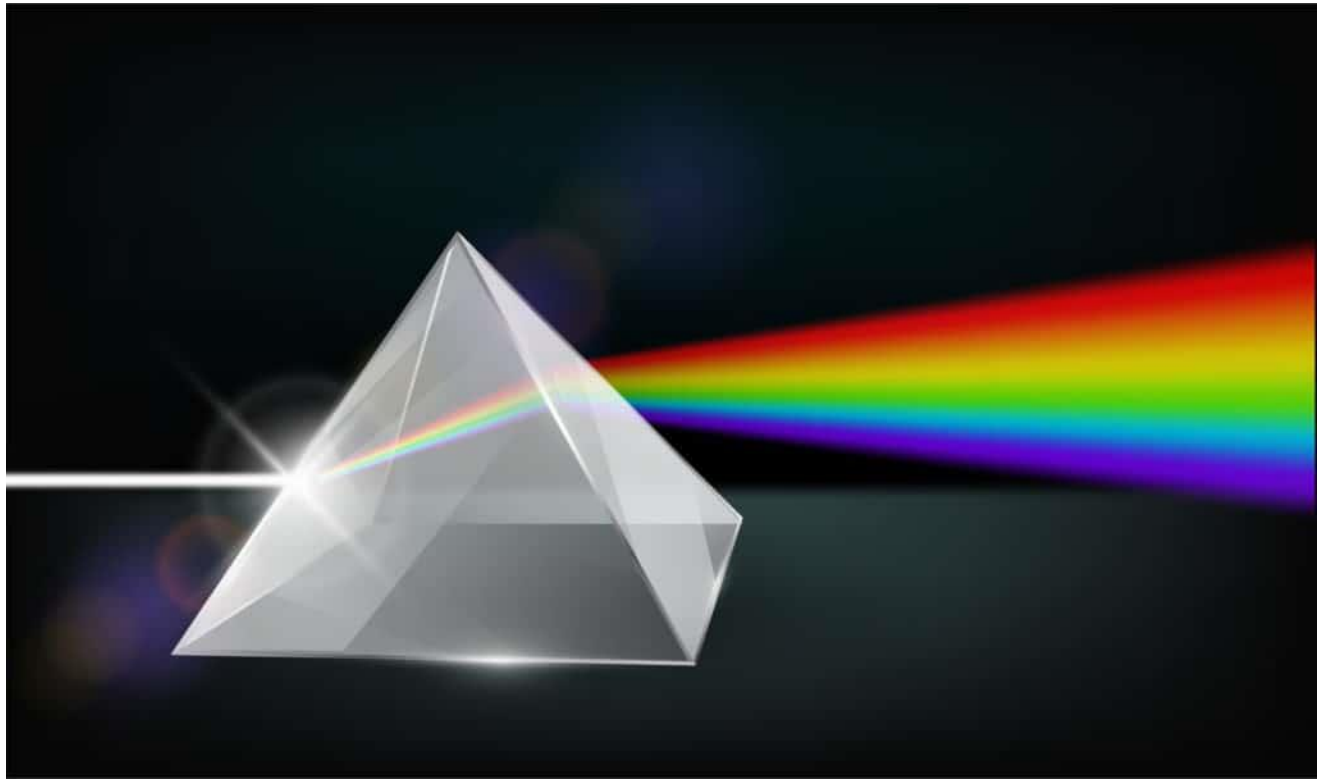
CONTINUOUS
EPISODIC
DELAYED

ALSO, CO-MORBIDITIES/CO-OCCURRING CONDITIONS

THE ***PRISM*** PRINCIPLES OF TREATMENT OF CPTSD APPLICABLE TO EUPD/BPD

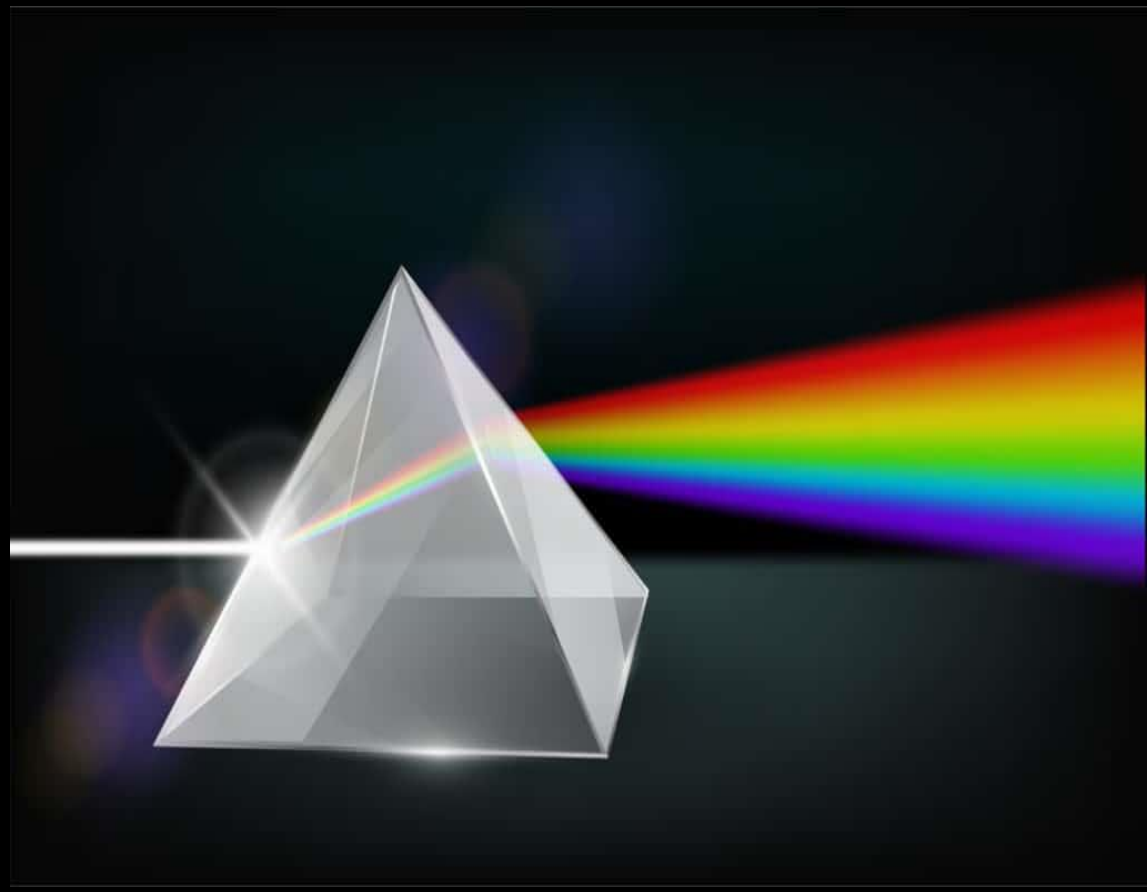
THE *PRISM* PRINCIPLES

- Personalized
- Relational
- Integrated
- Sequenced
- Multi-modal and multi-component



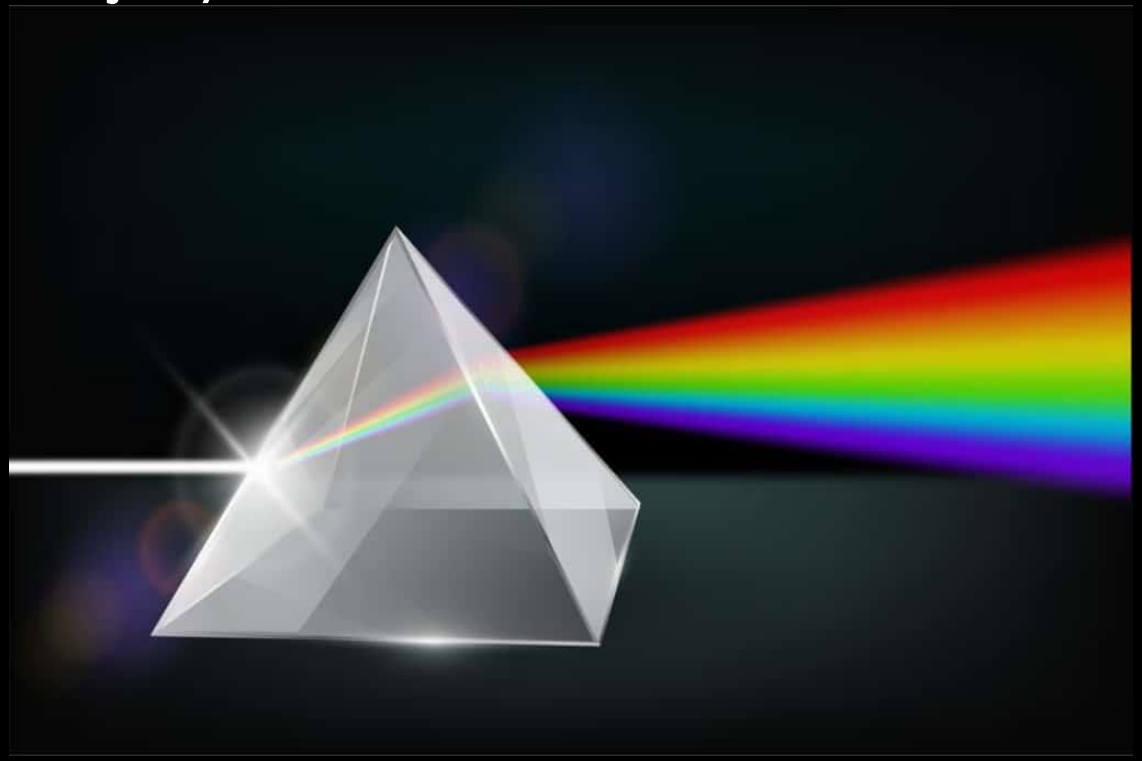
PRISM

- **Personalized/**phenomenological
- Plain old psychotherapy (Allen), plus
- Psychophysiological approaches
- Psychotherapy &/or psychopharmacology
- Person-centered/experiential
- Philosophy & principles of treatment
- Prosidy & patience
- Priorities identified
- Preferences of client
- Personalization vs. disowning
- Presentification
  - Past and-present-centered but future-oriented
  - Possibilities
- Preparation, training, and professionalism of therapist

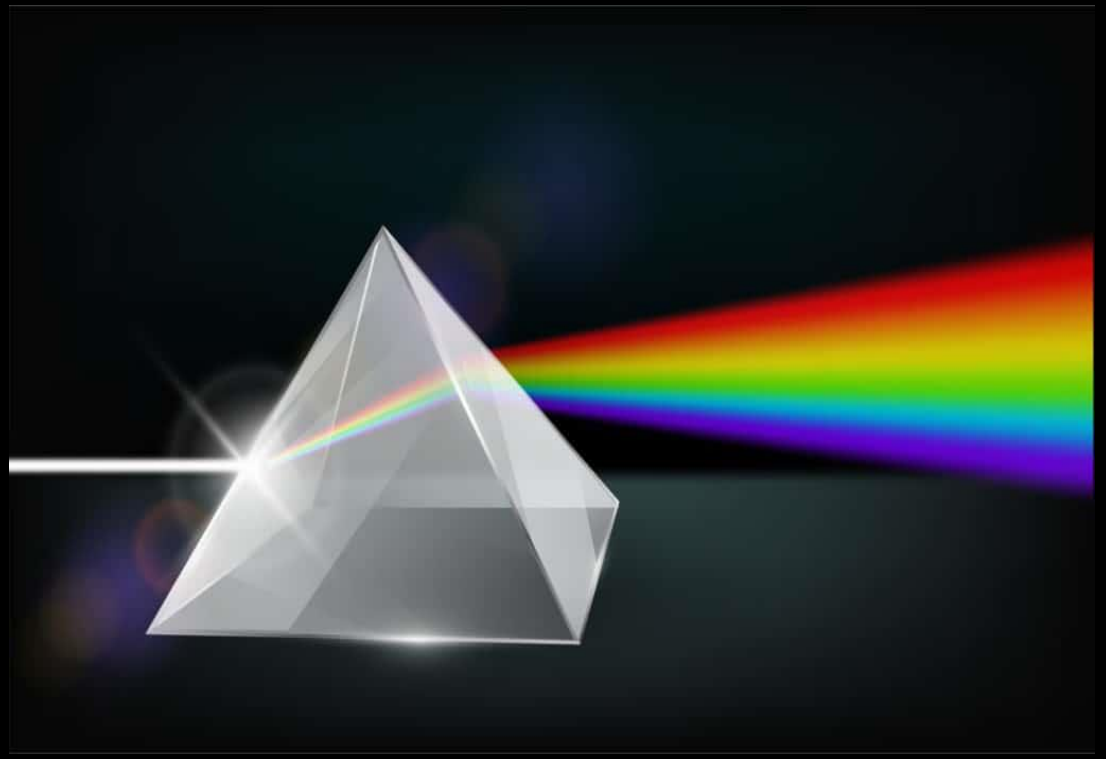


PRISM

- **Relational** healing for relational injury
- Respectful
- Resonant
- Reflexive and not reactive
- Resilience enhancing
- Resolution of trauma
- Reinforce the right thing (Linehan)
- Recovery-oriented
- Restoration of Self and relational capacity
- Risk management



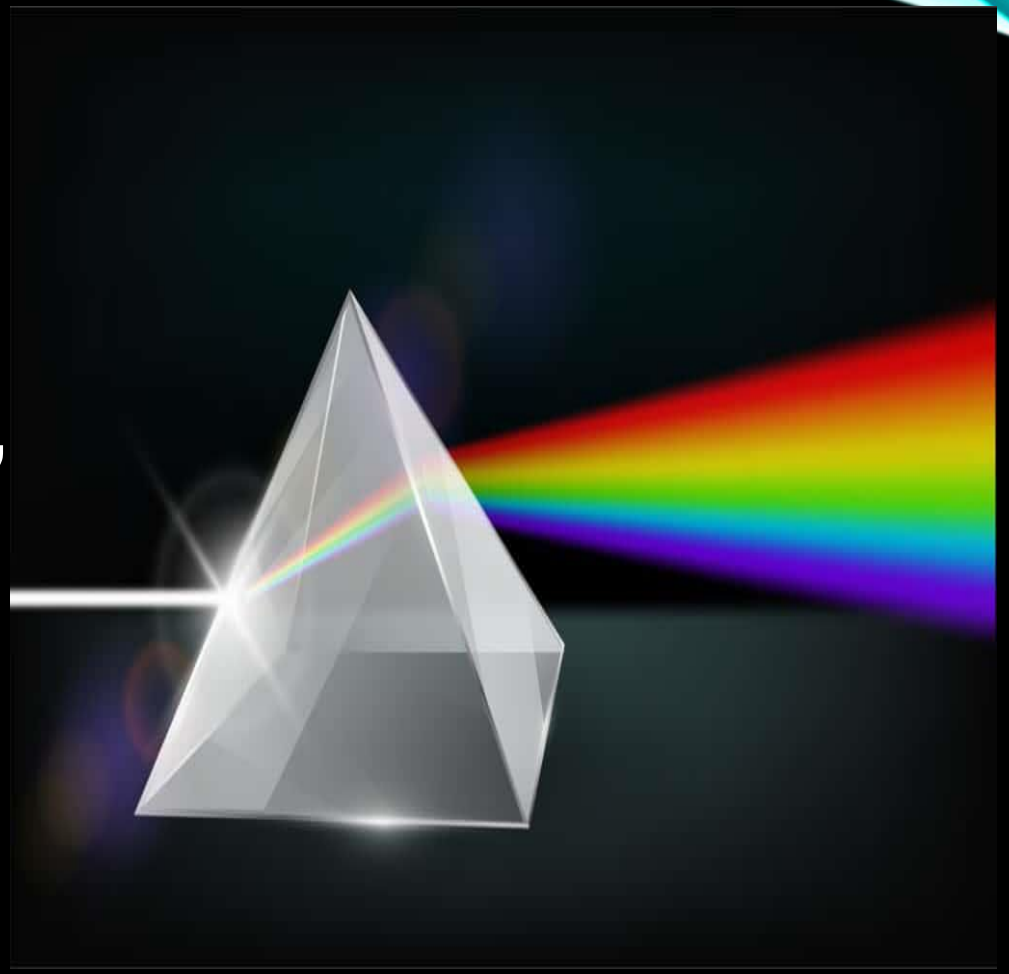
PRISM



- **Integrative**
- Individualized
- Interpersonal
- Identity development
- Intensity titrated
- Impactful to the client
- Intersectionality and context considered
- Impact on the client and therapist
  - Negative and positive transformation possibilities

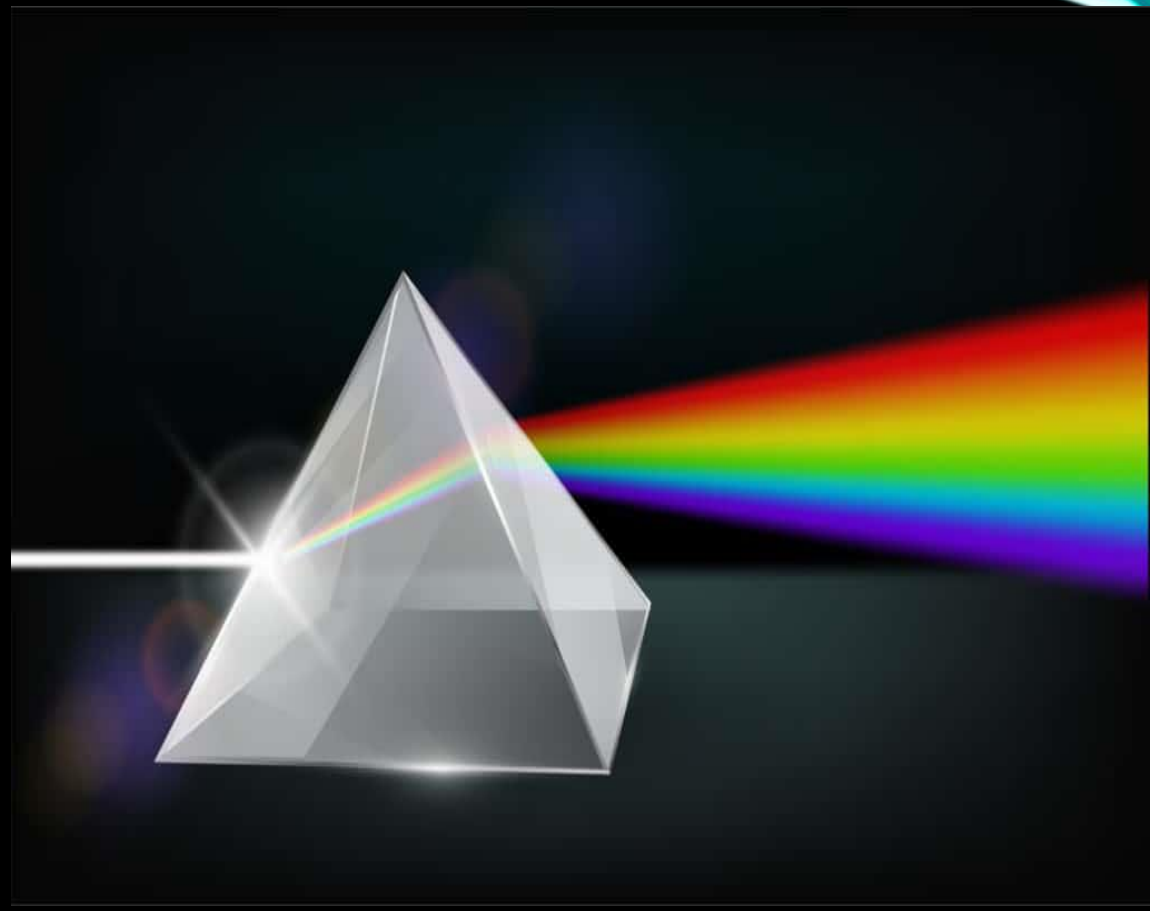
PRISM

- **Sequenced/phased (?)**
- Safety as priority
  - From self and others, community
- Security of relationship: "Safe Haven"
- Security of attachment "earned"
- Strategic/selective
- Self-regulation
- Strength-based
- Self-identification and development
- Somatosensory
- Supervision and consultation



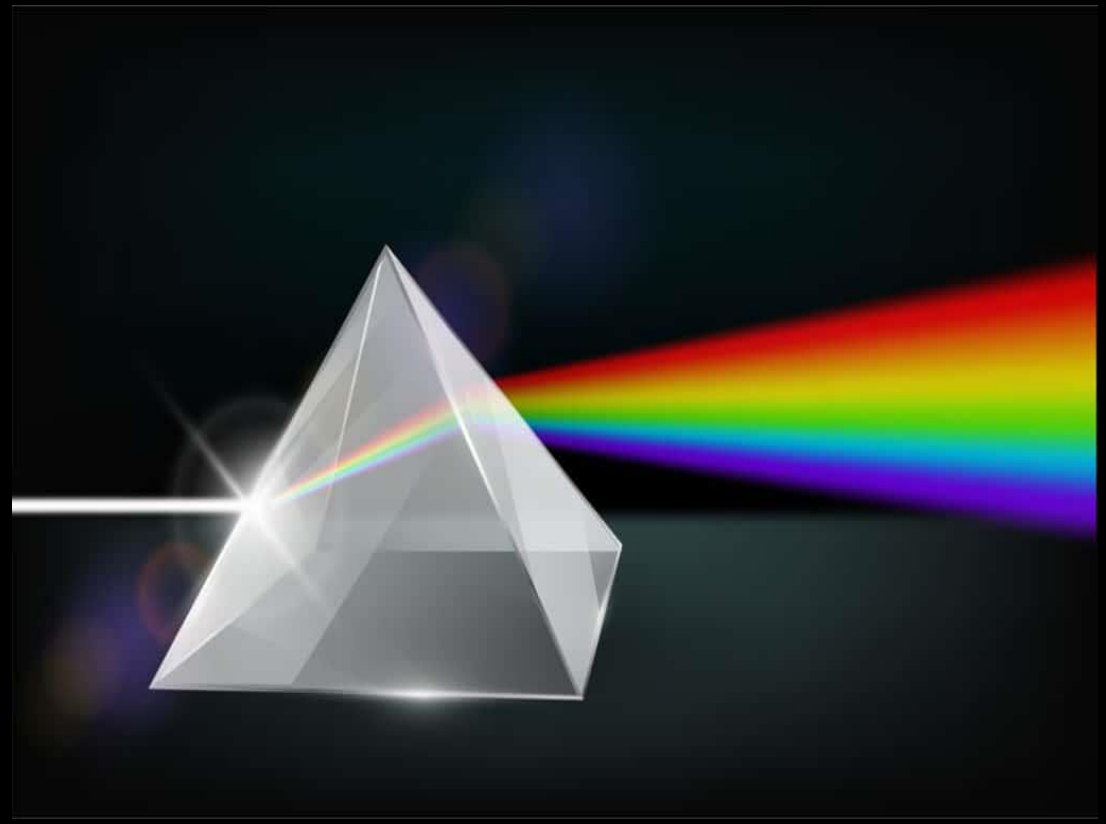
PRISM

- **Multi:**
  - **-dimensional**
  - **-component**
  - **-modal**
- Modification as need
- Memory processing as indicated
- Modulation
- "Make haste slowly"
- Modeling
- Mindfulness and mentalization
- Medication and psychedelics?



PRISMA (ITALIAN)

- **Attunement**
- Attachment style considered
- Accepting vs. judging
- Activation/arousal management
- Approach vs. avoid
- Adequate level of functioning
- Active v. passive orientation
  - Recovery is the client's



TREATMENT GUIDELINES: PROS AND CONS

RECOMMENDED TREATMENTS

SEQUENCING

EXCEPTIONS AND CUSTOMIZATION

CLINICAL PRACTICE GUIDELINES FOR "CLASSIC" PTSD

- Treatment outcomes: ***decrease of PTSD symptoms, remission of diagnosis***
- Trauma-Focused Treatments (TFTs), have the most research evidence
- Benefits: They work (for symptoms)!
  - Ever increasing data
  - Mixed samples of different populations, including CPTSD & BPD
- Limitations: Not for everyone
  - Usually single vs. combined treatment
  - Dropout rates high; harms/adversity not addressed
  - Generalizability & feasibility

CPG: EFFICACIOUS TREATMENTS FOR CLASSIC PTSD

- Prolonged Exposure (PE)
- Cognitive Processing Therapy (CPT)
- Eye Movement Desensitization and Reprocessing Therapy (EMDR)
- Cognitive (CT) and Cognitive Behavior Therapy (CBT)
- Brief Eclectic Psychotherapy for PTSD (BEPP)
- Interpersonal Psychotherapy (IPT)
- Present-Centered Therapy (PCT)
- Narrative Exposure Therapy (NET)
- STAIR Narrative (STAIR NPT)
- Psych-education & other supportive
- Psychopharmacology: 3 main classes

SOME LIMITATIONS OF PTSD CPGS TO CPTSD

- Developed according to Institute of Medicine Standards
  - Use of RCTs and limited scoping questions in Systematic Review
  - How applicable are these to behavioral/mental health?
- No inclusion of qualitative studies
- Subject pool limitations
- Some include diverse subjects
- Applicability and generalizability?
- Limited attention relationship variables and information
- Little information on adverse effects/dropouts

EVIDENCE-BASED RELATIONAL VARIABLES (EBR) OMITTED

- Despite a large body of RCT efficacy evidence
- Attachment and relational approaches undergird whatever techniques are used
- Need to be incorporated
- Both relationship & technique make up the treatment

the relationship is a technical intervention

QUESTION OF APPLICABILITY AND GENERALIZABILITY

FROM RESEARCH SETTING TO "REAL WORLD"

AND TO CPTSD AND DSOs

****

LACK OF DATA DOES NOT MEAN LACK OF EFFICACY

RESEARCH IS UNDERWAY FOR CPTSD TREATMENT

TREATMENT

As with PTSD, comprehensive treatment must be:

BIO-SOMATIC

PSYCHO-SOCIAL

SPIRITUAL

&

Context, Culture, Race, Gender & Identity/Status Sensitive

PRISM
AND
SEQUENCED, RELATIONSHIP-BASED TREATMENT

CROSSOVER GUIDELINE: RECOMMENDED TREATMENTS FOR CPTSD (ISTSS COMPLEX TRAUMA TASK FORCE SURVEY RESULTS, 2011)

- Sequenced or phased
- Customized: interventions tailored to specific symptoms
  - "First line" approaches:
    - Interpersonal approach
    - Emotional regulation
    - Cognitive re-structuring
    - Anxiety and stress management
    - Narration of trauma memory
  - "Second line":
    - Meditation/mindfulness
- Course and duration of treatment unclear, but longer than for PTSD sx relief

EFFICACIOUS TREATMENTS FOR CPTSD/CSTD

- PE: (Foa), Prolonged Exposure, applied later
- CPT: (Resnick), Cognitive Processing Therapy, applied later ??
- EMDR: (Shapiro), Eye Movement Desensitization and Reprocessing, applied by stage
- EFT: (Greenberg; Johnson, for couples) Emotionally Focused Treatment
- EFTT: (Paivio & Leone) Emotionally Focused Trauma Treatment
- IPT: (Markowitz) Interpersonal Psychotherapy
- IRRT: (Smucker & Dancu) Imaginal Restructuring and Reprocessing
- NET: (Schauer et al.) Narrative Exposure Therapy
- PCT: (Gold, 2020) Present- and Person-Centered Therapy
- SCAN: (Lanius & Frewen) Social Cognitive and Affective Neuroscience
- Some group models

"HYBRID" AND ADAPTED MODELS FOR CPTSD

- TARGET (Ford)—multiple chapters
- STAIR-NTP (Cloitre)—revised book
- Contextual Treatment (Gold)—revised book
- Components Model (Hopper et al.)—new book
- EFTT, Narrative (Paivio & Angus)—new book
- Seeking Safety (Najavits): addictions—new book
- DBT & ACT adapted for trauma treatment—new books
- Psychodynamic/psychoanalytic, relational—new books
- Treatments for dissociation—new books
- Other models, topics, and workbooks...

THE QUESTIONS ARE NOW:

What to use when?

What is effective for whom?

The necessity of sequencing?: unimodal vs. phased?

IT'S OFTEN LIKE A PUZZLE BUT IS DYNAMIC AND EVER-CHANGING

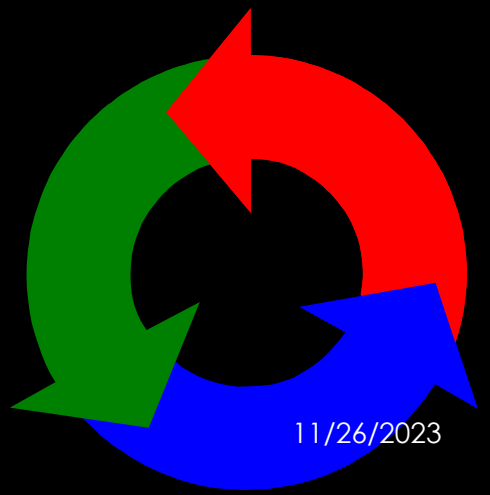
One size does not fit all
(Courtois, 1999; Cloitre, 2015)

Customization is needed

Sequenced model is linear but not lockstep/rigid: envision it as a spiral

COMPLEX TRAUMA TREATMENT SEQUENCE

- Pre-treatment: intro, assessment, treatment planning
- 1. SAFETY & SECURITY: stabilization, skill-building, education, building of relationship and mutual language
- 2. Trauma memory processing: gradual and prolonged exposure, putting pieces together, grieving
- 3. Re-Integration: to life, meaning-making, and self and relational development



EARLY STAGE: ADDRESSING DSOs

- Emotional regulation: Affect identification and modulation
  - Somatic and psychological approaches
  - Attachment development
- Identity: Attunement and reflection of individual
  - Somatic and psychological approaches
  - Attachment style/personality and related issues
  - Cognitive errors & distortions
- Relational:
  - Attunement, attachment security, and collaboration
  - Transference and countertransference

INTERSECTIONS BETWEEN TREATMENT FOR CPTSD AND BPD/EUPD

- Mentalization (Fonagy et al.)
- DBT-PTSD—phased (Bohus et al.)
  - Commitment
  - Trauma model/motivation
  - Skills & cognitive elements
  - Skills assisted exposure
  - Radical acceptance
  - A life worth living
  - Future orientation/farewell
- Arts/expressive therapies
- Groups & therapeutic communities
- Addiction treatment
- Mindfulness
- Self-compassion treatment
- Medication + psychotherapy
- Somatosensory approaches
- Sequenced to include TFT evidence-based treatments, especially in the second phase
- Sequenced and flexible
- Multi-modal vs. uni-modal
- Hope for recovery and growth

INNOVATIONS AND EMERGING TREATMENTS

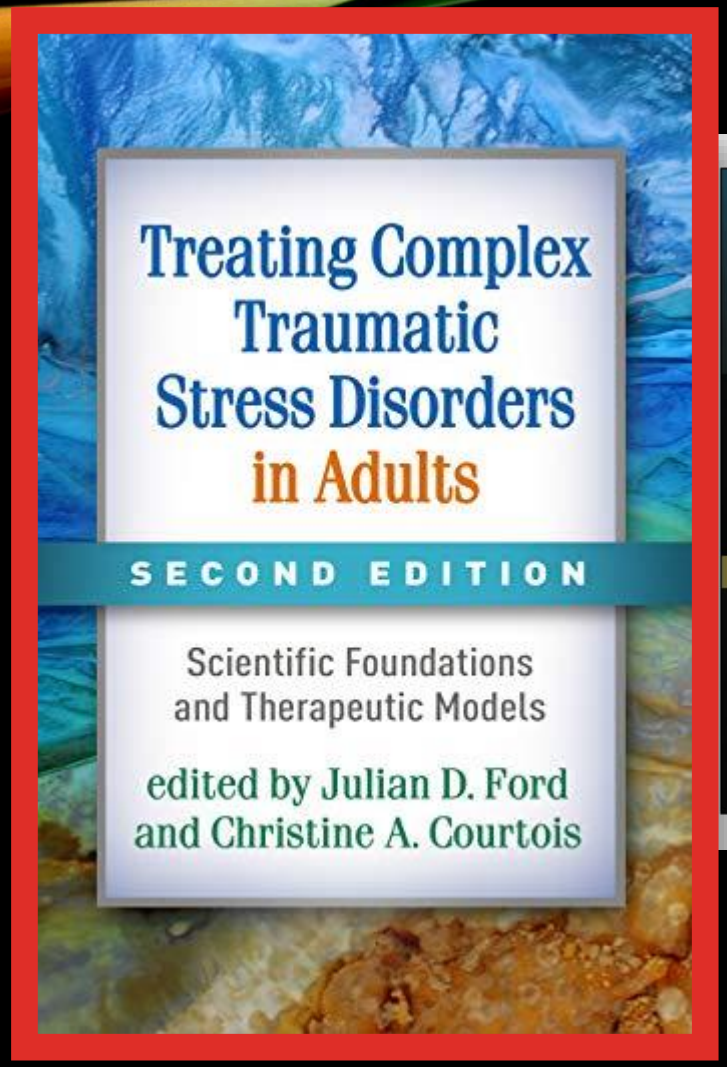
- More attention to the body: drawing on the body's wisdom
  - Somatosensory attention and approaches
  - Making the implicit explicit
- More attention to the mind and neuroplasticity
  - Neuroscience approaches
    - Vegal nerve and other
    - Interpersonal neurobiology
- Relational and attachment-based approaches
- Flexible, modular treatment
- Medications and psychedelics?

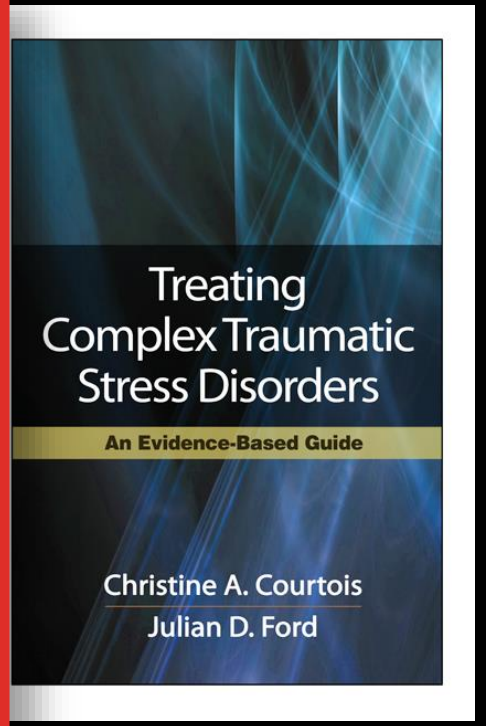
INNOVATIONS AND EMERGING TREATMENTS

- Modular, multi-component treatment based on assessment
  - complexity of trauma and symptoms
  - need for tailoring to patient
- Patient-treatment matching models or algorithms
- Hierarchy of problems
- Repeat assessment and adjustment of treatment (Briere & Lanktree)
- Collaboration and session by session feedback & adjustment

A WORD ABOUT TRAINING

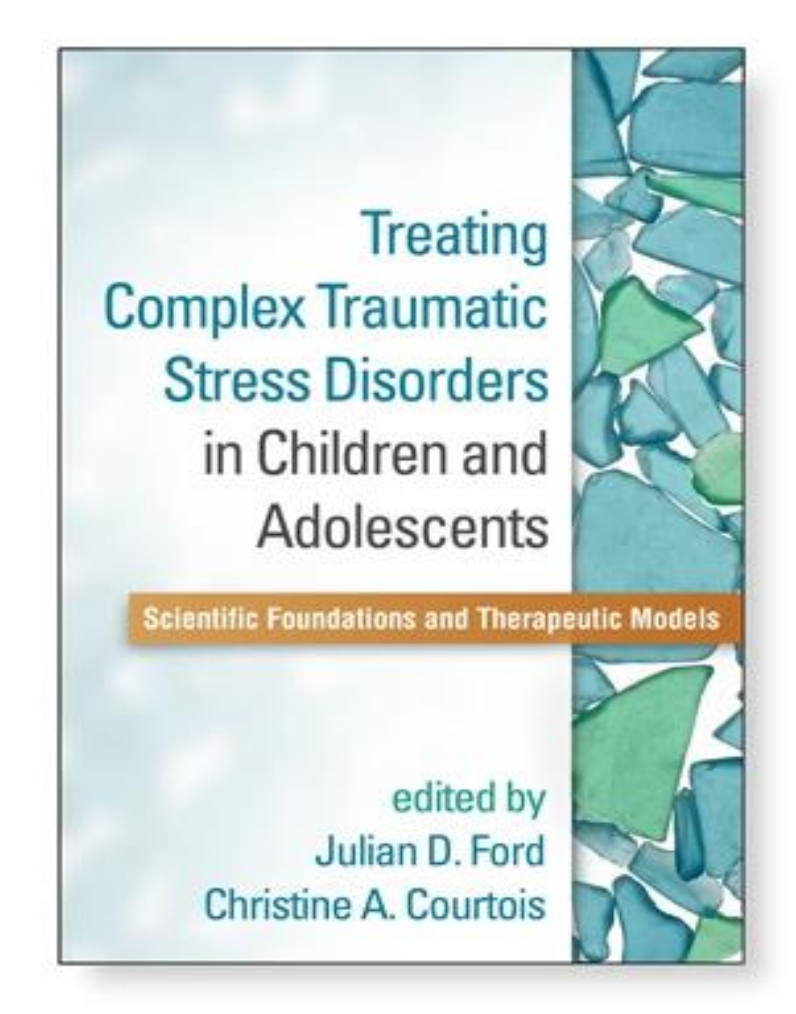
- Therapists need education and training to do this work
  - Often lacking in formal training curriculum
- Consider what you need and develop a plan of study
  - Lots of options so check out before you sign up
- Suggestions:
  - Read!
  - Take CE courses on an ongoing basis
  - Train in different treatment modalities
  - Get certification where available
- Get ongoing consultation and supervision
- Join professional organizations & attend conferences
- Beware applying treatments haphazardly or without training





REVISED EDITION, 2020

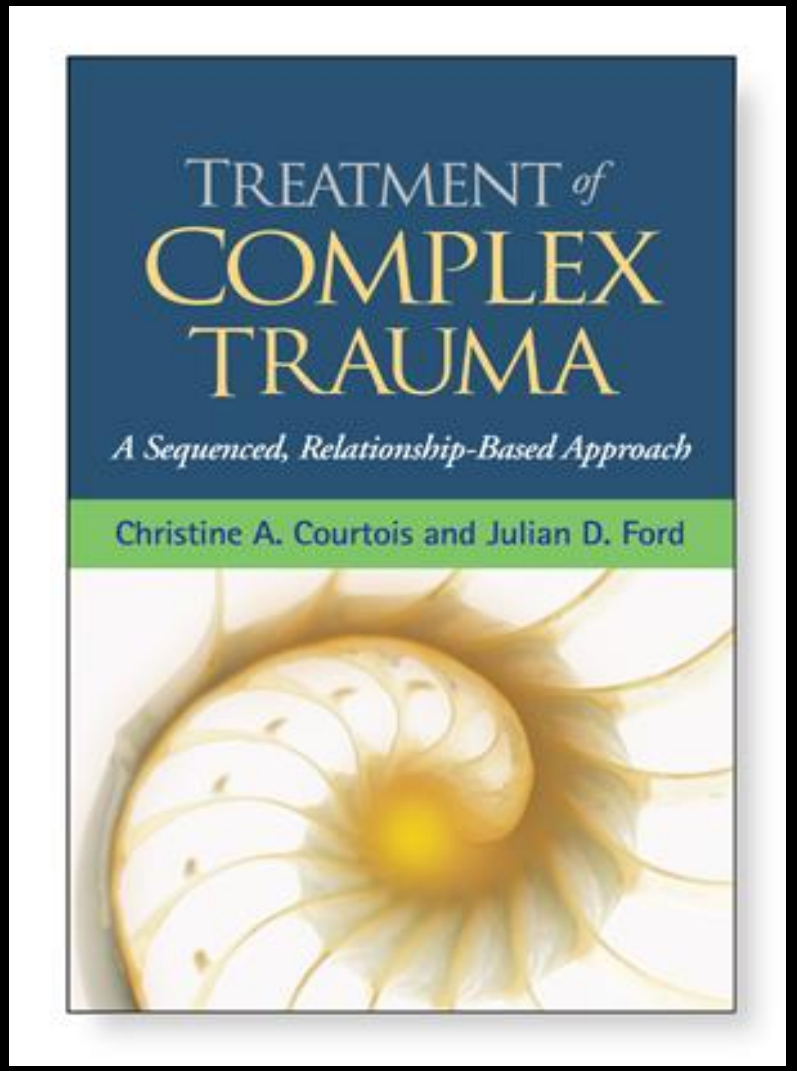
PUBLISHED, 2013, CO-EDITED



11/26/2023

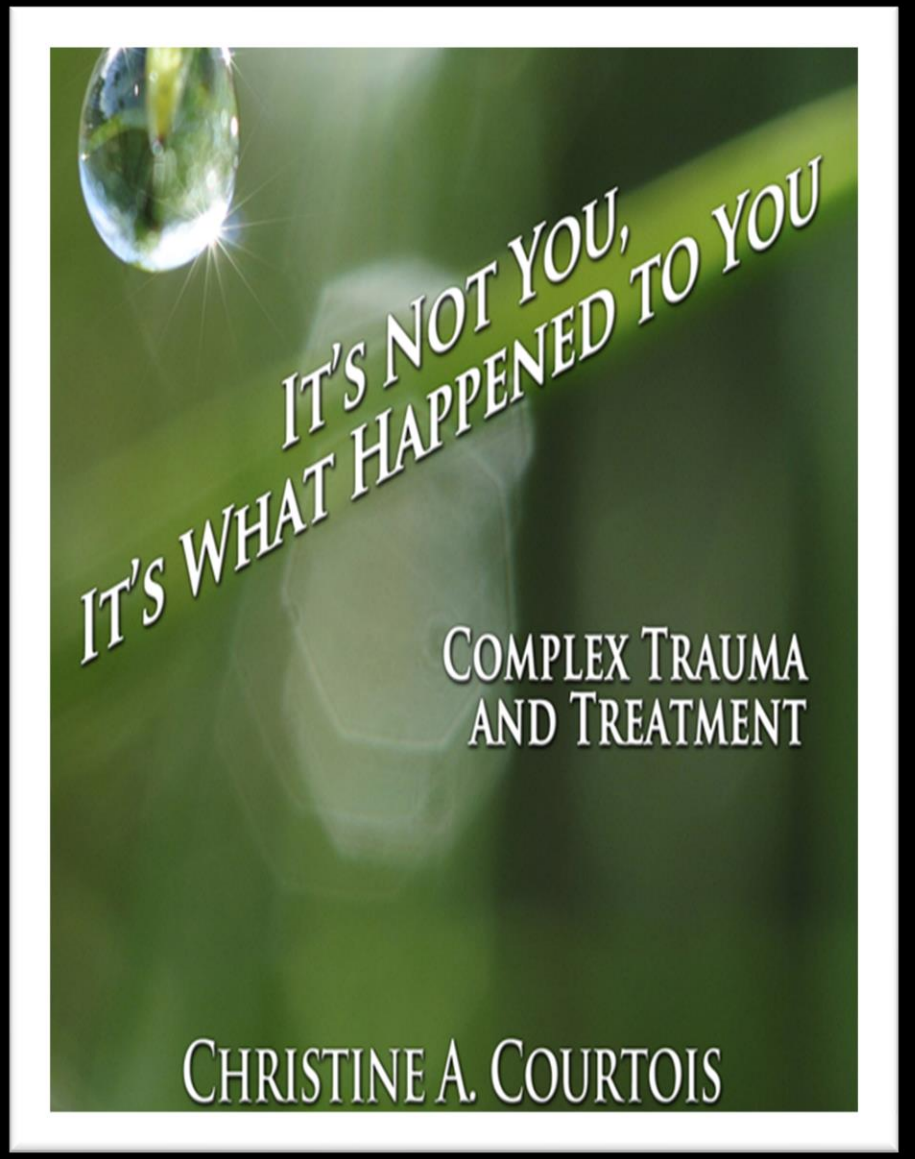
PUBLISHED, 2012, CO-AUTHORED

UNDER REVISION



PUBLISHED 2014, RE-ISSUED 2020

A trade book for survivor/ consumers and supporters



AVAILABLE TREATMENT GUIDELINES FOR PTSD

- ISTSS Guidelines (Bisson et al., 2020 ; Foa, Friedman, Keane, & Cohen; 2011, Foa, Keane & Friedman, 2000)
- American Psychological Association (2017, under revision)
- Veterans' Administration (US DoD, 2004, 2017, 2021)
- Australian (Phoenix) Centre for Posttraumatic Mental Health (2007, 2017)
- National Institute of Clinical Excellence (NICE, UK, 2005)
- American Psychiatric Association (2003)
- Clinical Efficiency Support Team (CREST, Northern Ireland, 2003)
- Journal of Clinical Psychiatry (2000)

TREATMENT RECOMMENDATIONS AND GUIDELINES FOR CPTSD

- Courtois, 1999
- CREST, 2003
- Courtois, Ford, & Cloitre, 2009; 2020
- Blue Knot Australia (Keselman & Stavropolous, 2018, 2012)
- ISTSS complex trauma expert consensus survey, Cloitre et al., 2011, *JTS*; Cloitre et al., 2012--available at ISTSS.org)
- UK Psychological Trauma Society (2017)
- Joint Division 56 and ISSTD guidelines (forthcoming)

OTHER RELEVANT TREATMENT GUIDELINES

- Dissociative Disorders
  - Adult (ISST-D, 1994, 1997, 2005, 2011, new set under development)
  - Children (ISSD, 2001)
- Delayed memory issues
  - Courtois (1999; Mollon, 2004)

RESOURCES

- Blue Knot.au.org
- ISTSS.org
  - Complex Trauma Special Interest Group
- ISST-D.org
- NCPTSD.va.gov (info and links)
- NCTSN.org (child resources)
- APA Div. 56: Psychological Trauma traumadivision@apa.org
- Child Trauma Academy.org