MindBody Breakthrough
Restoring Control, Inspiring Success

Treating Complex Post-Traumatic Stress Disorder (CPTSD)

With

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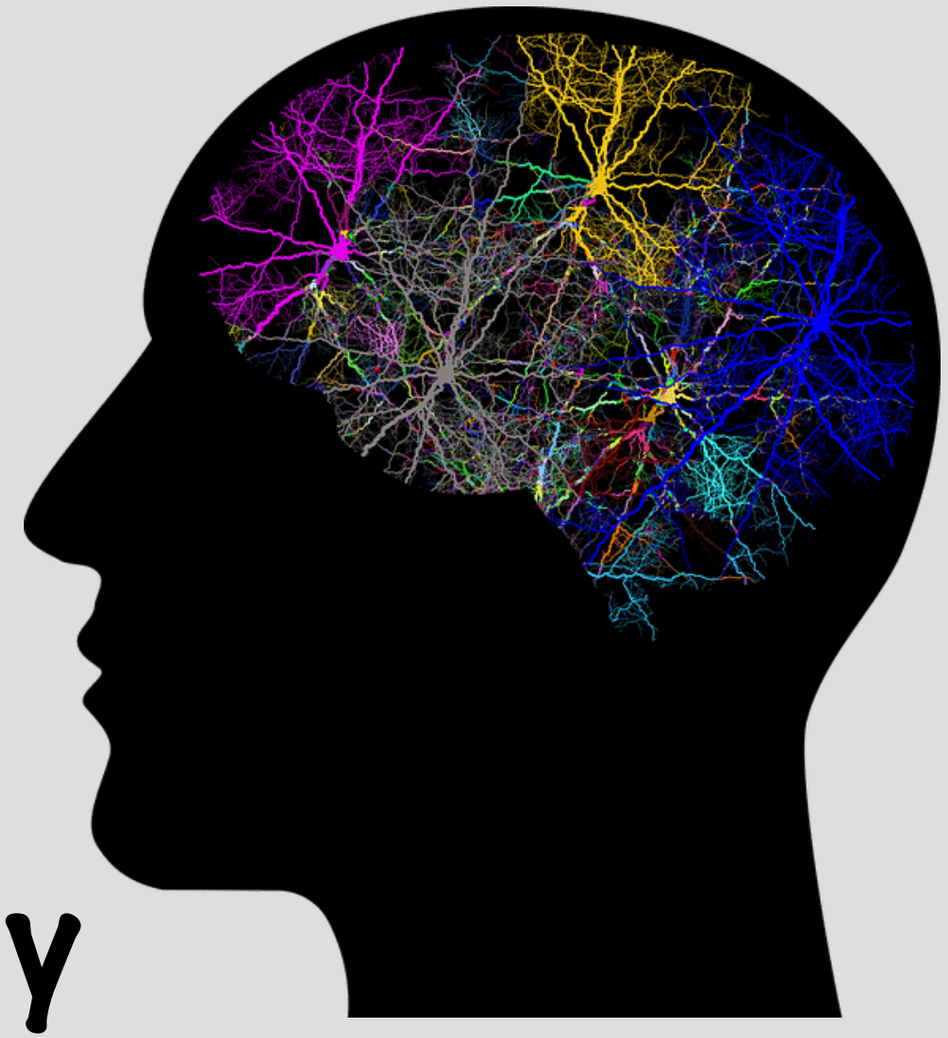
www.mindbodybreakthrough.net

Course Outline

- Basic Understanding
- Regions of the Brain Implicated in C-PTSD
- The A.S.I.E.C.C. Recovery Framework



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Session 1

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What is Complex Post-Traumatic Stress Disorder (C-PTSD)?

Complex post-traumatic stress disorder (C-PTSD) is a psychological response to prolonged and repeated interpersonal trauma, in which escape is difficult or impossible. Cortman, C. & Walden, J. (2018); Herman, J.L. (1997)

C-PTSD is a more severe form of PTSD. The PTSD diagnosis was originally developed for adults who had suffered from a single-event trauma, such as rape, car accident, or war trauma.(National Child Traumatic Stress Network, 2013).

Repeated and prolonged trauma during childhood or adulthood presents a group of symptoms that differ from those described for PTSD. van der Kolk B (2005)

As a result, C-PTSD has been included as a diagnostic category in the International Classification of Diseases, 11th Edition (ICD-11).

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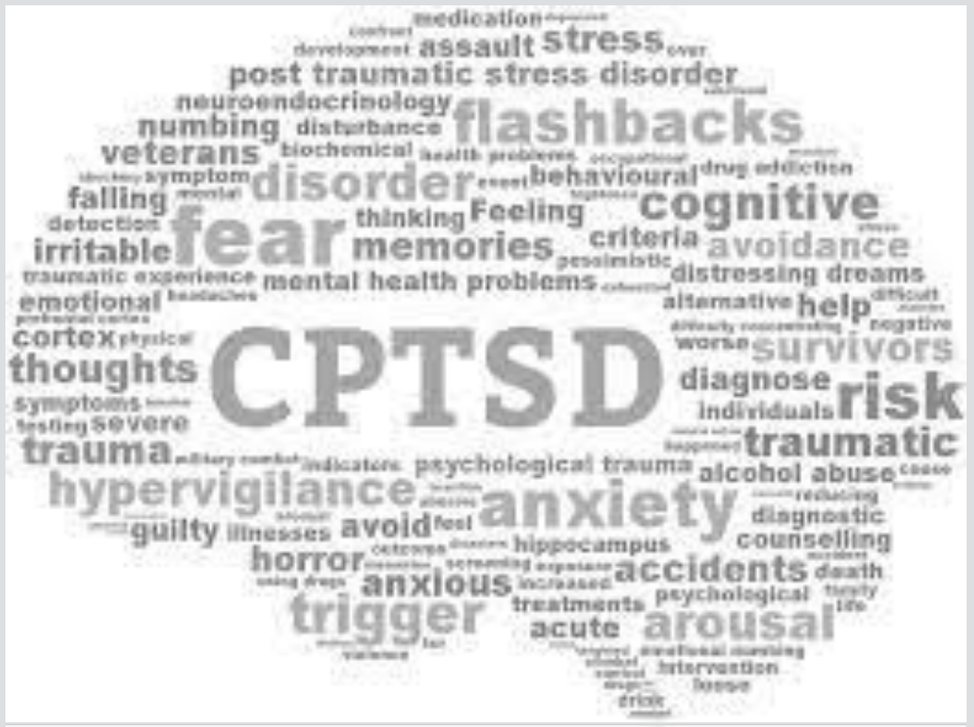
Causes of C-PTSD

The core foundation of C-PTSD is rooted in repeated childhood traumatisation or prolonged and inescapable captivity/entrapment in adulthood. Ford, J.D. et al. (2013):van der Kolk B (2005)

This includes survivors of:

- Chronic psychological, sexual and physical abuse
- Hostage/kidnapping
- Chronic intimate partner violence
- Slavery
- Human trafficking
- Childhood neglect
- Prolonged workplace or school bullying
- Prisoners of war
- Prolonged narcissistic (child) abuse



Gene-environment interactions:

Some genes have been found to interact with severity of child abuse as a predictor of adult C-PTSD symptoms; e.g. FKBP5 gene, DA transporter gene, serotonin transporter proteins, women's pituitary adenylate cyclase-activating peptide (PACAP). Binder E.B. et al 2019; Segman, R.H. et al. 2002; Ressler, K.J. et al. 2011)

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Common C-PTSD Symptoms in Children and Adolescence

(Cook, A. et al. 2003)

- **Insecure attachment issues**: difficulty attuning to others' emotional states, problems with boundaries, lack of trust towards others and the world, social isolation, etc.
- **Biological issues**: sensory-motor developmental dysfunction, hypersensitivity to physical contact, excessive somatic symptoms, increased medical problems (e.g., asthma, skin problems, pelvic pains, autoimmune illnesses)
- **Emotional dysregulation:** difficulty describing feelings and other internal states, poor emotional regulation, and difficulties communicating needs, wants and wishes
- **Dissociation**: distinct alterations in states of consciousness, amnesia, depersonalisation, derealisation, two or more dissociative ego states with impaired memory integration

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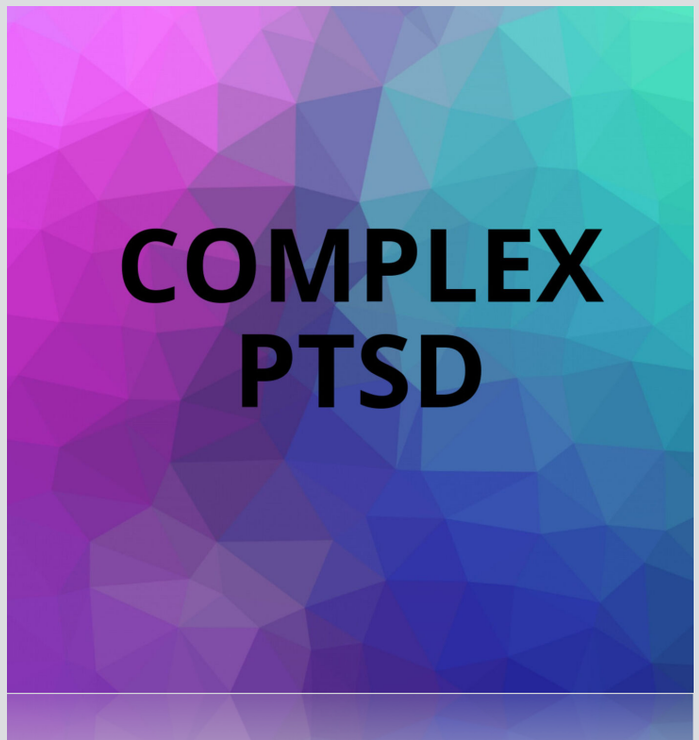
Common C-PTSD Symptoms in Children and Adolescence

(Cook, A. et al. 2003)

-**Behavioural control issues:** self-destructive behaviours, eating disorder, sleep problems, excessive compliance, oppositional behaviours, substance abuse, aggression against others, behavioural re-enactments of trauma

-**Cognition**: difficulty regulating attention; problems with a variety of *executive functions*, learning difficulty, difficulty planning and anticipating, problems in language development, difficulty processing new information; difficulty focusing and completing tasks; problems with orientation in time and space, acoustic and visual perceptual problems

-**Self-concept problems**: fragmented and disconnected autobiographical narrative, disturbed body image, low self-esteem, toxic shame, toxic guilt, and negative internal working models of self.



Common C-PTSD Symptoms in Adults

(ICD-11 11th Edition; Herman, J.L. (1997); Pelcovitz D., et al. (1997)

All diagnostic requirements for PTSD are met (re-experiencing of trauma, avoidance of thoughts and memories of trauma, and hyper-vigilance). In addition, Complex PTSD is characterised by severe and persistent:

- problems with emotional regulation; such as persistent dysphoria (a profound state of anxiety, agitation, depression, unease), chronic suicidal preoccupation, self-injury, explosive or extremely inhibited anger, and compulsive or extremely inhibited sexuality

- problems with self-perception; such as a sense of helplessness, toxic shame, guilt and self-blame (vicious inner critics), a sense of being defective and flawed, and a sense of being completely different from other human beings (may include a sense of specialness, utter aloneness, a belief that no other person can understand, or a feeling of nonhuman identity)

- problems with consciousness: such as amnesia or improved recall for traumatic events (hyper-amnesia), episodes of dissociation, depersonalisation/derealisation, and reliving experiences (either in the form of intrusive PTSD symptoms or in ruminative preoccupation)

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Common C-PTSD Symptoms in Adults

(ICD-11 11th Edition; Herman, J.L. (1997); Pelcovitz D., et al. (1997)

- problem with perception of the perpetrators; such as a preoccupation with the relationship with a perpetrator (including a preoccupation with revenge), an unrealistic attribution of total power to a perpetrator, a sense of a special or supernatural relationship with a perpetrator, and acceptance of a perpetrator's belief system or rationalisations

- problems with relations with others; such as isolation and withdrawal, disruption in intimate relationships, a repeated search for a rescuer (may alternate with isolation and withdrawal), persistent distrust, and repeated failures of self-protection.

- problems with systems of meaning; such as a loss of sustaining faith in self (self-abandonment) and a sense of hopelessness and despair.

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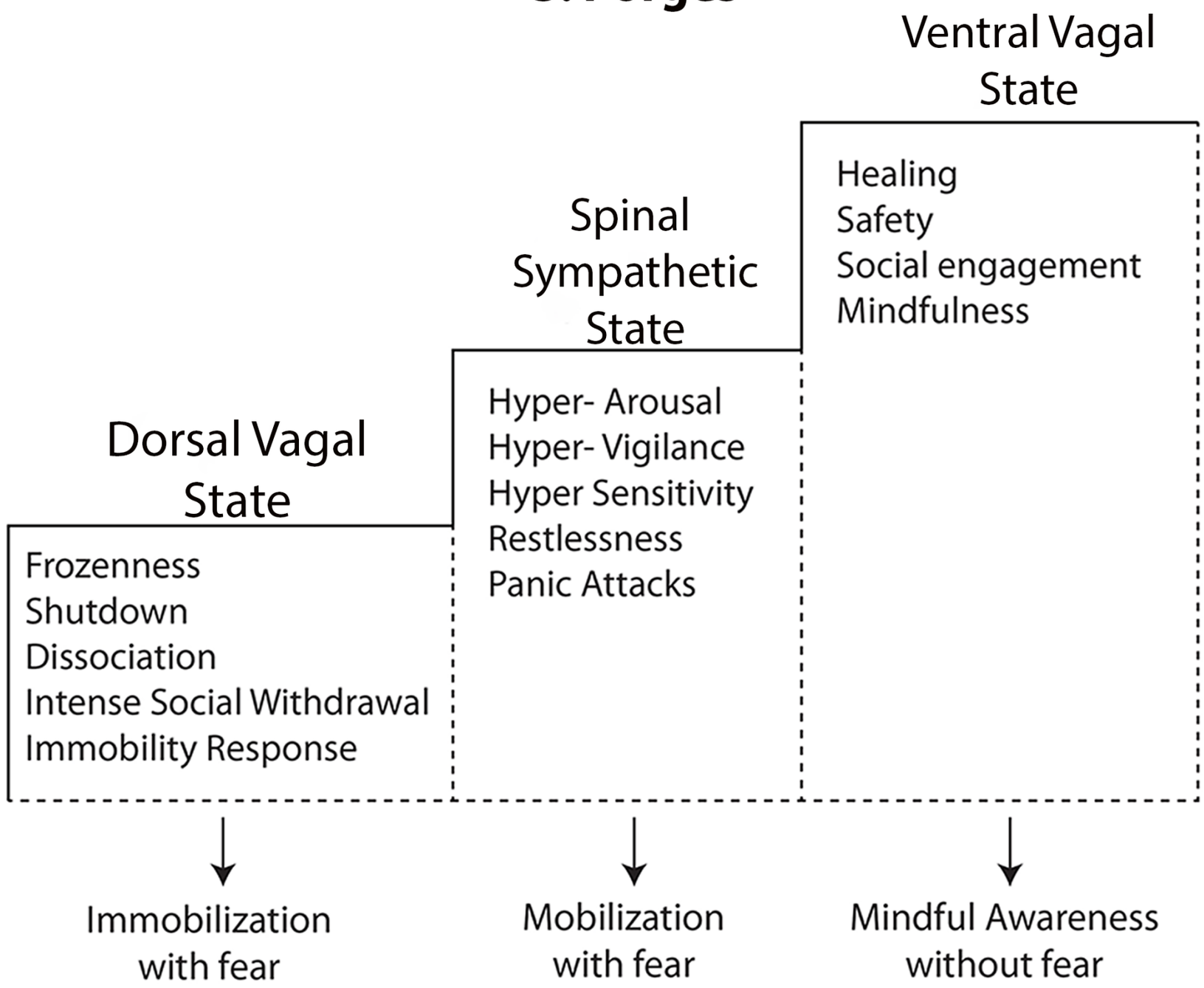
The Polyvagal Theory
S. Porges



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4 Subconscious Defences In C-PTSD

Walker, P. (2013)

In C-PTSD, the intrinsic human survival mechanism is acted out as personality defences to cope with the intense emotions of C-PTSD:

- The **FIGHT** defence (**Narcissistic** type) (Control to connect, rage to be safe)

Controlling, enslaving, explosive, demanding perfection, sociopath, conduct disorder, entitlement, bully, autocrat

- The **FLIGHT** defence (**Obsessive/compulsive** type) (Perfect to connect, perfect to be safe)

Busyholic, compelled by perfectionism, mood disorder(bipolar), always rushing or worrying, micromanager, adrenaline junkie, panicky, ADHD

- The **FREEZE** defence (**Dissociative** type) (Freeze to connect, hide to be safe)

Hiding, isolating, achievement-phobic, couch potato, hermit (loner), Schizophrenic, inattentive ADHD

- The **FAWN** defence (**Codependence** type) (Conform to connect, crawl to be safe)

Servitude, people-pleaser, slave, doormat, parentified child, social perfectionism, loss of authentic self

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Session 2

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The Brain Regions Implicated in C-PTSD

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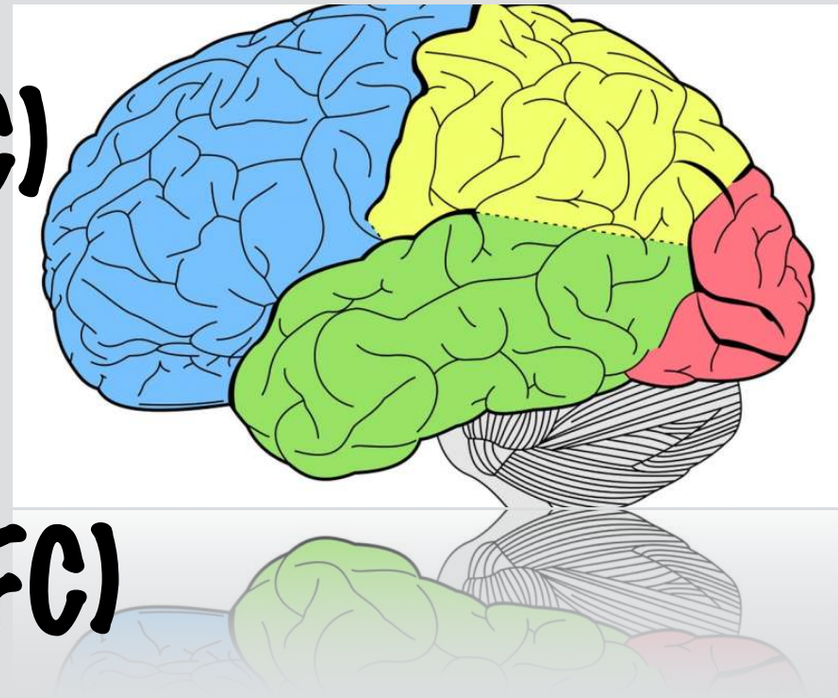
Brain Regions Implicated in C-PTSD

(Woodward, S.H., et al. 2006; McGovern R.A. & Sheith, S.A., 2017; Hamner, M.B., et al., 1999)

Using functional brain scans (fMRIs, DTI, and SPECT), a C-PTSD brain shows distinct abnormalities in a variety of brain regions.

These regions are:

- Anterior Cingulate Cortex (ACC)
- Amygdala
- Medial-Prefrontal Cortex (mPFC)
- Hippocampus
- HPA axis



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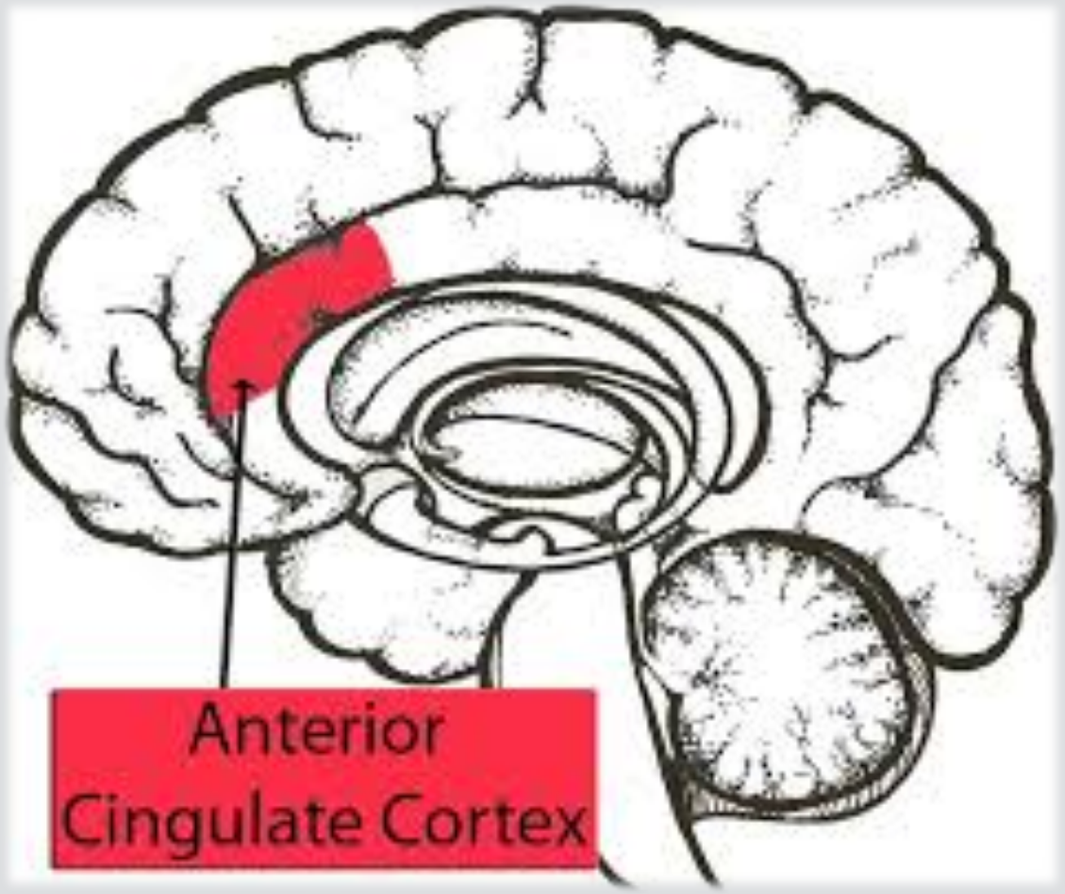
Anterior Cingulate Cortex (ACC)

In C-PTSD, the ACC serves as a gear-shifter that gets stuck in exaggerated emotional and behavioural responses to conditioned fear (hyper-arousal).
(Hamner, M.B., et al., 1999; Young D.A. et al. 2018)



ACC malfunction has also been linked to obsessive threat sensitivity and compulsive threat response found in both OCD and PTSD
(McGovern RA and Sheith SA, 2017: Hamner, M.B., et al., 1999)

Complex trauma shrinks the ACC volume, affecting its functions; such as self-sensing, cognitive flexibility, fear and intrusive thoughts regulation. Woodward, S.H., et al. (2006)

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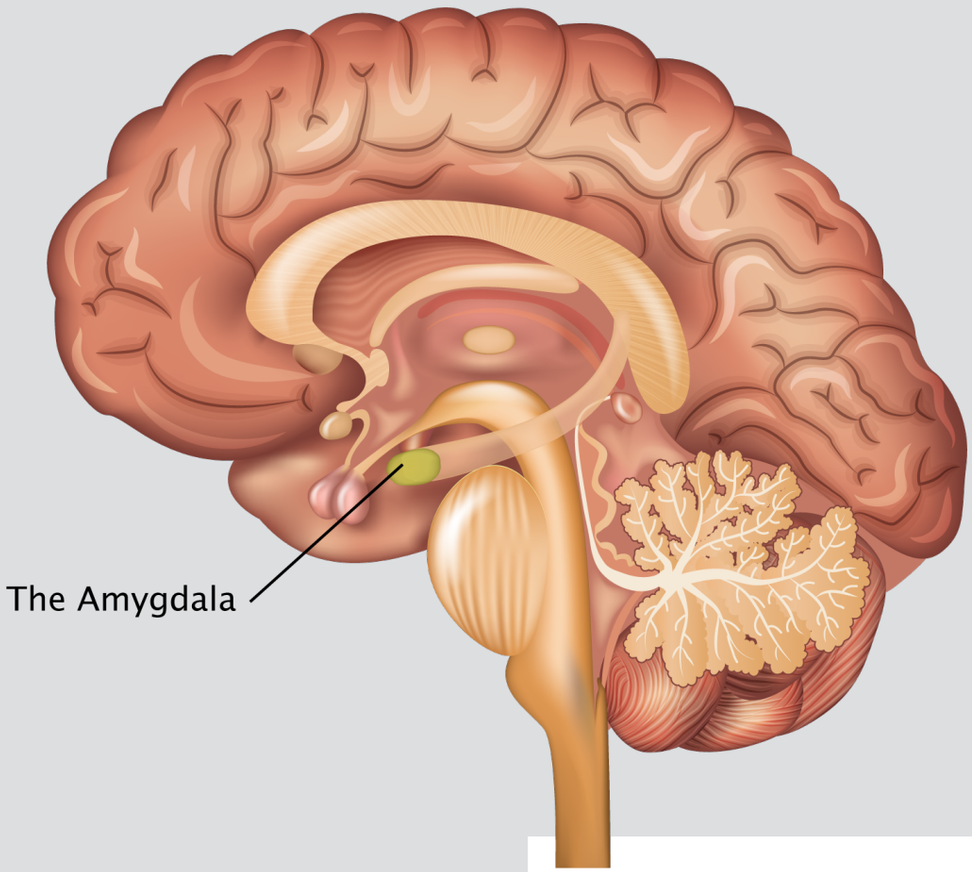
Amygdala

The amygdala is the fear and anxiety centre in the brain (chief security officer) involved in the activation of the fight/flight response. Simon, D. et al, 2014; Thorsen et al, 2018.

The amygdala plays a primary role in the acquisition and expression of conditioned fear and in the magnification of emotional memory. Koenigs, M., & Grafman, J. (2009)

Hyper-activation of the amygdala centre has been observed in complex trauma. Koenigs, M., & Grafman, J. (2009)

Individuals with borderline personality disorder and early abuse (CPTSD) have been found to have smaller amygdala volume. Vermetten, E. et al. (2011)



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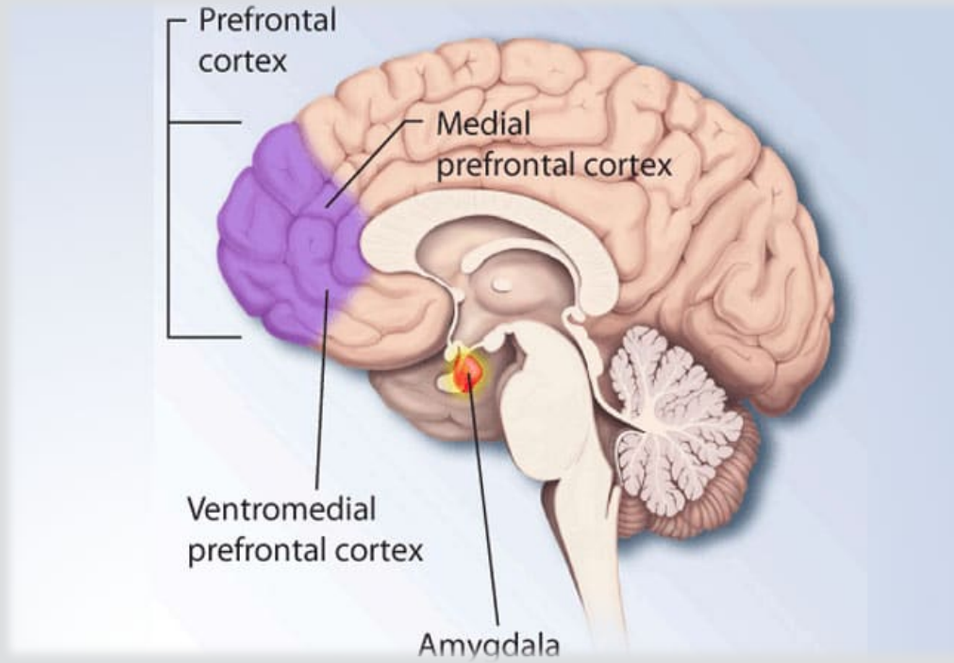
Medial-Prefrontal Cortex (mPFC)

Koenigs, M. & Grafman, J. (2009)

- mPFC is involved in the **extinction** of conditioned fear and in the appropriate regulation of **negative emotion**

- The mPFC serves as a **breaking system** for the amygdala. A defect in this inhibitory capacity has been linked to exaggerated PTSD symptoms



- Functional imaging studies of complex trauma show **hypo-activity** in the mPFC.
- Individuals with PTSD exhibit **decreased volumes** of the pre-frontal cortex. Rauch, S.L. et al. (2003)

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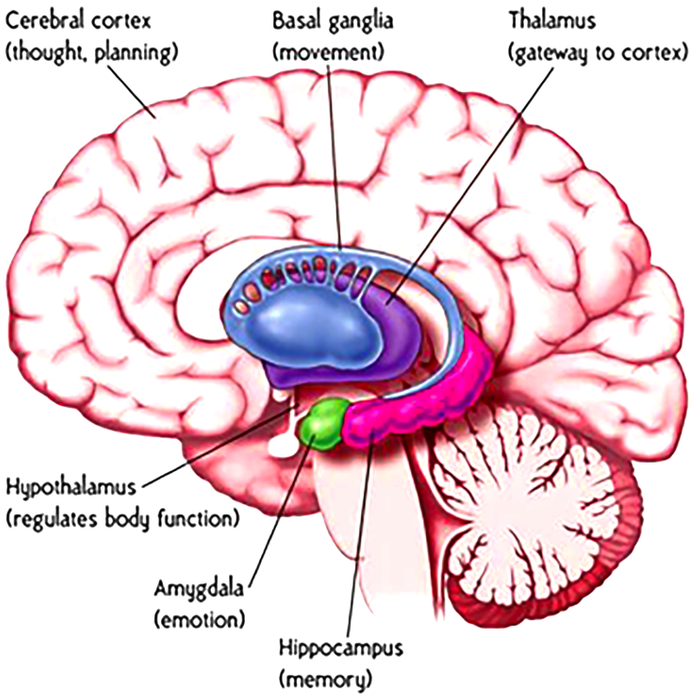
Hippocampus

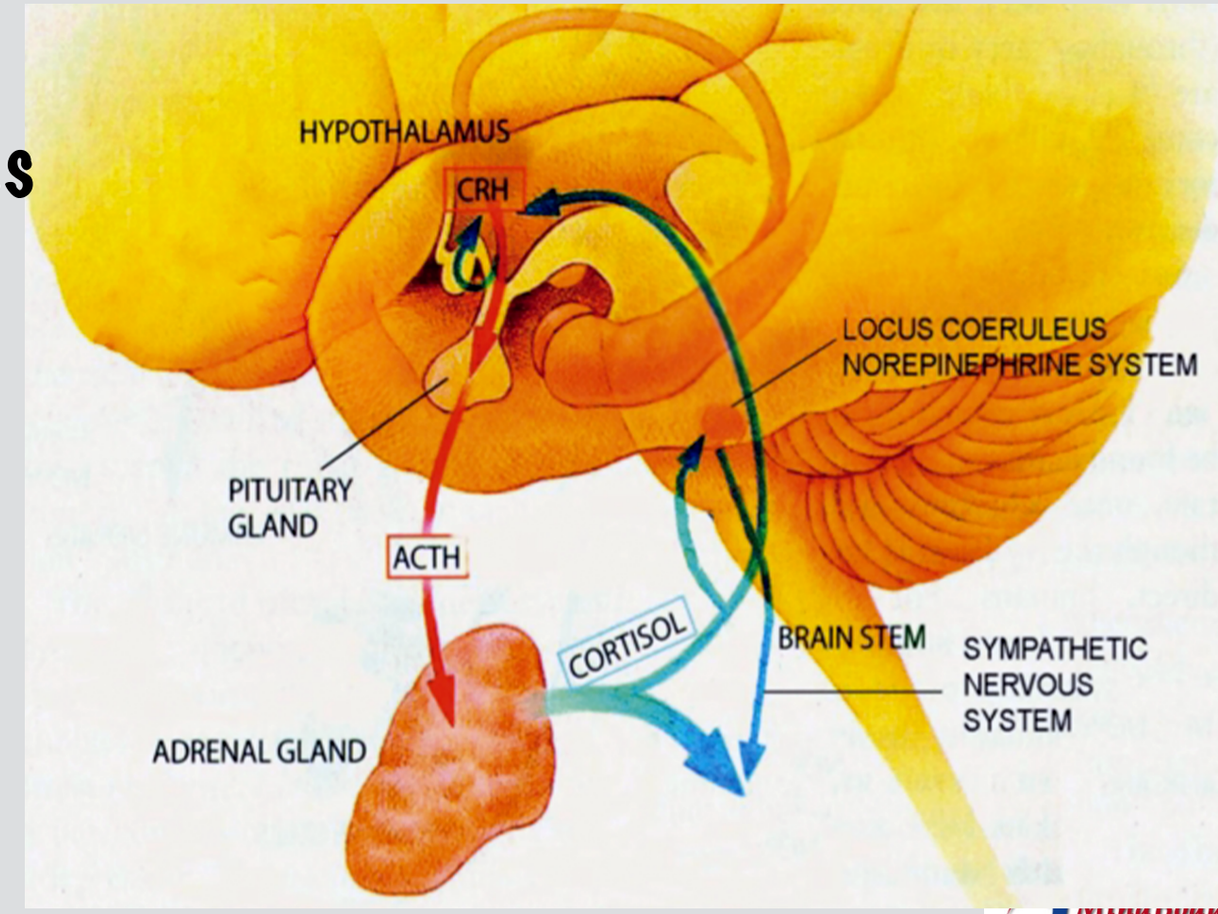
- Hippocampus plays a critical role in memory, learning, and stress regulation. Brunson, K.L. et al 2003
- The anterior hippocampus (aHPC) has a central role in encoding short-term memory, anxiety-related behaviour, stress response, emotional memory and unconditioned fear. Abdallah, C. G. Et al. 2017
- The posterior hippocampus (pHPC) has a central role in encoding long-term memory, spacial memory, autobiographical memory (implicit), and contextual fear conditioning. Abdallah, C. G. Et al. 2017
- PFC - aHPC dysconnectivity has been observed in individuals with PTSD, leading to hyperarousal or numbing symptoms. Abdallah, C. G. Et al. 2017
- Smaller hippocampal volume has been reported in several stress-related psychiatric disorders, including post-traumatic stress disorder (PTSD). Vermetten, E. Et al. (2011)



Hypothalamic-Pituitary-Adrenal (HPA) Axis

Jonathan E. S. & Charles B. N. (2011); de Quervain, D.J. 2008; Resnick, H.S. et al. 1995

- The hypothalamic-pituitary-adrenal axis is the body's major response system for stress, producing cortisol and adrenaline.
- The hippocampus and prefrontal cortex (PFC) inhibit the HPA axis activities.
- The amygdala and brain stem neurones stimulate the HPA axis
- Low cortisol levels at the time of exposure to trauma may predict the development of PTSD
- Sustained cortisol exposure degenerates the hippocampal neurones, interferes with the retrieval of traumatic memories, and impairs neurogenesis
- Complex trauma can trigger thyroid abnormalities by breaking down the hypothalamic-pituitary-thyroid (HPT) axis



Neurobiological Regions Affected in Complex Post-Traumatic Stress Disorder		
Feature	**Change**	**Effect**
Hippocampus	Reduced volume and activity	Alters stress responses and extinction
Amygdala	Increased activity	Promotes hypervigilance and impairs discrimination of threat
Cortex	Reduced prefrontal volume	Dysregulates executive functions
	Reduced anterior cingulate volume	Impairs the extinction of fear responses
	Decreased medial prefrontal activation	Poor executive functions, impairs the extinction of fear responses
Hypothalamic-pituitary-adrenal axis	Hypocortisolism	Disinhibits CRH/NE and upregulates response to stress
		Drives abnormal stress encoding and fear processing
	Sustained, increased level of CRH	Blunts ACTH response to CRH stimulation
		Promotes hippocampal atrophy
Hypothalamic-pituitary-thyroid axis	Abnormal T3: T4 ratio	Increases subjective anxiety

Jonathan E. S. & Charles B. N. (2011)

Neurochemicals Affected in Complex Post-Traumatic Stress Disorder

Feature	Change	Effect
Catecholamines	Increased dopamine levels	Interferes with fear conditioning by mesolimbic system
	Increased norepinephrine levels/ activity	Increases arousal, startle response, encoding of fear memories
		Increases pulse, blood pressure, and response to memories
Serotonin	Decreased concentrations of 5 HT in: • Dorsal raphé • Median raphé • Dorsal/median raphé	Disturbs dynamic between amygdala and hippocampus
		Compromises anxiolytic effects (body's natural anxiety relief effort)
		Increases vigilance, startle, impulsivity, and memory intrusions
Amino acids	Decreased GABA activity	Compromises anxiolytic effects (body's natural anxiety relief effort)
	Increased glutamate	Fosters derealisation and dissociation
peptides	Decreased plasma NPY concentrations	Leaves CRH/NE unopposed and upregulates response to stress
	Increased CSF β-endorphin levels (endogenous opioid)	Fosters numbing, stress-induced analgesia, and dissociation

Jonathan E. S. & Charles B. N. (2011)

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Session 3

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The A.S.I.E.C.C. Framework for Healing Complex PTSD

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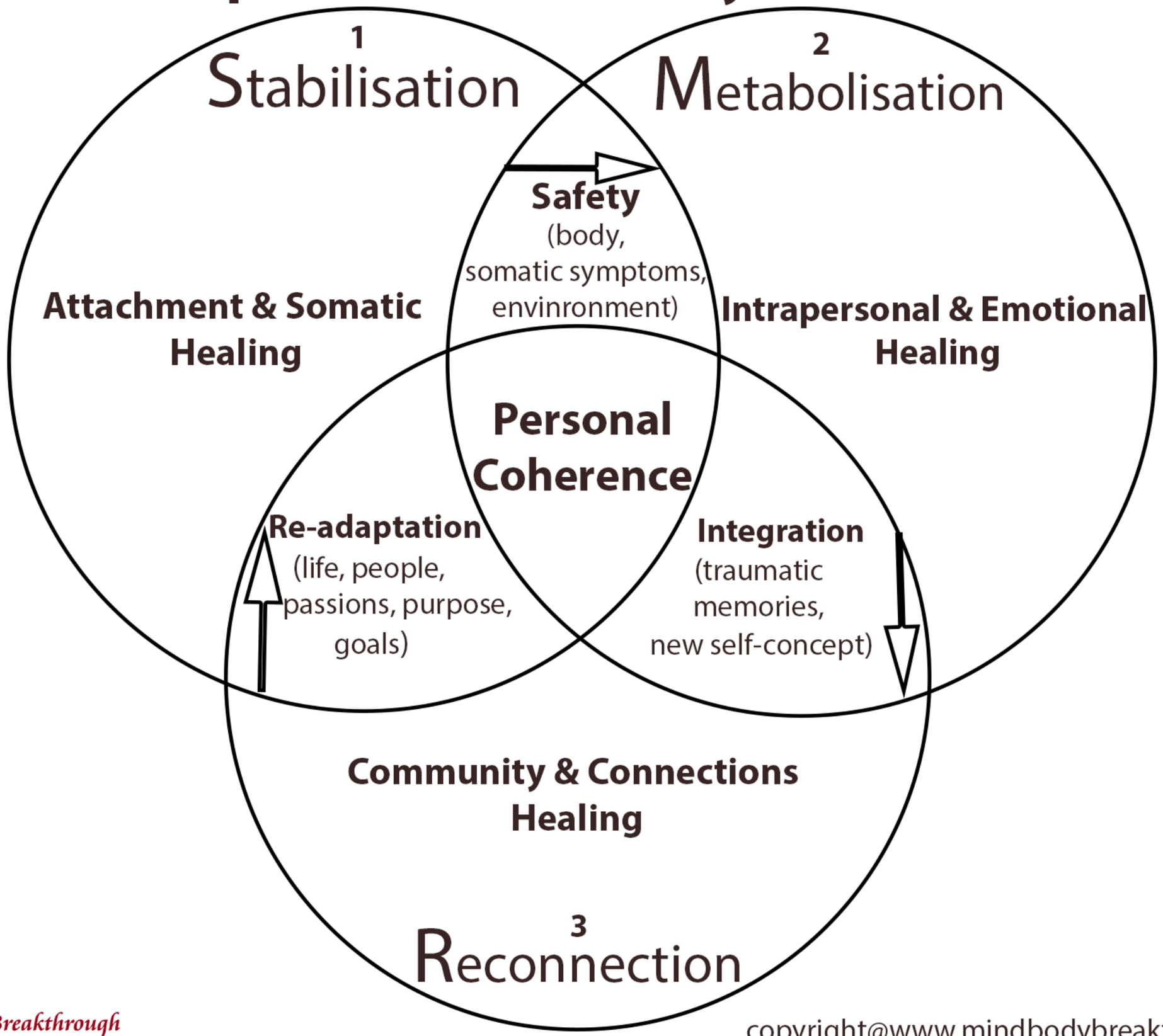
Complex PTSD Recovery Framework



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1. Stabilisation (attachment and somatic healing)

In this first recovery stage, the priority of therapy is to establish survivor's sense of safety; about their environment, mind and somatic symptoms.

C-PTSD makes survivors to feel unsafe physically, cognitively, emotionally, symptomatically, and relationally.

The stabilisation stage includes:

- Neutralising sources of traumatisation/medical attention to any injuries
- Finding a good enough secure attachment figure; e.g. empathic, available and emotional attuned relative, friend or therapist (co-regulation)
- Psycho-education; e.g. the brain science of C-PTSD
- C-PTSD symptoms stabilisation; such as, using a variety of somatic therapies (somatic re-negotiation exercises, massage, yoga, acupuncture, EFT, EMDR, grounding, mindfulness, etc)

- Environmental safety; such as, a safe living situation, mobility, financial security, safe refuge, etc.
- Stabilising self-destructive behaviours; e.g. substance abuse, eating disorder, suicidality, etc.
- Boosting brain resilience; rCBF activities, such as, regular exercise, sleep, good eating habit, self-care, etc.
- Balancing key hormones to reduce inflammation profile; e.g insulin, eicosanoids

2. Metabolisation (intra-personal and emotional healing)

In this second recovery stage, the survivor tells the traumatic stories in detail and completely; making full sense of the traumatic past, and renouncing a trauma-based self-concept.

The process of thoroughly reconstructing the horrors of the past gradually transforms survivor's traumatic memories into an integrated autobiographical story of their life.

After many repetitions, the telling of the traumatic story starts to get integrated and no longer arouses intense feelings in survivors.

There are three phases in the metabolisation stage:

- The therapeutic alliance phase
- The uncovering phase
- The grieving phase

The therapeutic alliance phase

The synergy and trust level between therapist and survivor must be strong before commencing the metabolisation phase.

Both parties are clear about the purpose of this stage, and everyone is willing to play their own unique role.

Therapist serves as a compassionate witness, while the client courageously recites the details of the traumatic memory.

Safety, pacing and timing should be prioritised. Avoiding traumatic memories lead to stagnation, while approaching them too abruptly could lead to damaging reliving of the trauma.

Survivor's somatic intrusive symptoms should be regularly monitored.

The uncovering work should be planned around other less intense activities in order to dampen its intensity.

Active uncovering work should be avoided whenever the survivor is facing an unexpected/emotionally stressful situation/crisis.

The uncovering phase

In the uncovering phase, survivor fully reconstructs the traumatic story. This should be carefully monitored as the unbearable moments close in.

First, survivors are encouraged to talk about their life before the trauma (e.g. their important relationships, resilience factors, dreams, hobbies, life difficulties).

The complete narrative must include the full integration of all related bodily sensations (visual, olfactory, kinesthetics, auditory, affective, gustatory (taste))

Follow-up questions about sensory memories should be asked to ensure adequate integration of all somatosensory fragmented memories.

Survivors must recite not just what happened but also feel the intense emotional feelings that are attached to each disclosure.

All the traumatic memories, including related imageries, feelings and other bodily sensations, should be eventually put into words.

Written uncovering story should be brought to the therapy room and read while the therapist serves as a witness.

During the recitation of traumatic memories, there should be a systematic reviewing of the events being recounted. The therapist compassionately helps survivors to find new meanings and interpretations to their memories.

The uncovering phase

Therapist should be ready to share in the emotional burden of the trauma and affirm the worthiness and dignity of the survivor.

Emotional regulation (e.g. calm, relaxation, compassion) should be re-mirrored to survivor by the therapist in order to help reconfigure their dysregulated internal self-regulatory mechanism.

Regarding major amnesiac gaps in the traumatic story, hypno-therapeutic technique may be used to make available the fragmented pieces of dissociated traumatic memory. Consent and careful preparation must be observed.

Group therapy/peer support group can also help retrieve and integrate fragmented memories.

Intense uncovering work is better done in the first or second third of the session to allow clients to re-orient and calm down.

The grieving phase

The grieving phase is the last but crucial part of the metabolisation stage, where the full telling of the traumatic story plunges survivors into profound grief.

While some survivors may resist grieving as a way of denying victory to the perpetrator, it is only through adequate grieving that deep healing can be achieved.

Resistance to grieving is the most common cause of stagnation in the second stage of recovery.

Three Ego Defences that Hinder Adequate Grief Work (Herman, 1997)

- Ego defence by revenge
- Ego defence by forgiveness
- Ego defence by compensation

Ego defence by revenge

This is a magical fantasy of retaliation where the roles of perpetrator and victim are reversed. The survivor imagines that they can escape their shame, terror, pain and sense of helplessness by retaliating against the victimiser.

Although the victim imagines that revenge will bring relief, studies have shown that acts of revenge substantially increase PTSD symptoms. (Luefer, R.S., et al., 1985)

By fully grieving in safety, using all the grieving platforms (angering, crying, emoting and verbally ventilating), survivors gradually disengage from their ego defence by revenge and reconnect with their indestructible inner self.

Ego defence by forgiveness

The ego defence by forgiveness makes survivors to think that they can transcend their traumatic rage and symptoms through a defiant act of love.

Trauma can't be defiantly exorcised through either revenge or forgiveness. Rather, trauma must be properly processed and walked though for true healing to take place. Abrupt forgiveness should not be used as a defence against true grieving.

Once the victim has fully metabolised her traumatic memories and embraced the act of fully grieving, a sense of compassion or forgiveness for the victimiser may be experienced.

Ego defence by compensation

For many survivors, ego defence by compensation is a major hinderance to grieving. Because of the obvious injustice, survivor may feel strongly entitled to some form of compensation.

While the quest for fair compensation is often a vital part of recovery, it could also present a potential trap. Prolonged struggles for compensation may become a defence mechanism against facing the reality of the intense emotions of trauma.

For some survivors, compensation means more than any monetary gain; it is a way of retaliating, demanding an apology or publicly humiliating the victimisers.

Grieving is the only effective way to fully honour our losses. There is no adequate compensation.

Session 4

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3. Reconnection (community and connections healing)

In this third recovery stage, the survivor begins a courageous journey of reconnecting back to life, people, purpose, passions, and goals.

Having come to terms with the traumatic past, the survivor now faces a huge task of creating a thriving future.

The focuses in this stage include:

- Engaging more actively in the world; not just from a defensive position for basic safety, but also from an offensive position as an active participator in life.
- Reconnecting to past positive aspirations, passion, purpose and setting new goals.
- Reconnecting to their personal power and deepening alliances with those they have learnt to trust.
- Strengthening their fighting and running responses, and consciously engaging their fears
- Actively engaging their fears and strengthening their fighting and running responses
- Strengthening personal connection with the authentic self.
- Building positive self-concept and sense of worth

3. Reconnection (community and connections healing)

- Addressing unhelpful and unconscious ways of coping with emotions or social situation that may put them at risk.
- Examining aspects of own trauma-induced personality or behaviours that can render them vulnerable to exploitation
- Incorporating the lessons of her traumatic experiences into her life and gradually passing them on to assist others
- Ongoing work regarding the stabilisation of the body, symptoms, environment, material needs and relationships
- Breaking the rule of silence (e.g. family disclosures) and passing backward the burden of toxic shame, fear, and guilt.

- Working on deepening intimacy and connections with lovers and family members while strengthening own ability to feel autonomous.
- Embracing the adolescent way of coping in social situations; such as using humour, laughter or giggling to 'ward off' embarrassment or shame, building tight friendships with a group of trusted others in order to explore the world together
- For survivors of sexual trauma, safe-sex guidelines must be established with partners, including identifying activities that can trigger traumatic memories. A high degree of cooperation,, commitment, and empathy is required from sexual abuse survivors' partners.
- Finding a survivor mission to transcend the past and make it a gift to others. Social actions help survivors to draw on their most mature and adaptive coping strategies of teamwork, patience, resourcefulness, altruism, initiative, energy and shared purpose.

Managing CPTSD Flashbacks

CPTSD flashback is a psychic dissociation into the overwhelming and disturbing emotions of the childhood trauma/initial trauma. In traumatic flashbacks, survivors abandon awareness and fully re-experience the toxic shame, fear, guilt and feelings of helplessness of the traumatic past.

Steps to Managing CPTSD Flashbacks:

- Recognise that you are having a flashback; say to yourself; "This is not me, it's a flashback - it's the amygdala hijacking".
- Take four deep breaths, and ground yourself; steady your head and use your peripheral vision to identify four things that you can see, hear, feel, smell or sense on your right and left. Verbalise them.
- Take four more deep breaths and reassure your yourself: say, 'I am no longer a helpless child, but a resilient adult with stronger resources and support network to protect myself and create my future.
- Slow down, and find a quiet place to ease back into your body, while checking into your special place (imaginary resource centre).

- Engage in a rCBF activity: such as walking, singing, playing with a pet, connecting with a child, etc., while riding out the fight/flight cycle

Identifying CPTSD Flashback Triggers

There are certain situations in life to watch out for as they are prone to triggering emotional flashbacks in CPTSD.

These include:

- Places, things, events, facial expressions or tone of voice that remind us of the abuser.
- Authority figures
- Talking to parents
- Having children
- New relationships
- Success
- Failure/setback/mistakes/crisis
- When you or others around you are angry
- When you are being praised
- When you're hurt or you hurt someone
- When receiving affection
- Stroking as an expression of sympathy or affection
- When tired or hungry
- When you're being criticised

Managing Criticisms to Avoid Being Triggered

CPTSD survivors are especially prone to experiencing emotional flashbacks when being criticised. The rule of thumb during a critical attack is; never defend yourself, as you can easily get triggered in the process. Rather, use any of the following criticism management techniques:

- **Columboing**: When you columbo your critic, you play dump and ask a lot of questions. You say, "Now let me see if I am getting this right.....You think I should stop wearing my hair in this way.' 'What is it about my hairstyle that you don't like?' The goal is to repeat the same question to whatever answer they provide until you get them out of their critical cover-up

- **Clarifying**: Like columboing, clarifying is a way of pinning your critic to the wall and escape their toxic shame-shifting intentions. Let's say a relative says, "you're not going to wear that red top again, are you?" Then you say, "What is it about that red top that you don't like?" "They look cheap," the relative said. Then you say, "What is it that you don't like about cheap tops? Continue to ask for clarification in this way until you dissipate your relative's critical energy.

Managing Criticisms to Avoid Being Triggered

- **Confirming:** This is a great technique to re-enforce your healthy self-concept in the middle of toxic criticisms. You say to yourself repeatedly, "It does not matter what you say or do to me, I am still a worthy and loveable person." Ensure that you **anchor** this positive affirmation, and visualise yourself as confident and resilient. This technique is most useful when dealing with extremely critical person who does not shift their position.

- **Fogging**: This is when you let the critic's comment go through you like a fog. You refuse to defend yourself. Rather, you use words like, "Fair enough," or "that's right," at the same time you are using the confirming technique in your mind.

- **Comforting**: Use this method when you have accidentally offended someone. The goal here is to comfort the person and not to blame or defend yourself. Allow the other person to express his feelings. Practise active listening. Acknowledge their frustrations, "Gosh, I hear that you are upset and angry." Apologise and make reasonable amends.

- **Confronting**: This is when you confront your critic directly and assertively. Look the person straight in the eyes and say what you perceive, interpret and feel about their criticism. For example, "When you make comments like that, you make me feel very small and stupid and I interpret that as a bullying tactic."

Managing Criticisms to Avoid Being Triggered

Confusing: Use this technique when every other technique fails in a non-intimate relationship. In confusing, you use either a made-up word or a big word out of context in order to get someone off your back. For example, a work colleague has just criticised you for coming in late and you want to avoid another fruitless argument. Look at him and say, "Oh gosh, the traffic was bragguddosiouss today. Your critic looks perplexed as his mind starts to search for the meaning of the unfamiliar word. You just smile and walk away.

Q&A Session

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"There are no constraints on the human mind, no walls around the human spirit, no barriers to our progress except those we ourselves erect."

—Ronald Reagan, 40th U.S President

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