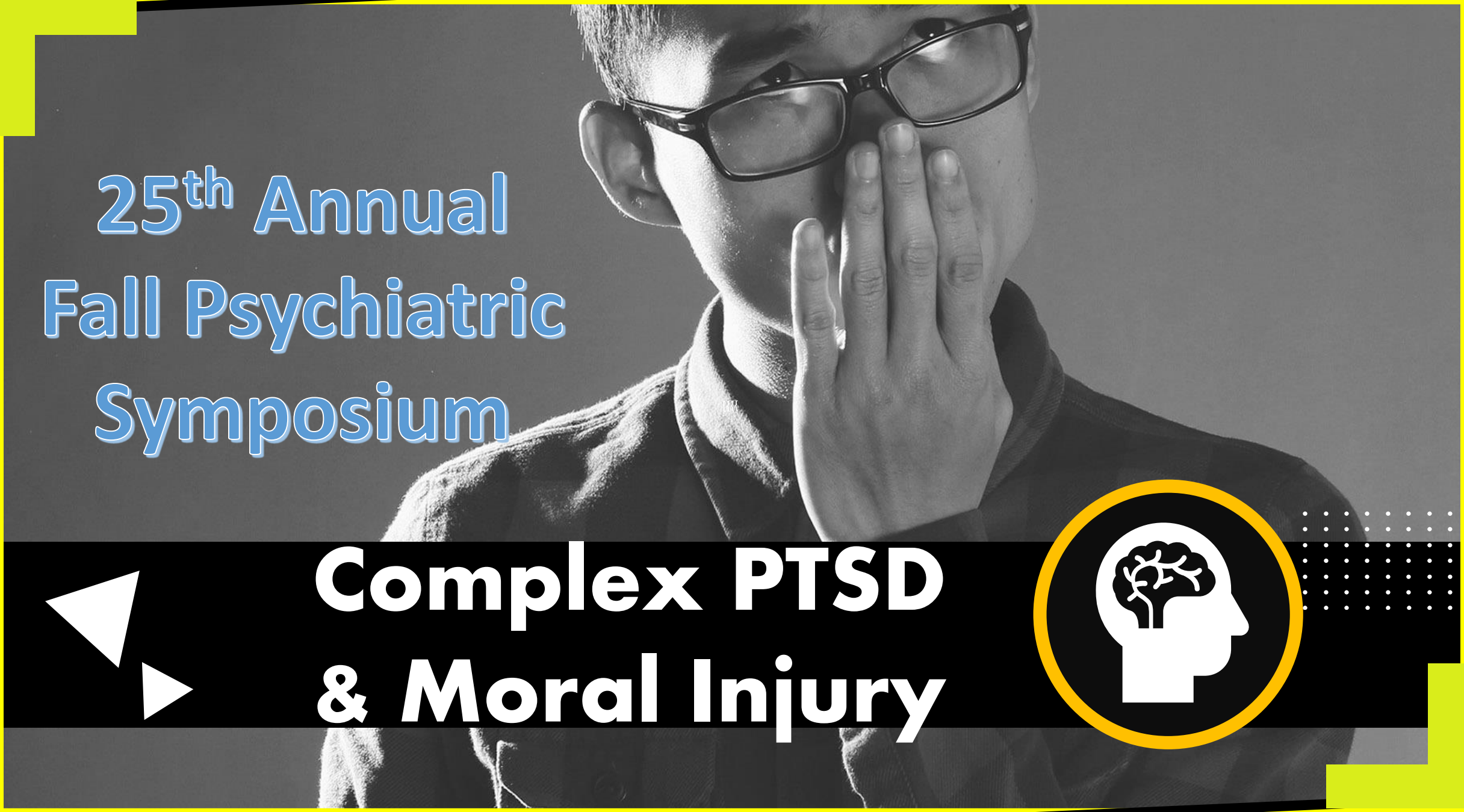
25th Annual
Fall Psychiatric
Symposium
Complex PTSD
& Moral Injury

Presenters

Lane M. Cook, M.D.

Psychiatrist, Private Practice

TMS of Knoxville

Knoxville, Tennessee

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8th Judicial District

Public Defenders Office

Disclosures

Lane M. Cook, M.D.

I have no actual or potential conflict of interest in relation to this program/presentation.

I am a paid speaker for Alkermes pharmaceutical with no bearing on this presentation.

I will be presenting off-label uses of certain drugs without any financial relationships.

Herb Piercy, IV, MSSW, LMSW

I have no actual or potential conflict of interest in relationship to this program/presentation.

Learning Objectives

Deep dive into Complex PTSD and Moral Injury

Explore the history, etiology, causes and treatments

Translational issues

Connect the dots between trauma and abuse and the dynamics and symptoms resulting in C-PTSD and Moral Injury

Assessment and Identification

Symptoms, rating scales, checklists

Treatments

Psychotherapy, medications, spiritual treatments, research

Resources

Books, journals, videos, symposiums, organizations

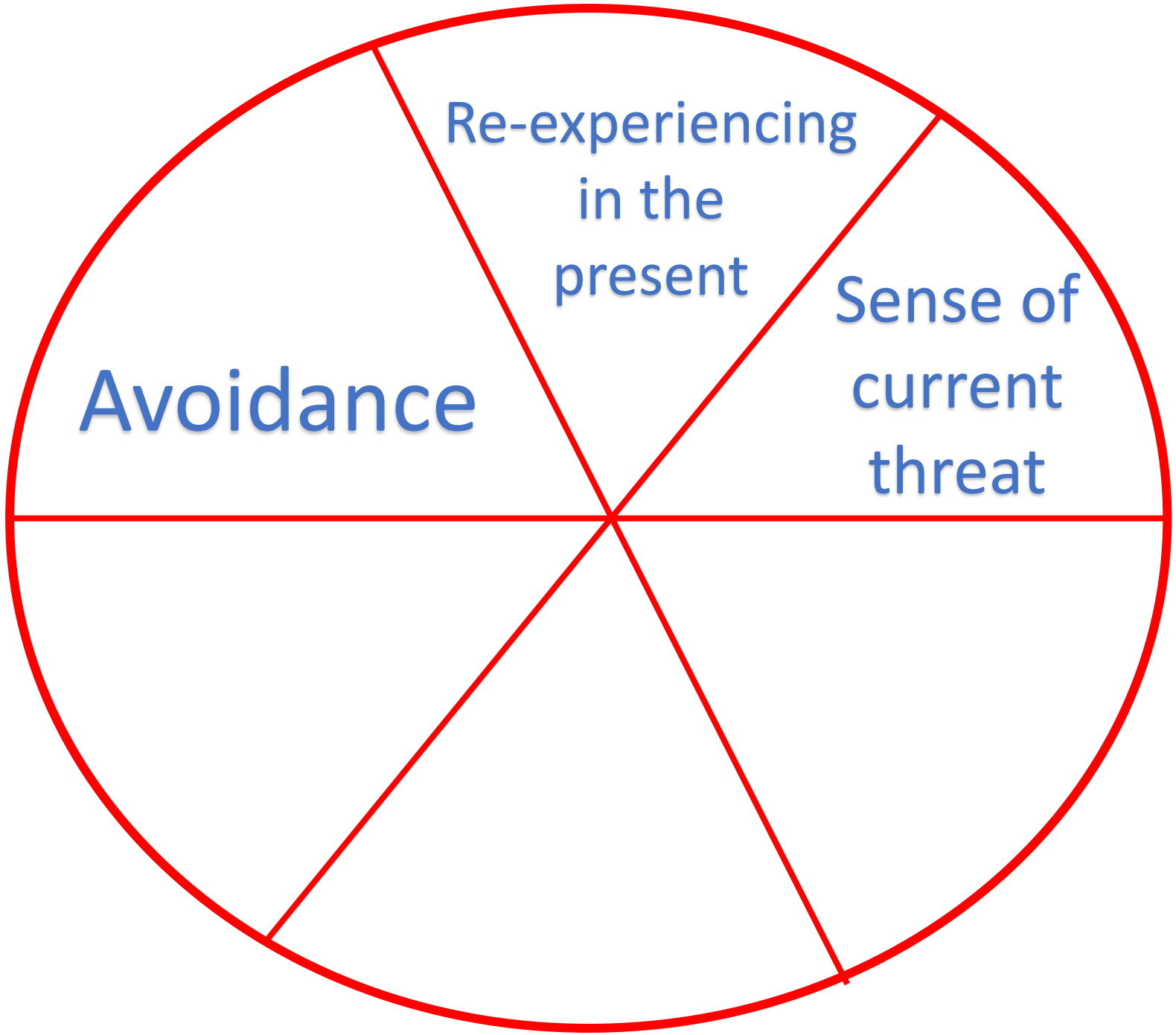
Complex Post Traumatic Stress Disorder

- ✓ About
- ✓ Causes
- ✓ Sign & Symptoms
- ✓ Tests
- ✓ Treatment
- ✓ Psychotherapy
- ✓ Medications if any
- ✓ Summary

Sign and Symptoms

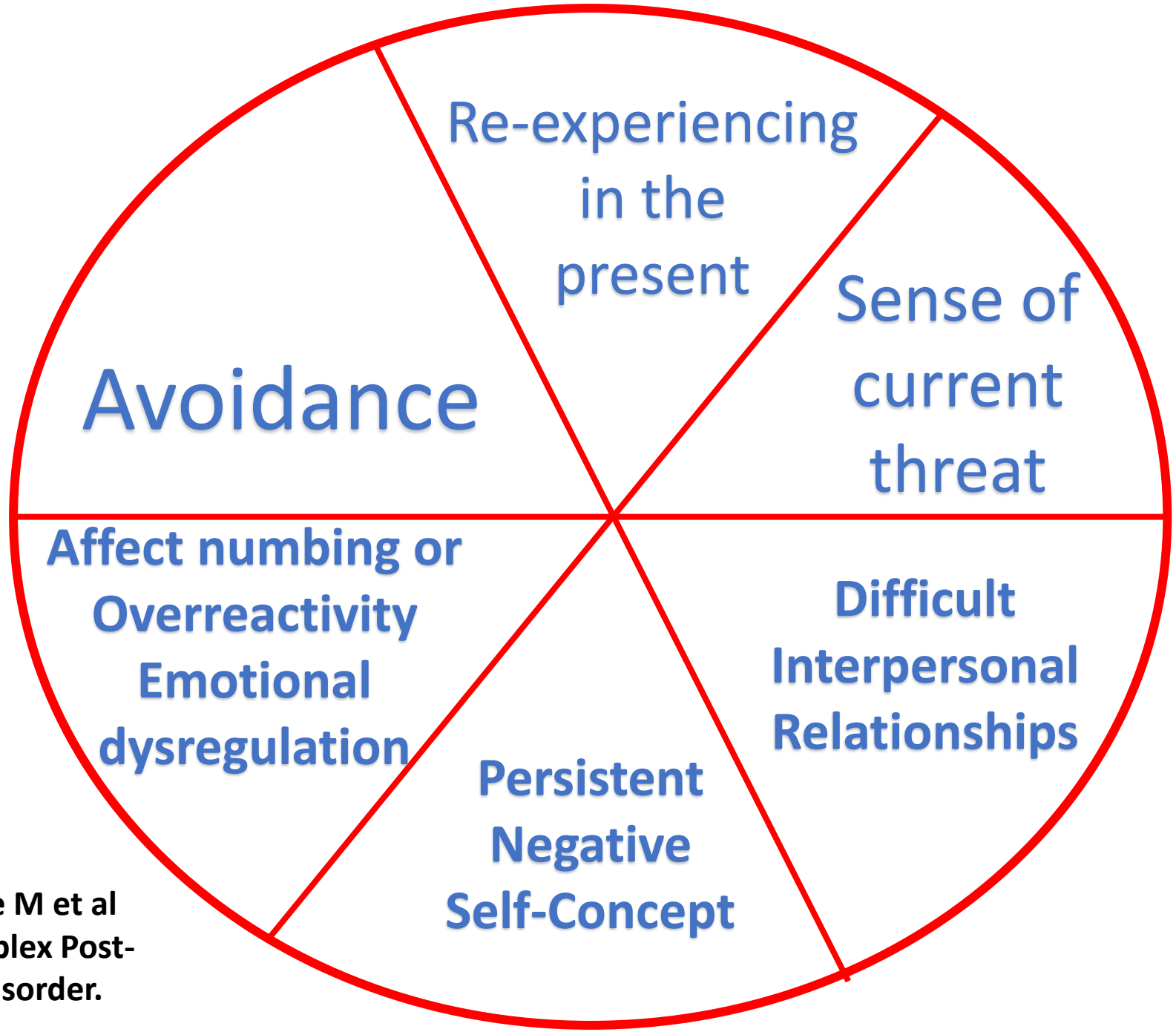
- Difficulty controlling your emotions
- Feeling very angry or distrustful towards the world
- Constant feelings of emptiness or hopelessness
- Feeling as if you are permanently damaged or worthless (moral injury)
- Feeling as if you are completely different to other people
- Feeling like nobody can understand what happened to you
- Avoiding friendships and relationships, or finding them very difficult
- Often experiencing dissociative symptoms such as depersonalization or derealization
- Somatic symptoms, such as headaches, dizziness, chest pains and stomach aches
- Regular suicidal feelings.

PTSD vs Complex PTSD



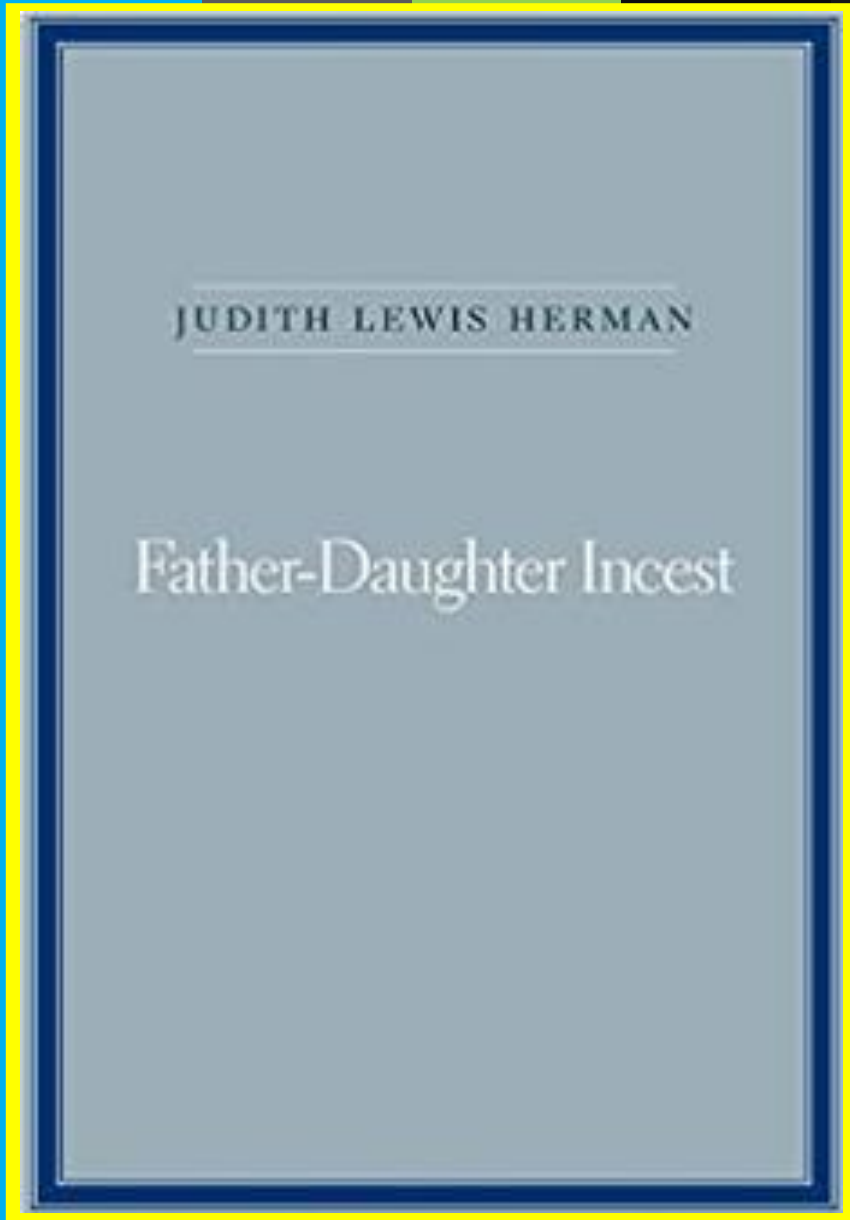
PTSD vs Complex PTSD

Complex PTSD

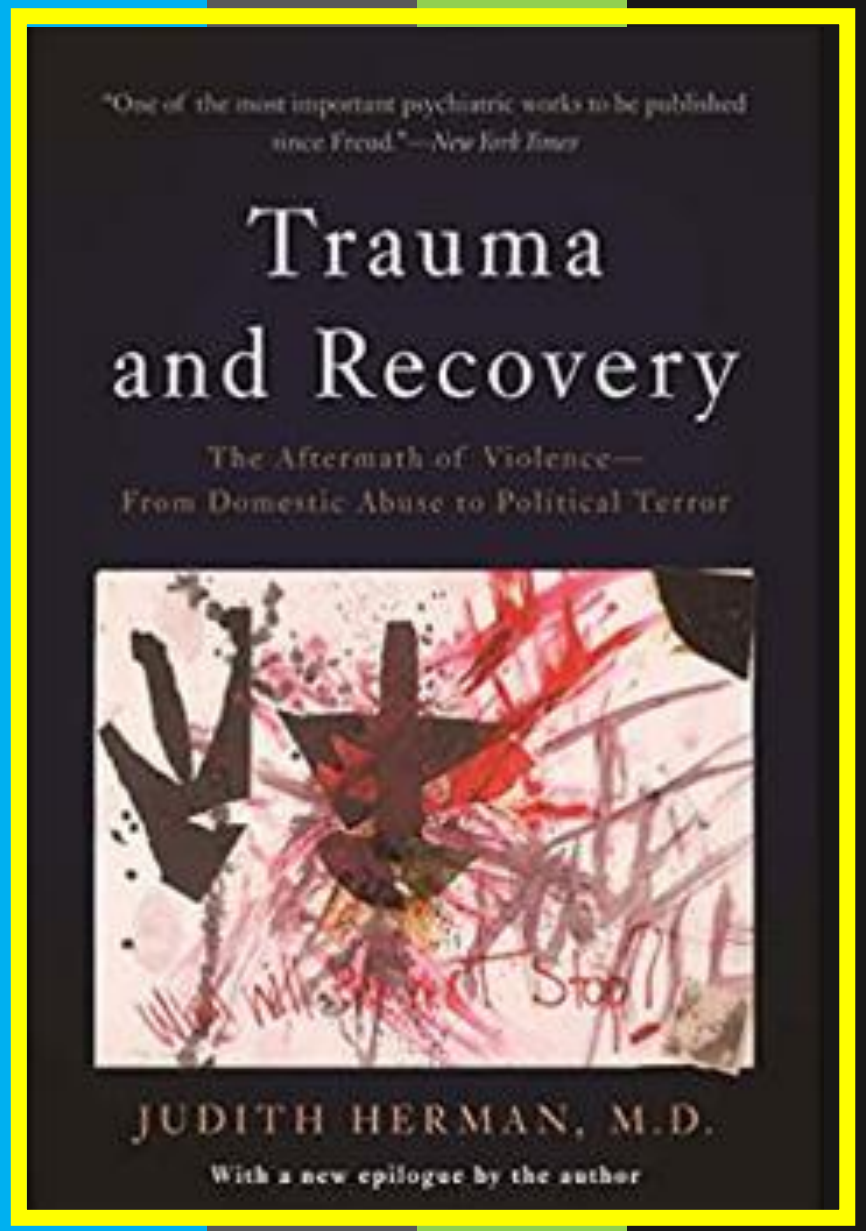


Maercker A, Cloitre M et al (July 2,2022). Complex Post-Traumatic Stress Disorder. *Lancet*, 400, 60-72

Early Work



- Psychiatrist Judith Herman's first major work, published in 1981
- Literature was sparse prior to this publication
- Describes the paucity of publications on the subject, dispelled the myth that incest was rare and the sexist bias of what was written (see forward).

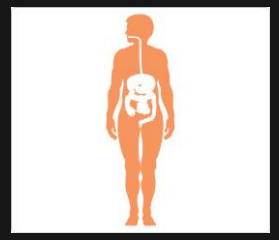


About C-PTSD

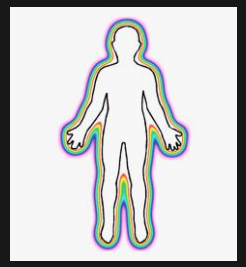
- First described in *Trauma and Recovery* by psychiatrist Judith Herman, M.D. in 1992
- Differentiated from PTSD by prolonged and repeated trauma and some form of captivity
- Not recognized in any DSM including DSM-IV & DSM-5, who considered but struck the Disorders of Extreme Stress Not Otherwise Specified (DESNOS) alternative

Judith Herman's Criteria - 1992

- Somatic



- Dissociative



- Affective

- Identity and relationships

Causes-
Repeated Trauma or Polyvictimization (multiple Types)

- Childhood abuse, neglect or abandonment
- Ongoing domestic violence or abuse
- Repeatedly witnessing violence or abuse, combat, child soldiers
- Captivity, being forced or manipulated into prostitution (sex trafficking), torture, kidnapping or slavery, cults

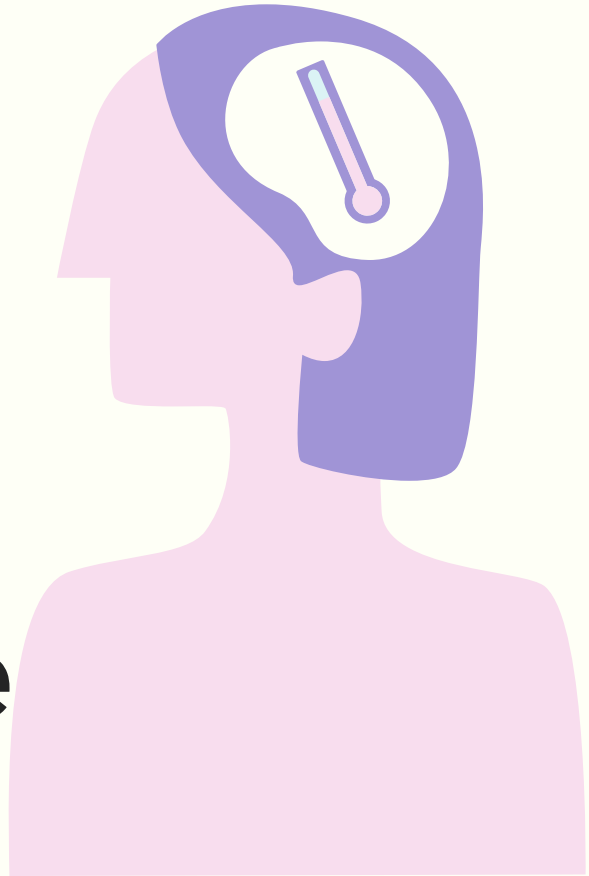
Identity Problems

- Abusers/perpetrators control most aspects of the victims life for a period of time
  - Isolation of the victim from others
  - Destroys victim's sense of autonomy and self-worth, producing a negative self-concept
- Abusers often are the victim's source of survival and angering the abuser is dangerous

C-PTSD: Core symptoms of PTSD plus Disturbances in Self-Organization (DSO) - Marylene Cloitre, Ph.D.

Negative Self Concept

- Persistent beliefs about self as diminished, defeated or worthless
- Feelings of guilt and/or shame



Relationship Problems

- Through intermittent reinforcement, even small signs of affection or relief contribute to trauma bonding
- Promotes anxious-avoidance attachment
- Remaining in abusive situations – “sitting duck”

Loss of initiative & motivation

The accounts of coercive methods given by battered women, abused children, and coerced prostitutes bear an uncanny resemblance to those hostages, political prisoners, and survivors of concentration camps.

Prolonged confinement produces a trauma bond between victim and persecutor. The field of initiative is narrowed considerably, dictated by the perpetrator. This regression to "psychological infantilism" compels victims to cling to the persecutor.

Prolonged captivity undermines or destroys the ordinary sense of a relative safe sphere of initiative, in which there *is some tolerance for trial and error*. To the chronically traumatized person, any independent action is insubordination, which carries the risk of dire punishment.

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, *5*(3), 377–391.

C-PTSD: Core symptoms of PTSD plus Disturbances in Self-Organization (DSO) - Marylene Cloitre, Ph.D.

Interpersonal difficulties

- Persistent difficulties in sustaining relationships due to tendency to avoid, deride or have little interest others, social withdrawal
- Intense relationships with difficulty maintaining emotional connectiveness

Developmental vulnerabilities 1

Research reveals that adverse childhood experiences have a differential effect on sensitive brain areas, especially within the limbic circuit, during specific maturation phases. For instance, sensitive periods for the limbic circuit (including the amygdala and hippocampus) and areas involved in stress regulation (such as the prefrontal cortex) are during preadolescence (approximately 9–12 years) and early adolescence (approximately 13 years). This could contribute to the heterogeneity of study results in different PTSD populations based primarily on cross-sectional diagnoses.

Maercker A, Cloitre M et al (July 2,2022). Complex Post-Traumatic Stress Disorder. Lancet, 400, 60-72

Herzog JI, Thome J, Demirakca T, et al. Influence of severity of type and timing of retrospectively reported childhood maltreatment on female amygdala and hippocampal volume. *Sci Rep* 2020; 10: 1903.

Developmental vulnerabilities 2

A lot of skills to pack into a short time span

There is evidence that trauma exposure creates risk for complex PTSD in ways that are sensitive to the developmental epoch in which the trauma has occurred. For example, trauma in childhood can adversely affect attachment patterns and mental integration capabilities. This includes, for instance, an adverse effect during adolescence on the formation of one's own social identity and the acquisition of morality and values, and in early adulthood, taking responsibility for people and assignments, all of which are accompanied by emotion regulation and relationship skills development.

Maercker A, Cloitre M et al (July 2,2022). Complex Post-Traumatic Stress Disorder. *Lancet*, 400, 60-72

Effects of persistent trauma on a child

Living in an unpredictable world interferes with the development of object constancy; as a result, they lack verbal and conceptual representations of both their inner world and of their surroundings. As a consequence, they have little sense of their own contributions to what happens to them. Without internal maps to guide them, they act instead of plan, show their wishes in their behaviors, rather than discussing what they want. They take, rather than ask. Unable to appreciate clearly who they, or others are, they do not know how to enlist other people as allies on their behalf; people are sources of terror or gratification, but rarely fellow-human beings with their own sets of needs and desires. They have difficulty appreciating novelty; without a map to compare and contrast, anything new is potentially threatening. What is familiar tends to be experienced as safer, even if it is a predictable source of terror.

"Down will come baby, cradle and all: Diagnostic and therapeutic implications of chronic trauma on child development" - Annette Streeck-Fischer, Bessel A. van der Kolk available from

https://www.cttntraumatraining.org/complex-trauma.html

National Child Traumatic Stress Network Study

- In a large clinician survey of children and adolescents served by the National Child Traumatic Stress Network, Dr. Joseph Spinazzola and his colleagues identified five difficulties most pervasively faced by youth receiving assessment or treatment services due to histories of trauma.
- Four of these difficulties were reported to be relevant to over half of all children and adolescents represented by this survey:

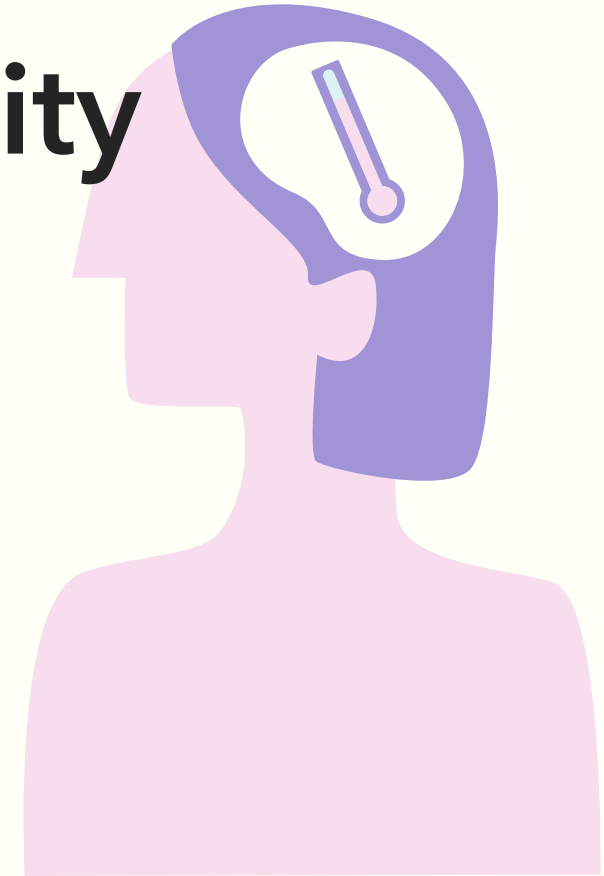
1. Affect Dysregulation: problems recognizing, shifting, communicating, and tolerating strong feelings and emotions
2. Attentional Dysregulation: difficulty directing attention and sustaining concentration on present-focused, goal-directed activities and tasks
3. Negative Self-Image: chronic struggles with low self-esteem, distorted body-image, lack of self-worth, self-blame, and self-loathing
4. Impulsivity: difficulty controlling strong urges to engage in risky and potentially harmful or self-destructive actions and behaviors
5. Finally, nearly half of the youth covered by this survey also experience significant difficulties with aggression.

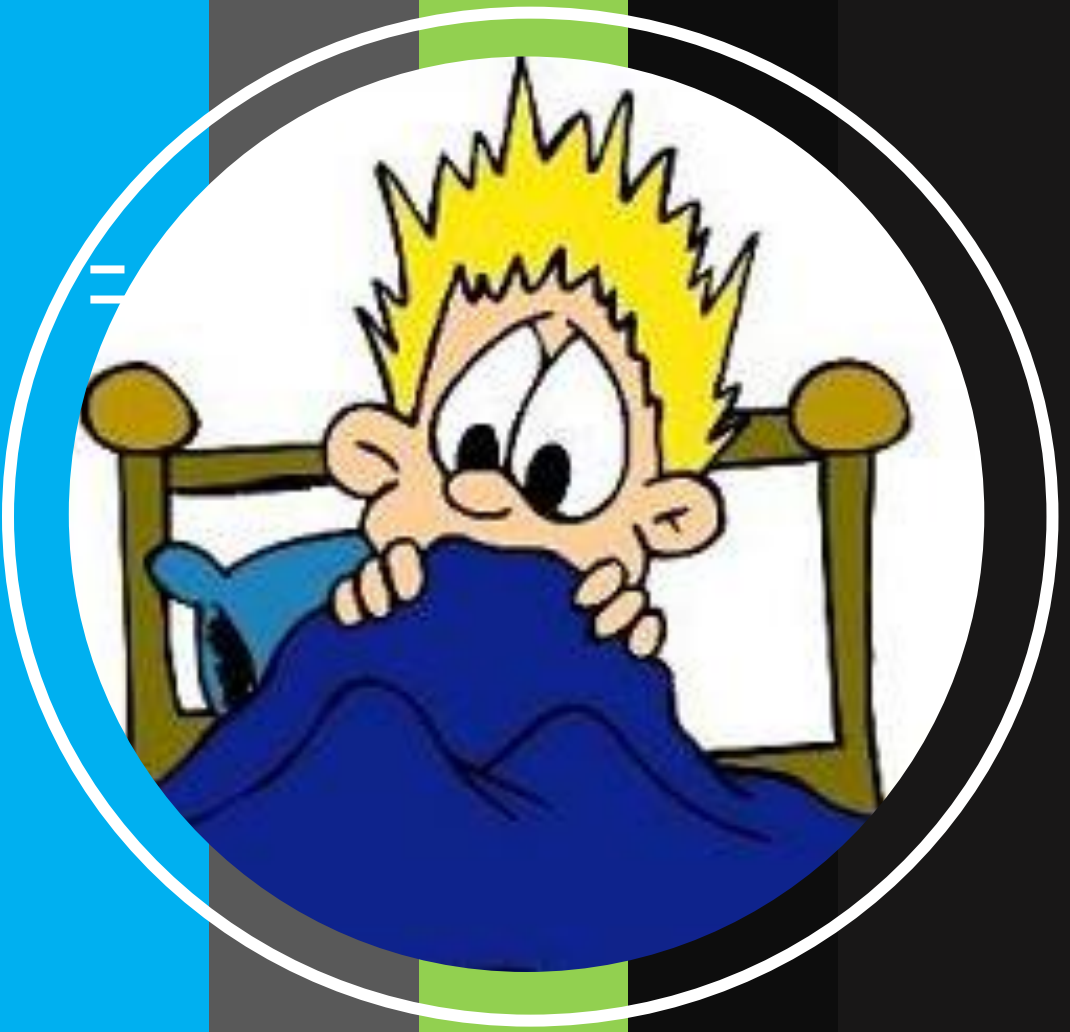
- These five difficulties were followed by a host of others each occurring in a subset of traumatized youth, including somatic symptoms, attachment difficulties, conduct and sexualized behavior problems, dissociation, and finally PTSD.

C-PTSD: Core symptoms of PTSD plus Disturbances in Self-Organization (DSO) - Marylene Cloitre, Ph.D.

Emotional dysregulation

- Heightened emotional reactivity
- Violent outbursts
- Reckless or self-destructive behavior
- Dissociates under stress





Somatization – physical complaints

> “Chronically traumatized people are hypervigilant, anxious and agitated, without any recognizable baseline state of calm or comfort.”

Hilberman, E. “Overview: the "wife-beater's wife" reconsidered.” *The American journal of psychiatry* vol. 137,11 (1980): 1336-47.

Symptoms

- Hypervigilance
- Anxious/angry
- Easily startled
- Insomnia
- Back pain, pelvic pain, headaches, GI distress
- Choking/smothering sensations/panic attacks

Dissociation

“People in captivity become adept practitioners of the arts of altered consciousness. Through the practice of dissociation, voluntary thought suppression, minimization and outright denial, they learn to alter an unbearable reality.”

- Judith Herman

Dissociation

“Disturbances in time sense, memory and concentration are almost universally reported. Alterations in time sense begin with the obliteration of the future and eventually progress to the obliteration of the past.”

- Judith Herman

Affective Changes

Bitterness of feeling abandoned by man and God are extremely common, leading to chronic and often severe depression as well as moral injury.
Hyperarousal and intrusion symptoms fuse with vegetative symptoms of depression forming the "survivor triad" of nightmares, insomnia and psychosomatic symptoms.
Humiliated rage adds to the depression which is often suppressed while captive to ensure survival.

Anger and rage:

- Outwardly expressed – verbal and physical abuse to others
- Inward bound – suicidal ideation, self-mutilation, substance abuse

Compassion Fatigue & Secondary Trauma

The compassion fatigue resilience (CFR) model is the latest iteration in successive models that attempt to account for the variance in CFR (higher resilience resulting in lower compassion fatigue). The model helps account for why some people experience little to no compassion stress whereas others do, despite the same levels of exposure and competence when working with the traumatized. This multidimensional model of resilience provides the best estimate yet in depicting STS reactions that account for the increase/decrease of STS. This model has the potential for guiding both research and practice, and teaching trauma survivors and future trauma-exposed professionals how to build up their secondary stress resilience and become more effective in managing secondary stress when their “hearts go out” to the suffering.

Ludick, M., & Figley, C. R. (2017). Toward a mechanism for secondary trauma induction and reduction: Reimagining a theory of secondary traumatic stress. *Traumatology, 23*(1), 112.

C-PTSD: Core symptoms of PTSD plus Disturbances in Self-Organization (DSO) - Marylene Cloitre, Ph.D.

Negative Self Concept

- Persistent beliefs about self as diminished, defeated or worthless
- Feelings of guilt and/or shame

Emotional dysregulation

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Interpersonal difficulties

- Persistent difficulties in sustaining relationships due to tendency to avoid, deride or have little interest others, social withdrawal
- Intense relationships with difficulty maintaining emotional connectiveness

International Trauma Questionnaire

CPTSD. A diagnosis of CPTSD requires the endorsement of one of two symptoms from each of the three PTSD symptoms clusters (re-experiencing in the here and now, avoidance, and sense of current threat) and one of two symptoms from each of the three Disturbances in Self-Organization (DSO) clusters: (1) affective dysregulation, (2) negative self-concept, and (3) disturbances in relationships. Functional impairment must be identified where at least one indicator of functional impairment is endorsed related to the PTSD symptoms and one indicator of functional impairment is endorsed related to the DSO symptoms. Endorsement of a symptom or functional impairment item is defined as a score > 2.

International Trauma Questionnaire

Instructions: Please identify the experience that troubles you most and answer the questions in relation to this experience.

Brief description of the experience

_____

When did the experience occur? (circle one)

a. less than 6 months ago
b. 6 to 12 months ago
c. 1 to 5 years ago
d. 5 to 10 years ago
e. 10 to 20 years ago
f. more than 20 years ago

https://www.traumameasuresglobal.com/itq

PTSD Questions

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

C-PTSD Questions

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, have 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

Scoring

DSO – Disturbances in Self-Organization

1. Diagnostic scoring for PTSD and CPTSD

PTSD

If P1 or P2 > 2 criteria for Re-experiencing in the here and now (Re_dx) met
If P3 or P4 > 2 criteria for Avoidance (Av_dx) met
If P5 or P6 > 2 criteria for Sense of current threat (Th_dx) met
AND
At least one of P7, P8, or P9 > 2 meets criteria for PTSD functional impairment (PTSDFI)
If criteria for 'Re_dx' AND 'Av_dx' AND 'Th_dx' AND 'PTSDFI' are met, the criteria for PTSD are met.

CPTSD

If C1 or C2 > 2 criteria for Affective dysregulation (AD_dx) met
If C3 or C4 > 2 criteria for Negative self-concept (NSC_dx) met
If C5 or C6 > 2 criteria for Disturbances in relationships (DR_dx) met
AND
At least one of C7, C8, or C9 > 2 meets criteria for DSO functional impairment (DSOFI)
If criteria for 'AD_dx' AND 'NSC_dx' AND 'DR_dx', and 'DSOFI' are met, the criteria for DSO are met.
PTSD is diagnosed if the criteria for PTSD are met but NOT for DSO.
CPTSD is diagnosed if the criteria for PTSD are met AND criteria for DSO are met.
Not meeting the criteria for PTSD or meeting only the criteria for DSO results in no diagnosis.

2. Dimensional scoring for PTSD and CPTSD.

Scores can be calculated for each PTSD and DSO symptom cluster and summed to produce PTSD and DSO scores.

PTSD

Sum of Likert scores for P1 and P2 = Re-experiencing in the here and now score (Re)
Sum of Likert scores for P3 and P4 = Avoidance score (Av)
Sum of Likert scores for P5 and P6 = Sense of current threat (Th)
PTSD score = Sum of Re, Av, and Th

DSO

Sum of Likert scores for C1 and C2 = Affective dysregulation (AD)
Sum of Likert scores for C3 and C4 = Negative self-concept (NSC)
Sum of Likert scores for C5 and C6 = Disturbances in relationships (DR)
DSO score = Sum of AD, NSC, and DR

Rating Scales

https://www.mdapp.co/ptsd-checklist-calculator-549/

Intrusion

Avoidance

Negativity

Arousal

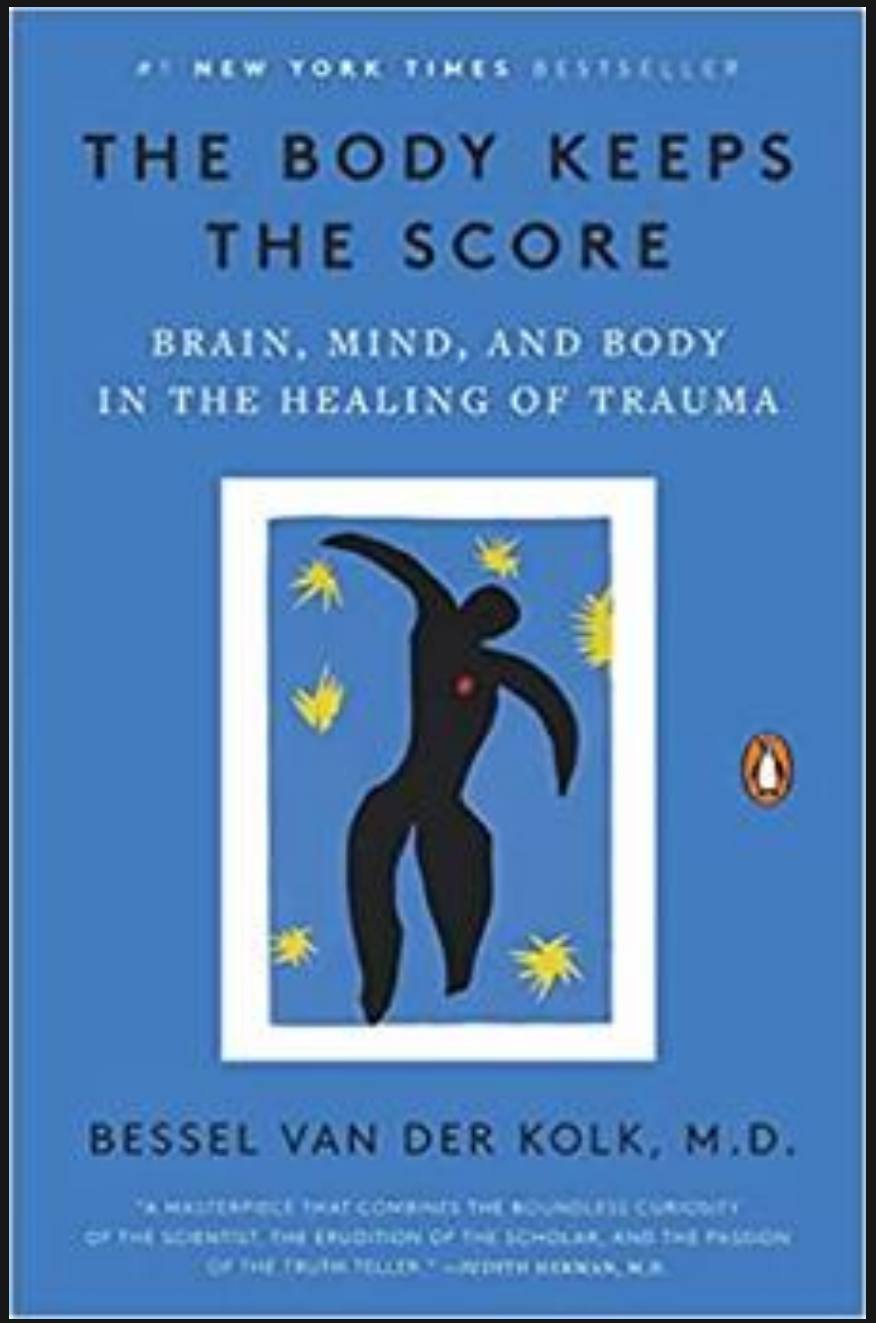
PCL-5

		Not at all	A little bit	Moderately	Quite a bit	Extremely
1.	Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2.	Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3.	Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4.	Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5.	Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6.	Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7.	Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8.	Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9.	Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10.	Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11.	Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12.	Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13.	Feeling distant or cut off from other people?	0	1	2	3	4
14.	Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15.	Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16.	Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17.	Being "superalert" or watchful or on guard?	0	1	2	3	4
18.	Feeling jumpy or easily startled?	0	1	2	3	4
19.	Having difficulty concentrating?	0	1	2	3	4
20.	Trouble falling or staying asleep?	0	1	2	3	4

Moral Injury & C-PTSD

Further Work 2015

A pioneer in trauma research and the effects on the brain and the body.
"Being able to feel safe with other people is probably the single most important aspect of mental health; safe connections are fundamental to meaningful and satisfying lives."



Controversies of Complex PTSD Category

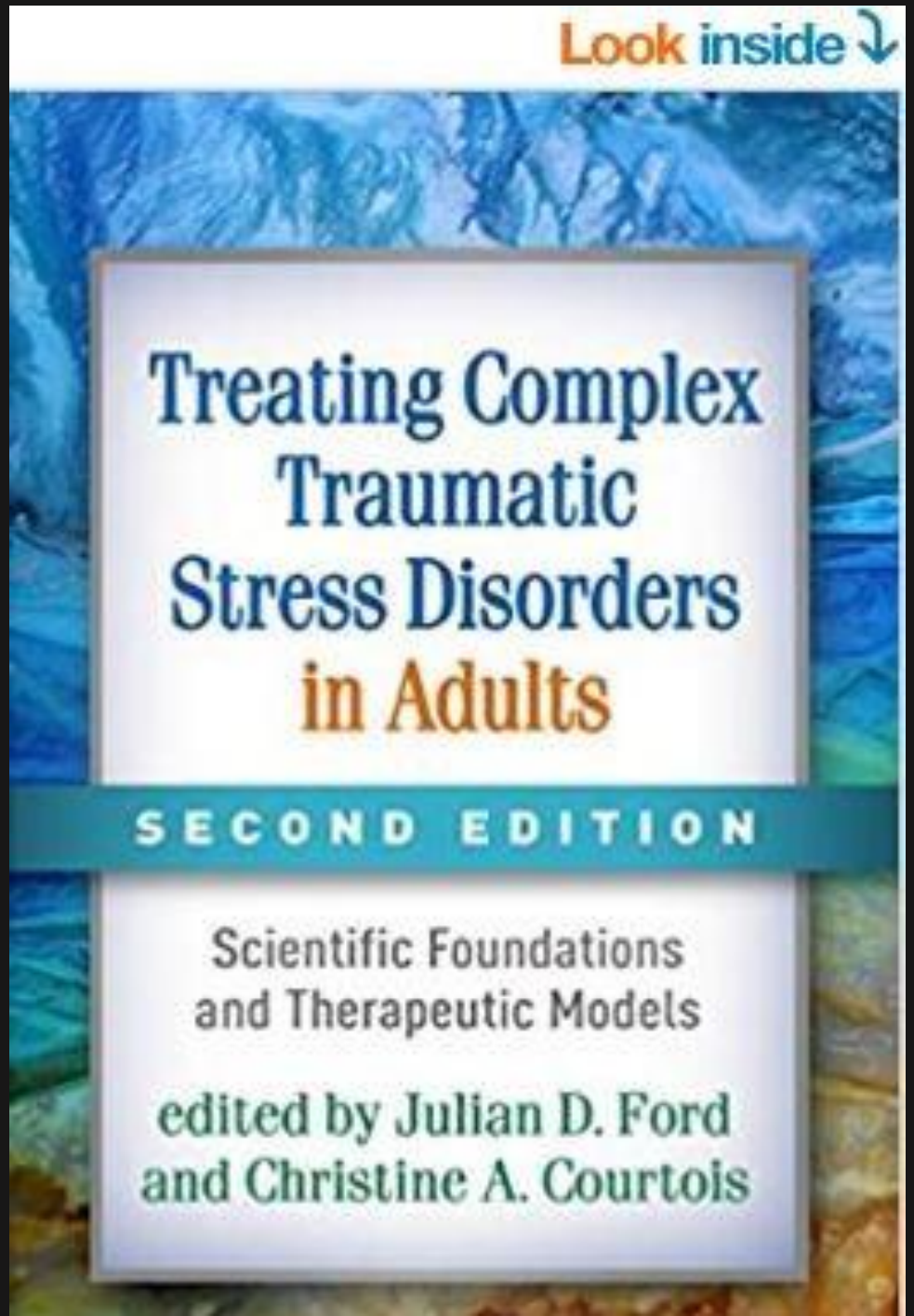
"To err is human, but to really screw things up requires a design committee of bureaucrats."

— Henry Spencer

From the Forward Of this Book

Click Link Below

Ford, J. D., & Courtois, C. A. (2020). *Treating complex traumatic stress disorders in adults : Scientific foundations and therapeutic models* (J. Ford, and C. Courtois (Eds.), 2nd ed.). New York: Guilford Press.



PTSD

DSM-IV

A: stressor: need 2 of 2:
1) experienced, witnessed, or was confronted with traumatic event and 2) intense fear, helplessness, or horror.

B. traumatic reexperienced: need 1 of 5:
(1) Recurrent and intrusive distressing recollections; (2) distressing dreams; (3) flashbacks; 4) Intense psychological distress at exposure to cues; (5) Physiological reactivity on exposure to cues

C. persistent avoidance of stimuli associated with the trauma and numbing: need 3 of 7:
(1) Efforts to avoid thoughts, feelings; (2) Efforts to avoid activities, places, or people; (3) Inability to recall an important aspect of the trauma; (4) Markedly diminished interest; (5) Feeling of detachment /estrangement; (6) Restricted affect; (7) Sense of a foreshortened future

D. persistent increased arousal: need 2 of 5:
(1) Difficulty falling /staying asleep; (2) Irritability/ outbursts of anger; (3) Difficulty concentrating; (4) Hypervigilance; (5) Exaggerated startle response

DSM-5

A: stressor: need 1 of 4:
1) Direct exposure; 2) Witnessing,; 3) Indirectly, by learning a close relative or close friend was exposed; 4) Repeated/extreme indirect exposure in the course of professional job (not through media).

Moral Injury

B: intrusion symptoms: need 1 of 5:
1) Recurrent, intrusive memories; 2) Traumatic nightmares; 3) flashbacks; 4) Intense/prolonged distress after exposure; 5) physiologic reactivity upon exposure to cues

C: persistent effortful avoidance of distressing trauma-related stimuli: need 1 of 2:
1) Trauma-related thoughts /feelings; 2) Trauma-related external reminders

D: negative cognitions/ mood: need 2 of 7:
1) Inability to recall key features of the trauma; 2) negative beliefs about oneself, the world; 3) distorted blame of self, others; 4) Persistent negative trauma-related emotions; 5) diminished interest; 6) Feeling alienated, detachment/estrangement; 7) Constricted affect

C-PTSD

E: alterations in arousal and reactivity: need 2 of 6:
1) Irritable or aggressive behavior; 2) Self-destructive/ reckless behavior; 3) Hypervigilance; 4) Exaggerated startle response; 5) Problems in concentration; 6) Sleep disturbance.

Pai A, Suris AM, North CS. Posttraumatic Stress Disorder in the *DSM-5*: Controversy, Change, and Conceptual Considerations. *Behavioral Sciences*. 2017; 7(1):7.

Barbano AC et al (2018).
Clinical implications of the proposed ICD-11 PTSD diagnostic criteria. Psychological Medicine 49, 483–490.

Psychological Medicine

cambridge.org/psm

Original Article

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Clinical implications of the proposed ICD-11 PTSD diagnostic criteria

Anna C. Barbano[1], Willem F. van der Mei[1], Richard A. Bryant[2], Douglas L. Delahanty[3], Terri A. deRoon-Cassini[4], Yutaka J. Matsuoka[5], Miranda Olff[6,7], Wei Qi[1], Andrew Ratanatharathorn[8], Ulrich Schnyder[9], Soraya Seedat[10], Ronald C. Kessler[11], Karestan C. Koenen[12] and Arieh Y. Shalev[1]

Abstract

Background. Projected changes to post-traumatic stress disorder (PTSD) diagnostic criteria in the upcoming International Classification of Diseases (ICD)-11 may affect the prevalence and severity of identified cases. This study examined differences in rates, severity, and overlap of diagnoses using ICD-10 and ICD-11 PTSD diagnostic criteria during consecutive assessments of recent survivors of traumatic events.

Methods. The study sample comprised 3863 survivors of traumatic events, evaluated in 11 longitudinal studies of PTSD. ICD-10 and ICD-11 diagnostic rules were applied to the Clinician-Administered PTSD Scale (CAPS) to derive ICD-10 and ICD-11 diagnoses at different time intervals between trauma occurrence and 15 months.

Results. The ICD-11 criteria identified fewer cases than the ICD-10 across assessment intervals (range −47.09% to −57.14%). Over 97% of ICD-11 PTSD cases met concurrent ICD-10 PTSD criteria. PTSD symptom severity of individuals identified by the ICD-11 criteria (CAPS total scores) was 31.38–36.49% higher than those identified by ICD-10 criteria alone. The latter, however, had CAPS scores indicative of moderate PTSD. ICD-11 was associated with similar or higher rates of comorbid mood and anxiety disorders. Individuals identified by either ICD-10 or ICD-11 shortly after traumatic events had similar longitudinal course.

Conclusions. This study indicates that significantly fewer individuals would be diagnosed with PTSD using the proposed ICD-11 criteria. Though ICD-11 criteria identify more severe cases, those meeting ICD-10 but not ICD-11 criteria remain in the moderate range of PTSD symptoms. Use of ICD-11 criteria will have critical implications for case identification in clinical practice, national reporting, and research.

New ICD-11 Criteria Will Reduce PTSD Diagnoses by 50%

Megan Brooks

May 14, 2018

Proposed changes to the upcoming 11th edition of the *International Classification of Diseases* (ICD-11) will reduce the proportion of individuals who meet diagnostic criteria for posttraumatic stress disorder (PTSD) by about 50%, a new study suggests.

"Importantly, our data suggest that ICD-11 might miss the moderate, and more easily treatable, cases of PTSD," lead author Anna Barbano, BS, a research associate in the Department of Psychiatry at New York University School of Medicine in New York City, told *Medscape Medical News*.

https://www.medscape.com/viewarticle/896584?ecd=ppc_google_rlsa-traf_mscp_news-perspectives_t1-psych_us

Final Version of ICD-11

- Unlike the DSM-5, with the final ICD-11 revision the lumping of both PTSD and C-PTSD was discontinued and the two were given separate and distinct diagnostic entities:
- PTSD code 6B40
- C-PTSD code 6B41

Is C-PTSD just PTSD with Comorbid Borderline Personality Disorder? No

C-PTSD

- Severe but stable negative self-concept
- Avoids and has difficulty maintaining relationships
- Lower incidence of suicide attempts and self-mutilation
- No significant fear of abandonment

Borderline Personality Disorder

- Shifting self-concept vacillating between negative and positives
- Rapid engagement but with idealization and devaluation
- Often suicidal and self-injurious behaviors exist
- Fear of abandonment

Cloitre, M. (2020). ICD-11 complex post-traumatic stress disorder: Simplifying diagnosis in trauma populations. *The British Journal of Psychiatry, 216*(3), 129-131. doi:10.1192/bjp.2020.43

Controversies of C- PTSD Therapy

Paradigm Shifts

Quicker is better?

Newer treatments have a different point of view

Traditional Stages of Psychotherapy/Healing

1. Establishment of a therapeutic alliance and safety/stabilization – therapist must empower the person, adopt a stance that what happened to the victim was wrong and immoral yet remain neutral in other ways. Teach self-nurturing and self-soothing and help decrease fight-flight symptoms, nightmares, flashbacks.
2. Remembrance and mourning for what was lost – recall of traumatic memories and dealing with them. Grieving the losses due to the trauma, expressing emotions that have been repressed.
3. Reconnecting with the self, community and society – accepting what happened but no longer letting it define the self as victim

7 Criteria for Resolution of Trauma

1. Physiological symptoms must be brought into manageable limits
2. The person must be able to bear the feelings associated with traumatic memories
3. Mastery over the memories with the ability to both remember the trauma and to put memory aside
4. The memory of the event is a cohesive narrative linked with feelings
5. Restoration of the damaged self-esteem
6. Important relationships have been reestablished
7. The person has reconstructed a coherent system of meaning and belief that encompasses the story of the trauma

Mary Harvey, An ecological view of psychological trauma, unpublished. In Trauma and Recovery, Judith Herman, 1997, p. 213

To Stabilize First or Not?

DEPRESSION AND ANXIETY 33:359–369 (2016)

Review

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

Ad De Jongh, Ph.D.,[1,2*] Patricia A. Resick, Ph.D.,[3] Lori A. Zoellner, Ph.D.,[4] Agnes van Minnen, Ph.D.,[5,6] Christopher W. Lee, Ph.D.,[7] Candice M. Monson, Ph.D.,[8] Edna B. Foa, Ph.D.,[9] Kathleen Wheeler, Ph.D.,[10] Erik ten Broeke, M.Sc.,[11] Norah Feeny, Ph.D.,[12] Sheila A.M. Rauch, Ph.D.,[13] Kathleen M. Chard, Ph.D.,[14] Kim T. Mueser, Ph.D.,[15] Denise M. Sloan, Ph.D.,[16,17] Mark van der Gaag, Ph.D.,[18] Barbara Olasov Rothbaum, Ph.D.,[19] Frank Neuner, Ph.D.,[20] Carlijn de Roos, M.Sc.,[21] Lieve M.J. Hehenkamp, M.Sc.,[22] Rita Rosner, Ph.D.,[23] and Iva A.E. Bicanic, Ph.D.[22]

Meta-analysis doesn't support stabilization phase

As reviewed in this paper, the research supporting the need for phase-based treatment for individuals with C-PTSD is methodologically limited. Further, there is no rigorous research to support the views that: (1) a phase-based approach is necessary for positive treatment outcomes for adults with C-PTSD, (2) front-line trauma-focused treatments have unacceptable risks or that adults with C-PTSD do not respond to them, and (3) adults with C-PTSD profit significantly more from trauma-focused treatments when preceded by a stabilization phase. The current treatment guidelines for C-PTSD may therefore be too conservative, risking that patients are denied or delayed in receiving conventional evidence-based treatments from which they might profit.

Eye-movement based rapid therapies

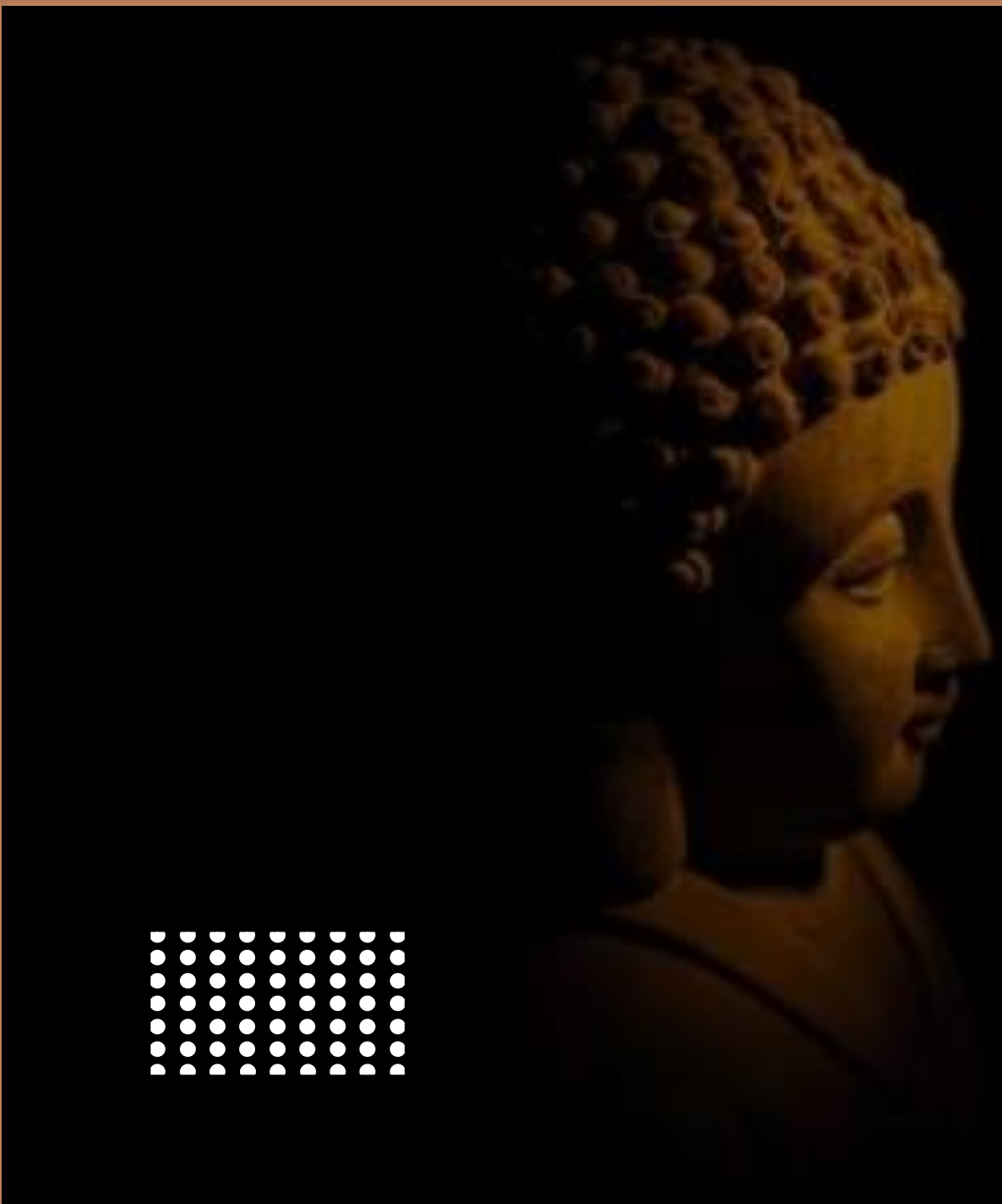
- EMDR/Eye Movement Desensitization and Reprocessing
- ART/Accelerated resolution therapy

MILITARY MEDICINE, 178, 12:1298, 2013

Randomized Controlled Trial of Accelerated Resolution Therapy (ART) for Symptoms of Combat-Related Post-Traumatic Stress Disorder (PTSD)

Kevin E. Kip, PhD; Laney Rosenzweig, MS*; Diego F. Hernandez, PsyD†; Amy Shuman, MSW‡; Kelly L. Sullivan, PhD§; Christopher J. Long, MSW*; James Taylor, MSc‖; Stephen McGhee, MSc‖; Sue Ann Girling, BSAS*; Trudy Wittenberg, BS*; Frances M. Sahebzamani, PhD*; Cecile A. Lengacher, PhD*; Rajendra Kadel, PhD*; David M. Diamond, PhD¶*

ABSTRACT Objectives: Therapies for post-traumatic stress disorder (PTSD) endorsed by the Department of Defense and Veterans Administration are relatively lengthy, costly, and yield variable success. We evaluated Accelerated Resolution Therapy (ART) for the treatment of combat-related psychological trauma. Methods: A randomized controlled trial of ART versus an Attention Control (AC) regimen was conducted among 57 U.S. service members/veterans. After random assignment, those assigned to AC were offered crossover to ART, with 3-month follow-up on all participants. Self-report symptoms of PTSD and comorbidities were analyzed among study completers and by the intention-to-treat principle. Results: Mean age was 41 ± 13 years with 19% female, 54% Army, and 68% with prior PTSD treatment. The ART was delivered in 3.7 ± 1.1 sessions with a 94% completion rate. Mean reductions in symptoms of PTSD, depression, anxiety, and trauma-related guilt were significantly greater ($p < 0.001$) with ART compared to AC. Favorable results for those treated with ART persisted at 3 months, including reduction in aggression ($p < 0.0001$). Adverse treatment-related events were rare and not serious. Conclusions. ART appears to be a safe and effective treatment for symptoms of combat-related PTSD, including refractory PTSD, and is delivered in significantly less time than therapies endorsed by the Department of Defense and Veterans Administration.



Treatment

“Pain is inevitable. Suffering is optional.”

This quote has been attributed to Buddha, the Dalai Lama, Japanese author Haruki Murakami, and Canadian politician Kathleen Casey.

Treatment and Medication

Diagnosis

Ensure the correct one is C-PTSD and not another disorder. Often comorbid with substance use disorder and others. ALWAYS ask about trauma, especially in depression

Medications

Unfortunately with few exceptions such as prazosin and others for nightmares and antidepressants, meds are less important than psychotherapy

Inpatient and Crises

Often arise, suicidal ideation, substance use disorders, psychosis require a higher level of care

Psychological Medicine

cambridge.org/psm

Review Article

Cite this article: Karatzias T *et al* (2019). Psychological interventions for ICD-11 complex PTSD symptoms: systematic review and meta-analysis. *Psychological Medicine* 1–15. https://doi.org/10.1017/S0033291719000436

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Key words:
Childhood trauma; CPTSD; meta-analysis; psychological therapies; randomised controlled trials; systematic review

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Psychological interventions for ICD-11 complex PTSD symptoms: systematic review and meta-analysis

Thanos Karatzias[1,2], Philip Murphy[1], Marylene Cloitre[3,4], Jonathan Bisson[5], Neil Roberts[5,6], Mark Shevlin[7], Philip Hyland[8], Andreas Maercker[9], Menachem Ben-Ezra[10], Peter Coventry[11], Susan Mason-Roberts[1], Aoife Bradley[1] and Paul Hutton[1]

Abstract

Background. The 11th revision to the WHO International Classification of Diseases (ICD-11) identified complex post-traumatic stress disorder (CPTSD) as a new condition. There is a pressing need to identify effective CPTSD interventions.

Methods. We conducted a systematic review and meta-analysis of randomised controlled trials (RCTs) of psychological interventions for post-traumatic stress disorder (PTSD), where participants were likely to have clinically significant baseline levels of one or more CPTSD symptom clusters (affect dysregulation, negative self-concept and/or disturbed relationships). We searched MEDLINE, PsycINFO, EMBASE and PILOTS databases (January 2018), and examined study and outcome quality.

Results. Fifty-one RCTs met inclusion criteria. Cognitive behavioural therapy (CBT), exposure alone (EA) and eye movement desensitisation and reprocessing (EMDR) were superior to usual care for PTSD symptoms, with effects ranging from $g = -0.90$ (CBT; $k = 27$, 95% CI −1.11 to −0.68; moderate quality) to $g = -1.26$ (EMDR; $k = 4$, 95% CI −2.01 to −0.51; low quality). CBT and EA each had moderate–large or large effects on negative self-concept, but only one trial of EMDR provided useable data. CBT, EA and EMDR each had moderate or moderate–large effects on disturbed relationships. Few RCTs reported affect dysregulation data. The benefits of all interventions were smaller when compared with non-specific interventions (e.g. befriending). Multivariate meta-regression suggested childhood-onset trauma was associated with a poorer outcome.

Conclusions. The development of effective interventions for CPTSD can build upon the success of PTSD interventions. Further research should assess the benefits of flexibility in intervention selection, sequencing and delivery, based on clinical need and patient preferences.

Karatzias, T., et al. (2019). Psychological interventions for ICD-11 complex PTSD symptoms: Systematic review and meta-analysis. *Psychological Medicine, 49*(11), 1761-1775.

Symptomatic treatment of the disorder

Flashbacks

Various meds including prazosin

Depression

SSRI's, SNRI's

Prazosin

Nightmares

Clonidine

Guanfacine

Cyproheptadine

Topiramate

Avoid Benzos and Antipsychotics

Scarff J. Think Beyond Prazosin when treating nightmares in PTSD. *Current Psychiatry*. 2015 December;14(12):56-57

Scarff J, *Current Psychiatry*. 2015 December;14(12):56-57

Link:

[Think beyond prazosin when treating nightmares in PTSD | MDedge Psychiatry]

Think beyond prazosin when treating nightmares in PTSD

Jonathan R. Scarff, MD

Dr. Scarff is Staff Psychiatrist, Veterans Affairs Outpatient Clinic, Spartanburg, South Carolina.

Disclosure
The author reports no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

Nightmares are a common feature of posttraumatic stress disorder (PTSD) that could lead to fatigue, impaired concentration, and poor work performance. The α-1 antagonist prazosin decreases noradrenergic hyperactivity and reduces nightmares; however, it can cause adverse effects, be contraindicated, or provide no benefit to some patients. Consider these alternative medications to reduce nightmares in PTSD.

Alpha-2 agonists

Clonidine and guanfacine are α-2 agonists, used to treat attention-deficit/hyperactivity disorder and high blood pressure, that decrease noradrenergic activity, and either medication might be preferable to prazosin because they are more likely to cause sedation. A review and a case series showed that many patients—some with comorbid traumatic brain injury—reported fewer nightmares after taking 0.2 to 0.6 mg of clonidine.[1,2] Guanfacine might be more beneficial because it has a longer half-life; 2 mg of guanfacine eliminated nightmares in 1 patient.[3] However, in a double-blind placebo-controlled study and an extension study, guanfacine did not reduce nightmares or other PTSD symptoms.[4,5]

Initiate 0.1 mg of clonidine at bedtime, and titrate to efficacy or to 0.6 mg. Similarly, initiate guanfacine at 1 mg, and titrate to efficacy or to 4 mg. Monitor for hypotension, excess sedation, dry mouth, and rebound hypertension.

Cyproheptadine

Used to treat serotonin syndrome, cyproheptadine's antagonism of serotonin 2A receptors has varying efficacy for reducing nightmares. Some patients have reported a decrease in nightmares at dosages ranging from 4 to 24 mg.[1,6] Other studies found no reduction in nightmares or diminished quality of sleep.[1,7]

Initiate cyproheptadine at 4 mg/d, titrate every 2 or 3 days, and monitor for sedation, confusion, or reduced efficacy of concurrent serotonergic medications. Cyproheptadine might be preferable for its sedating effect and potential to reduce sexual adverse effects from serotonergic medications.

Topiramate

Topiramate is approved for treatment of epilepsy and migraine headache. At 75 to 100 mg/d in a clinical trial, topiramate partially or completely suppressed nightmares.[8] Start with 25 mg/d, titrate to efficacy, and monitor for anorexia, paresthesias, and cognitive impairment. Topiramate might be better than prazosin for patients without renal impairment who want sedation, weight loss, or reduced irritability.

Am J Psychiatry 160:371-373, February 2003

Brief Report

Reduction of Nightmares and Other PTSD Symptoms in Combat Veterans by Prazosin: A Placebo-Controlled Study

Murray A. Raskind, M.D., Elaine R. Peskind, M.D., Evan D. Kanter, M.D., Eric C. Petrie, M.D., Allen Radant, M.D., Charles E. Thompson, M.D., Dorcas J. Dobie, M.D., David Hoff, PA-C, Rebekah J. Rein, J.D., Kristy Straits-Tröster, Ph.D., Ronald G. Thomas, Ph.D., and Miles M. McFall, Ph.D.

OBJECTIVE: Prazosin is a centrally active α_1 adrenergic antagonist. The authors' goal was to evaluate prazosin efficacy for nightmares, sleep disturbance, and overall posttraumatic stress disorder (PTSD) in combat veterans. **METHOD:** Ten Vietnam combat veterans with chronic PTSD and severe trauma-related nightmares each received prazosin and placebo in a 20-week double-blind crossover protocol. **RESULTS:** Prazosin (mean dose=9.5 mg/day at bedtime, SD=0.5) was superior to placebo for the three primary outcome measures: scores on the 1) recurrent distressing dreams item and the 2) difficulty falling/staying asleep item of the Clinician-Administered PTSD Scale and 3) change in overall PTSD severity and functional status according to the Clinical Global Impression of change. Total score and symptom cluster scores for reexperiencing, avoidance/numbing, and hyperarousal on the Clinician-Administered PTSD Scale also were significantly more improved in the prazosin condition, and prazosin was well tolerated. **CONCLUSIONS:** These data support the efficacy of prazosin for nightmares, sleep disturbance, and other PTSD symptoms.

The Knock on Prazosin

1. Although widely used throughout the U.S. for PTSD-associated nightmares, prazosin failed to work in a recent controlled trial, which was the largest to date, but that trial had a few flaws. The placebo rate was unusually high, and the investigators may have enriched their sample with patients who were less likely to respond to prazosin.[1,2]
2. This was a VA study, which limits the pool of potential prazosin responders because the medication is already widely used there for PTSD. They also excluded patients who responded to trazodone, which has adrenergic effects that are similar to prazosin's. I don't think this study refutes prazosin's benefits for nightmares, but it does remind us that PTSD is a complex illness that affects many types of patients.

1. *The Carlat Psychiatry Report*, April 2019; 2-3
2. Raskind MA et al, *N Engl J Med* 2018;378:507–517

Antidepressants -SSRI's and SNRI's

- Both sertraline/Zoloft and paroxetine/Paxil have FDA approval for PTSD but other SSRI's and SNRI's have similar mechanisms of action and effectiveness.
- Benefits include decrease in hyperarousal, improvement in depressive and anxiety symptoms, anti-ruminative effects.

Current and Future Directions

Dissociatives and Hallucinogens

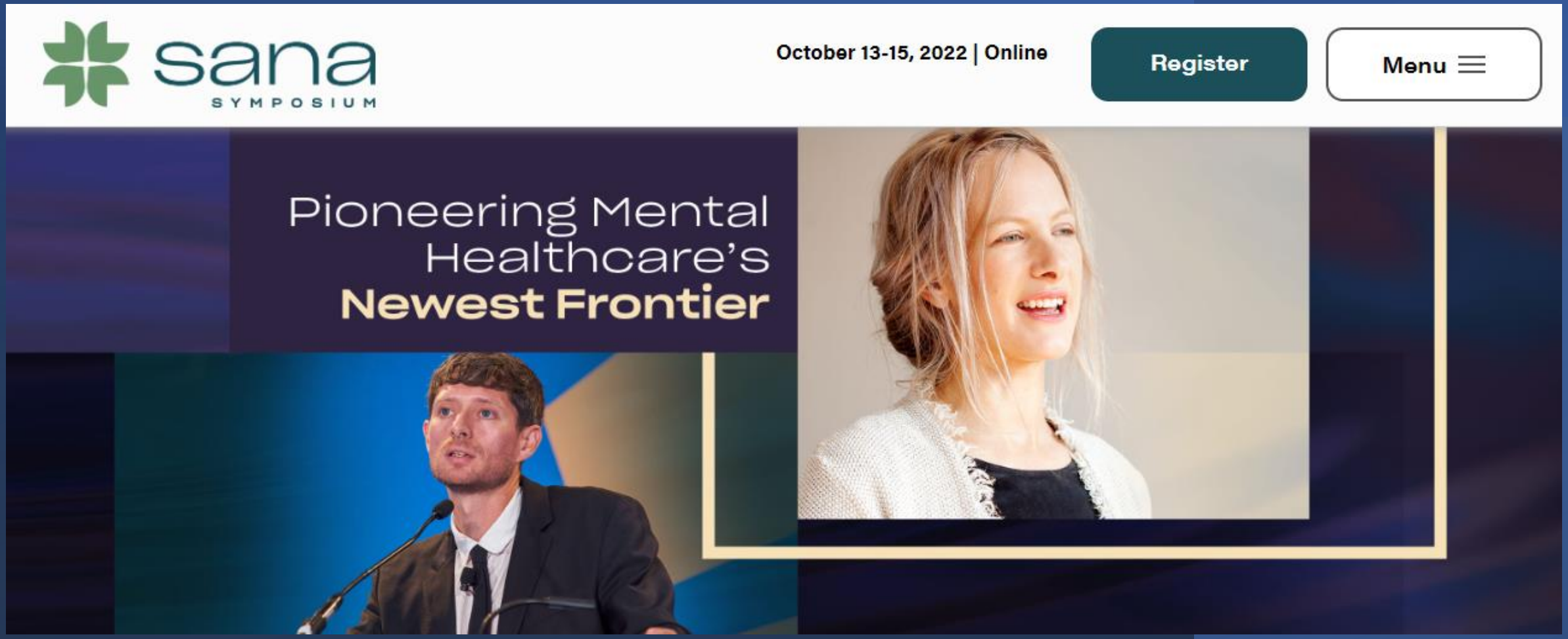
Ketamine and esketamine/Spravato are currently used legally and off-label for PTSD with varying results

The r-isomer of ketamine is in clinical trials for depression and is interesting for its lack of dissociation yet appears to be just as effective as the racemic ketamine and s-ketamine

Hallucinogens as psilocyin, MDMA are being studied in ongoing research and large companies have been doing courses and presentations for therapists and psychiatrists/NP's if and when the FDA and DEA will allow use of them in clinical settings.

Yang, C., Shirayama, Y., Zhang, Jc. *et al. R*-ketamine: a rapid-onset and sustained antidepressant without psychotomimetic side effects. *Transl Psychiatry* **5**, e632 (2015).

Clinicians may enroll in these courses now and in the future



www.sanasymposium.com

"A flower blooming in the desert proves to the world that adversity, no matter how great, can be overcome."

- Matshona Dhliwayo

Thanks for helping people

Thanks for helping people out of darkness

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Links to full articles in **blue**

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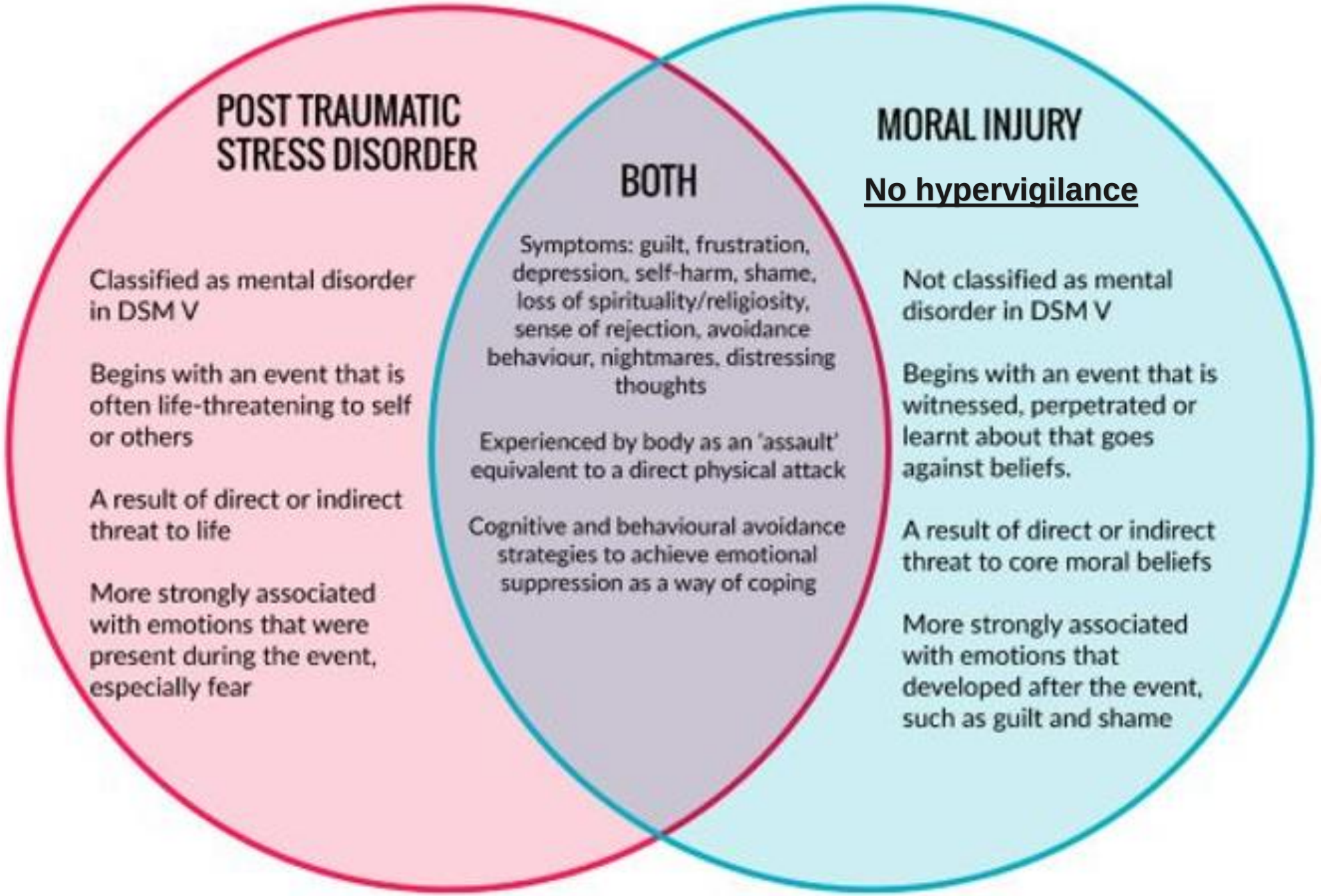

POST TRAUMATIC STRESS DISORDER
Classified as mental disorder in DSM V
Begins with an event that is often life-threatening to self or others
A result of direct or indirect threat to life
More strongly associated with emotions that were present during the event, especially fear
BOTH
Symptoms: guilt, frustration, depression, self-harm, shame, loss of spirituality/religiosity, sense of rejection, avoidance behaviour, nightmares, distressing thoughts
Experienced by body as an 'assault' equivalent to a direct physical attack
Cognitive and behavioural avoidance strategies to achieve emotional suppression as a way of coping
MORAL INJURY
No hypervigilance
Not classified as mental disorder in DSM V
Begins with an event that is witnessed, perpetrated or learnt about that goes against beliefs.
A result of direct or indirect threat to core moral beliefs
More strongly associated with emotions that developed after the event, such as guilt and shame

Moral Injury

What is it?

How do we differentiate it?

How do we treat it?

Possibly uncomfortable topics

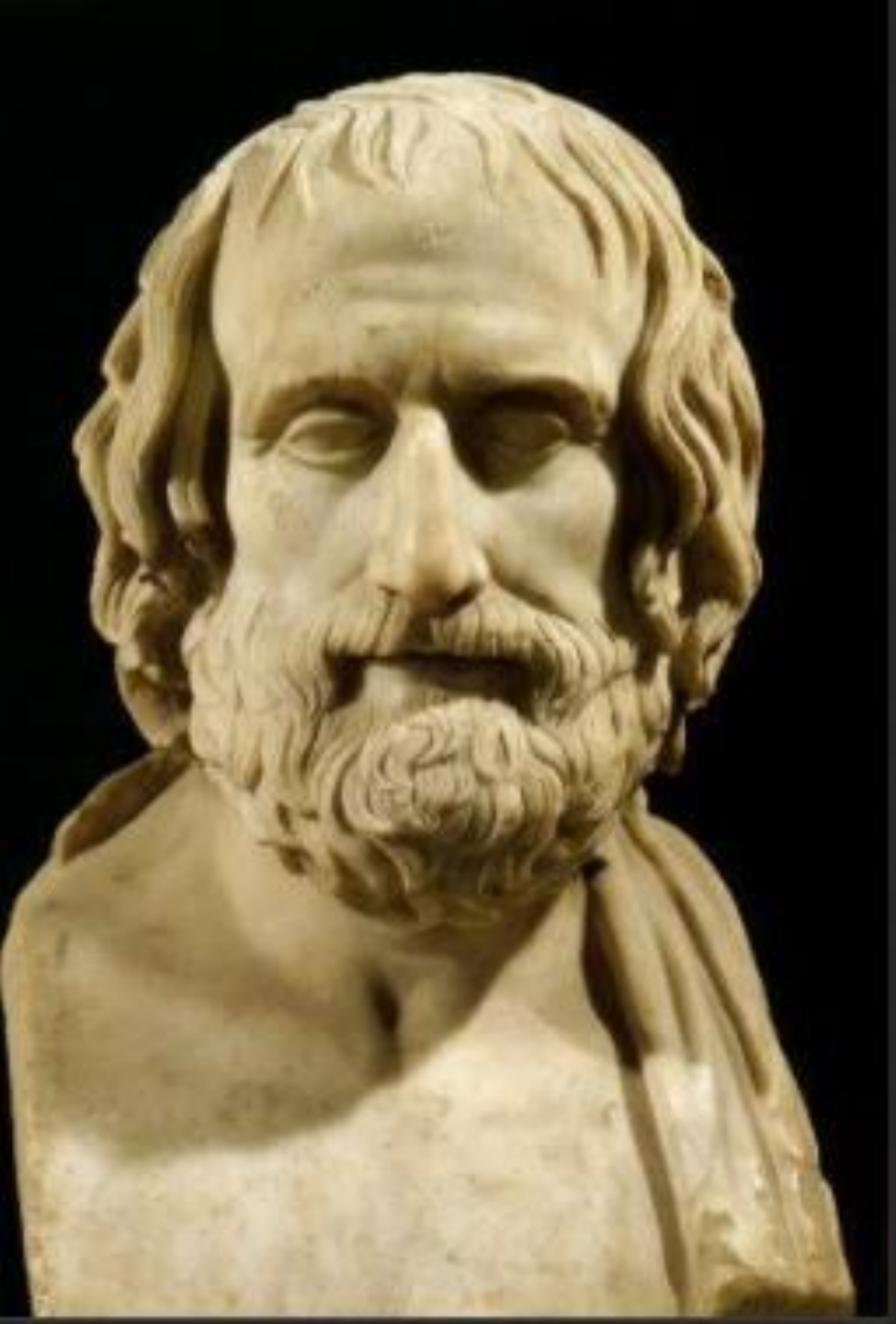
- Sexual Assault
- Combat
- Injuries
- No specific details, just general topics

“To violate your conscience is to commit moral suicide.” (Rev. Herman Keizer, Colonel and Chaplain, U.S. Army, Ret., quoted in Brock and Lettini, 2012)

Moral Injury Definition

"Moral injury has been defined as perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations."

Litz, Brett T et al. "Moral injury and moral repair in war veterans: a preliminary model and intervention strategy." *Clinical psychology review* vol. 29,8 (2009): 695-706



Historical Background

Euripides (416 BCE) originally used the “miasma” signifying the ancient Greek concept of moral defilement or pollution . . . Applicable to any transgression of moral values, whether applied to the perpetrator, the victim, or even the observer. In one of his plays, the character Herakles describes the feeling of miasmas as follows: “What can I do? Where can I hide from all this and not be found? What wings would take me high enough? How deep a hole would I have to dig? My shame for the evil I have done consumes me . . . I am soaked in blood-guilt, polluted, contagious . . . I am a pollutant, an offense to gods above.”

Koenig, Harold G, and Faten Al Zaben. “Moral Injury: An Increasingly Recognized and Widespread Syndrome.” *Journal of religion and health* vol. 60,5 (2021): 2989-3011. doi:10.1007/s10943-021-01328-0

Who can have moral injury?

Military
Health Care Workers
Victims of Abuse
Police Officers
Journalists
Social Workers

Examples

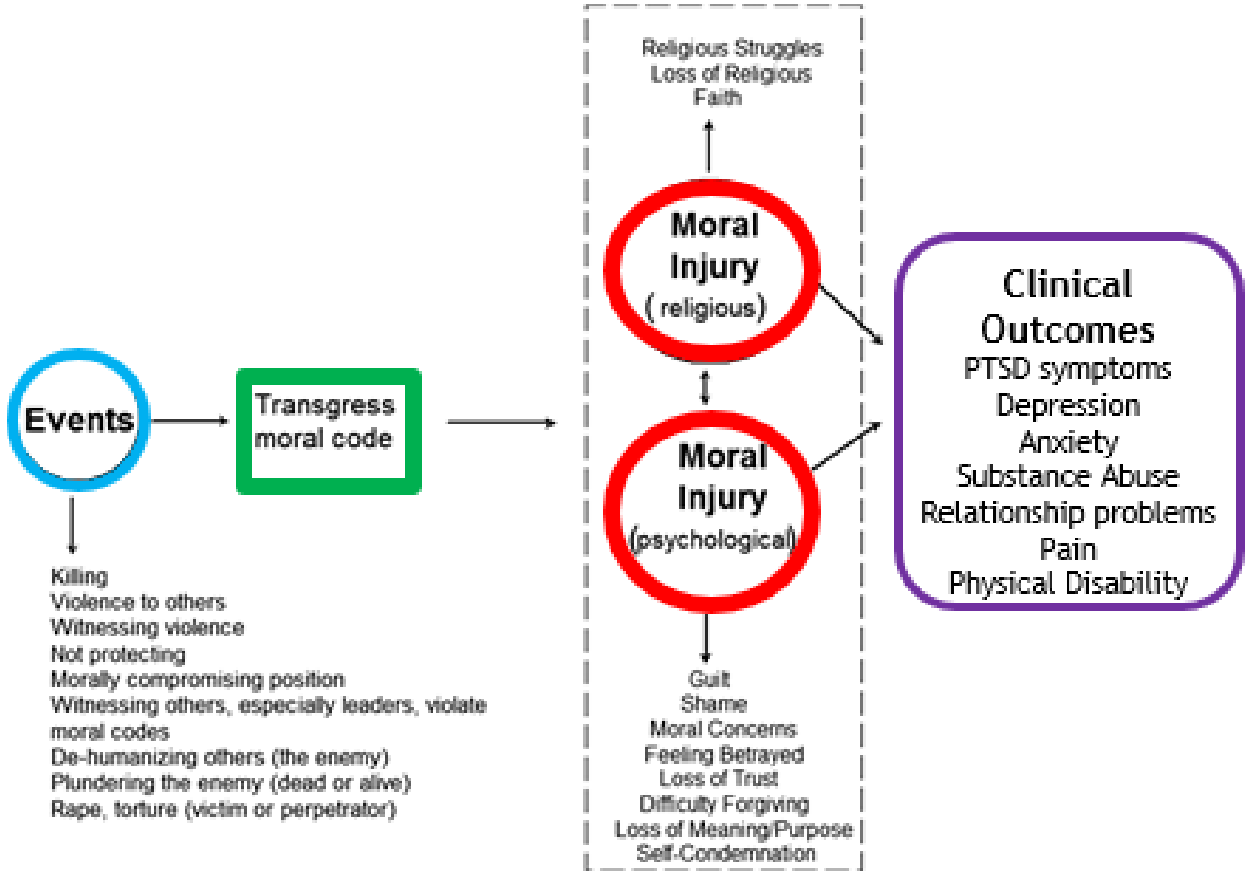
- Perpetrating
- Witnessing
- Failing to Prevent
- Learning About

Historical Background

Homer (8th century, BCE?): the character of Achilles in the *Iliad*

Shay, Jonathan M.D., *Achilles in Vietnam: Combat Trauma and the Undoing of Trauma* New York: Atheneum, 1994.

Figure 1. Model of dynamics involved in moral injury (adapted from Koenig et al, 2017).[29]



Journal of Religion and Health
https://doi.org/10.1007/s10943-022-01676-5

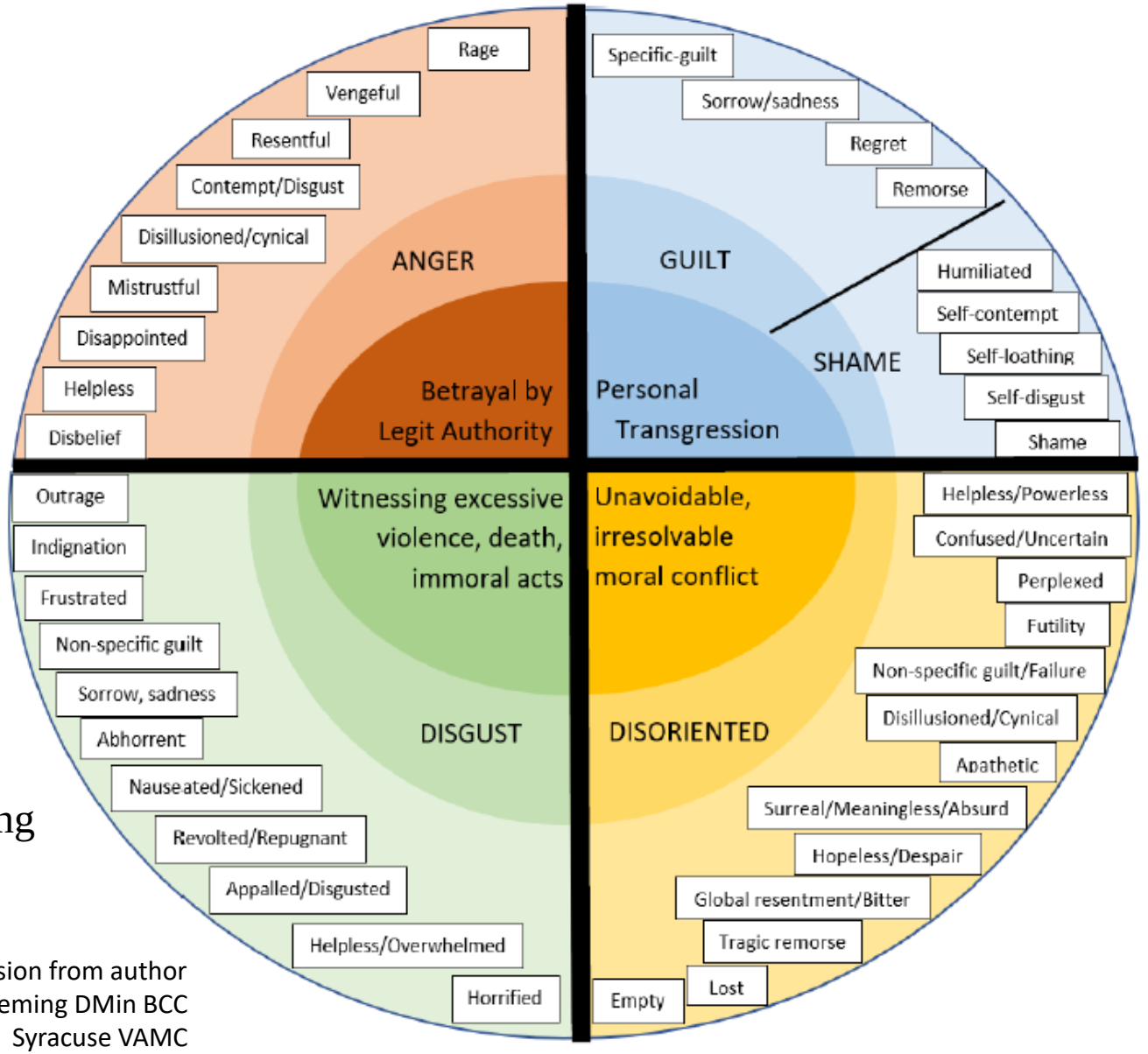
ORIGINAL PAPER

The Moral Injury Experience Wheel: An Instrument for Identifying Moral Emotions and Conceptualizing the Mechanisms of Moral Injury

Wesley H. Fleming[1]

Accepted: 16 September 2022

Fleming, W.H. The Moral Injury Experience Wheel: An Instrument for Identifying Moral Emotions and Conceptualizing the Mechanisms of Moral Injury. *J Relig Health* (2022).



Used with permission from author
Chaplain Wes Fleming DMin BCC
Syracuse VAMC

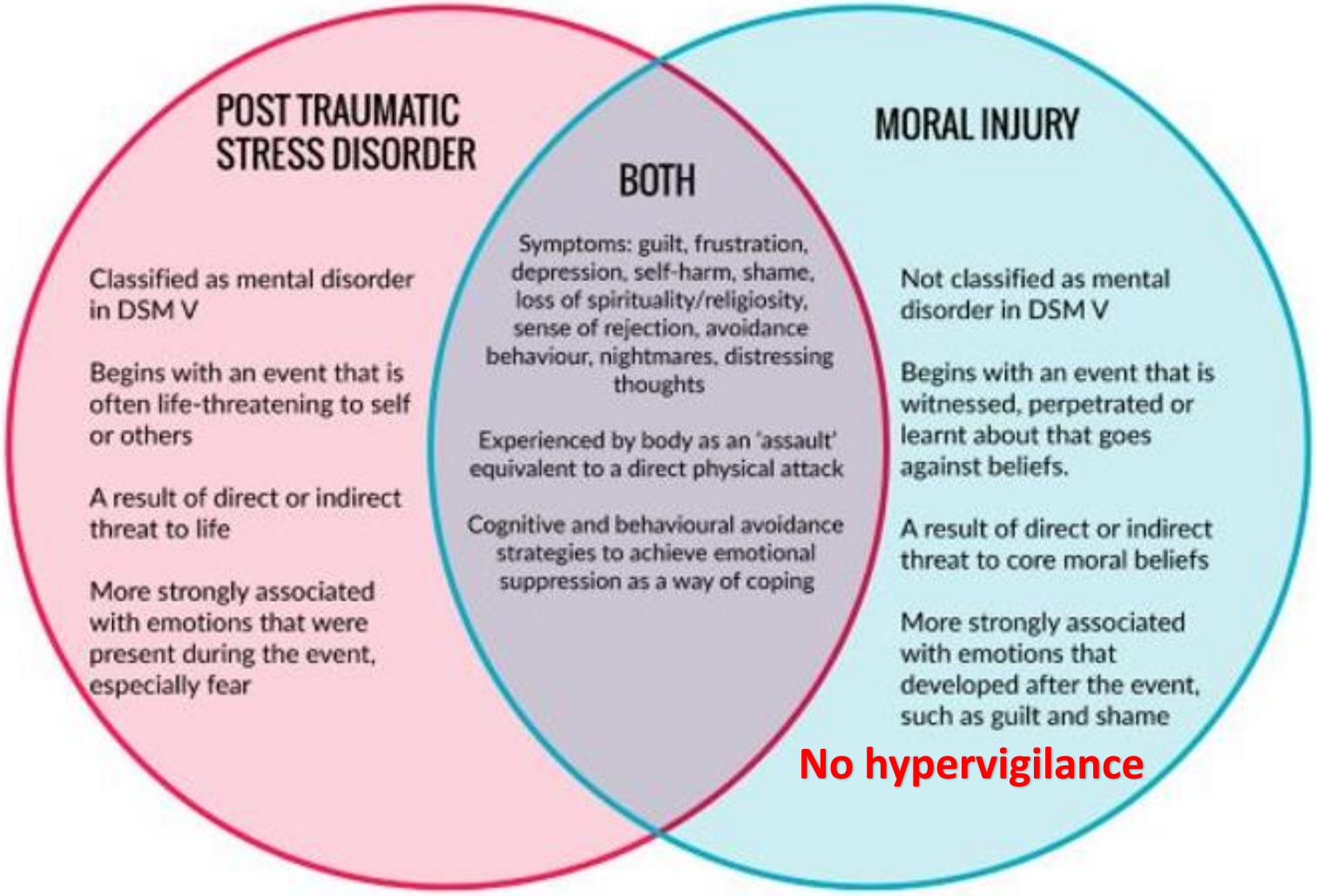
“PTSD is a mental disorder that requires a diagnosis. Moral injury is a dimensional problem – there is no threshold for the presence of moral injury, rather, at a given point in time, a Veteran may have none, or mild to extreme manifestations.

Transgression is not necessary for PTSD to develop nor does PTSD diagnosis sufficiently capture moral injury.

It is important to assess mental health symptoms and moral injury as separate manifestations of war trauma to form a comprehensive clinical picture and provide the most relevant treatment.”

National Center for PTSD

Overlapping Symptoms and Definitions



Moral Injury Symptom Scale - Military - Short Form

1 I feel betrayed by leaders I once trusted

1 Strongly agree 2 3 Mildly disagree 4 5 Neutral 6 7 Mildly agree 8 9 Strongly agree 10

2 I feel guilt over failing to save the life of someone in war

1 Strongly agree 2 3 Mildly disagree 4 5 Neutral 6 7 Mildly agree 8 9 Strongly agree 10

3 I feel ashamed about what I did or did not do during this time

1 Strongly agree 2 3 Mildly disagree 4 5 Neutral 6 7 Mildly agree 8 9 Strongly agree 10

4 I am troubled by having acted in ways that violated my own morals or values

1 Strongly agree 2 3 Mildly disagree 4 5 Neutral 6 7 Mildly agree 8 9 Strongly agree 10

5 Most people are trustworthy

1 Strongly agree 2 3 Mildly disagree 4 5 Neutral 6 7 Mildly agree 8 9 Strongly agree 10

6 I have a good sense of what makes my life meaningful

1 Absolutely untrue 2 Mostly untrue 4 Somewhat untrue 5 Can't say true or false 6 7 Somewhat true 8 Mostly true 9 10 Absolutely true

7 I have forgiven myself for what happened to me or others during combat

1 Strongly agree 2 3 Mildly disagree 4 5 Neutral 6 7 Mildly agree 8 9 Strongly agree 10

8 All in all, I am inclined to feel that I am a failure

1 Strongly agree 2 3 Mildly disagree 4 5 Neutral 6 7 Mildly agree 8 9 Strongly agree 10

9 I wondered what I did for God to punish me

1 A great deal 2 3 Quite a bit 4 5 6 Somewhat 7 8 9 10 Not at all

10 Compared to when you first went into the military has your religious faith since then...

1 Weakened a lot 2 3 Weakened a little 4 5 6 Strengthened a little 7 8 9 10 Strengthened a lot

11 Do the feelings you indicated above cause you significant distress or impair your ability to function in relationships, at work, or other areas of life important to you?

In other words, if you indicated any problems above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not at all ☐ Mild ☐ Moderate ☐ Very Much ☐ Extremely

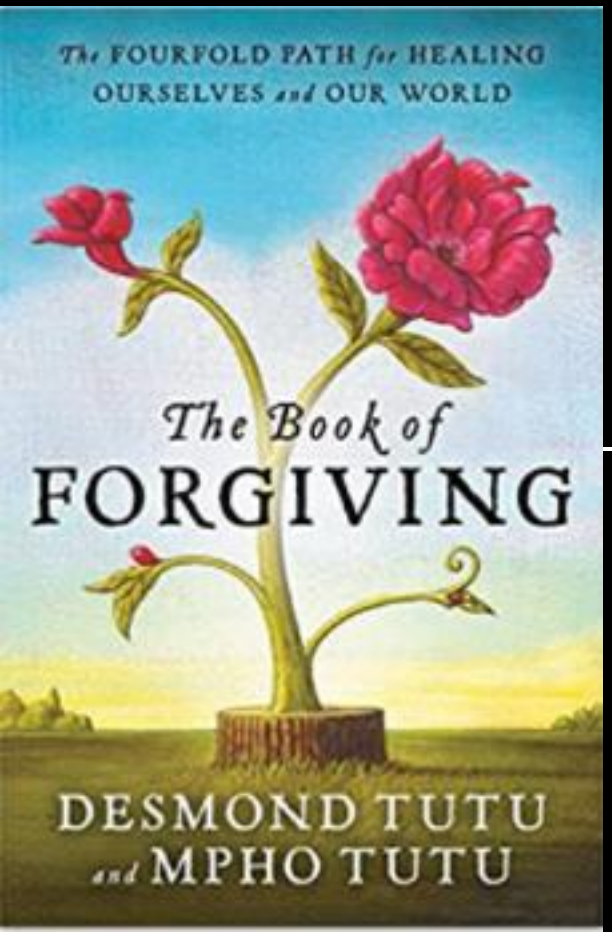
Moral Injury Events Scale (MIES)

	Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
1. I saw things that were morally wrong.	1	2	3	4	5	6
2. I am troubled by having witnessed others' immoral acts.	1	2	3	4	5	6
3. I acted in ways that violated my own moral code or values.	1	2	3	4	5	6
4. I am troubled by having acted in ways that violated my own morals or values.	1	2	3	4	5	6
5. I violated my own morals by failing to do something that I felt I should have done.	1	2	3	4	5	6
6. I am troubled because I violated my morals by failing to do something I felt I should have done.	1	2	3	4	5	6
7. I feel betrayed by leaders who I once trusted.	1	2	3	4	5	6
8. I feel betrayed by fellow service members who I once trusted.	1	2	3	4	5	6
9. I feel betrayed by others outside the U.S. military who I once trusted.	1	2	3	4	5	6

William Nash, MD. et al., Presented at Zarrow Symposium, Tulsa, OK, 20 September 2012

William P. Nash, MC USN (Ret.), Teresa L. Marino Carper, PhD, Mary Alice Mills, PhD, Teresa Au, PhD, Abigail Goldsmith, PhD, Brett T. Litz, PhD, Psychometric Evaluation of the Moral Injury Events Scale, *Military Medicine*, Volume 178, Issue 6, June 2013, Pages 646–652, https://doi.org/10.7205/MILMED-D-13-00017

Desmond and Mpho Tutu: The Fourfold Path for Forgiveness and Healing



Desmond and Mpho Tutu: The Fourfold Path for Forgiveness and Healing

1. Telling the story
2. Naming the hurt
3. Granting forgiveness
4. Renewing or releasing the relationship

Cognitive Therapy for Moral Injury?

- Ehlers and Clark's (2000) cognitive model of PTSD forms the basis of cognitive therapy for PTSD (CT-PTSD).
  - Trauma-focused cognitive behavioral therapy
  - Treatment usually consists of up to 12 weekly sessions of up to 90 minutes
  - Up to three monthly follow-up sessions if patients reexperience a limited number of traumas
  - More sessions may be needed if multiple traumatic events are reexperienced.

Ehlers, A. , & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. Behaviour Research and Therapy, 38, 319–345.

Aims of CT-PTSD with Moral Injury

- To modify threatening appraisals (personal meanings) of the trauma and its sequelae.
- To reduce re-experiencing by elaboration of the trauma memories and by 'breaking the link' between everyday stimuli and trauma memories ('then versus now' trigger discrimination training).
- To reduce cognitive strategies and behaviors that maintain a sense of current threat.

Murray, H., & Ehlers, A. (2021). Cognitive therapy for moral injury in post-traumatic stress disorder. *The Cognitive Behaviour Therapist, 14*, E8. doi:10.1017/S1754470X21000040

Psychoeducation and normalization

- Include psychoeducation on moral injury
- Normalize full range of peri-traumatic experiences
- Read others' accounts of similar experiences and use these as part of Socratic dialogue

Individualized case formulation

Formulate	Formulate role of peri-traumatic numbing and/or dissociation in inhibiting memory processing
Discuss	Discuss role of mental defeat in affecting view of self if applicable
Explore	Explore appraisals and role of previous beliefs and experiences

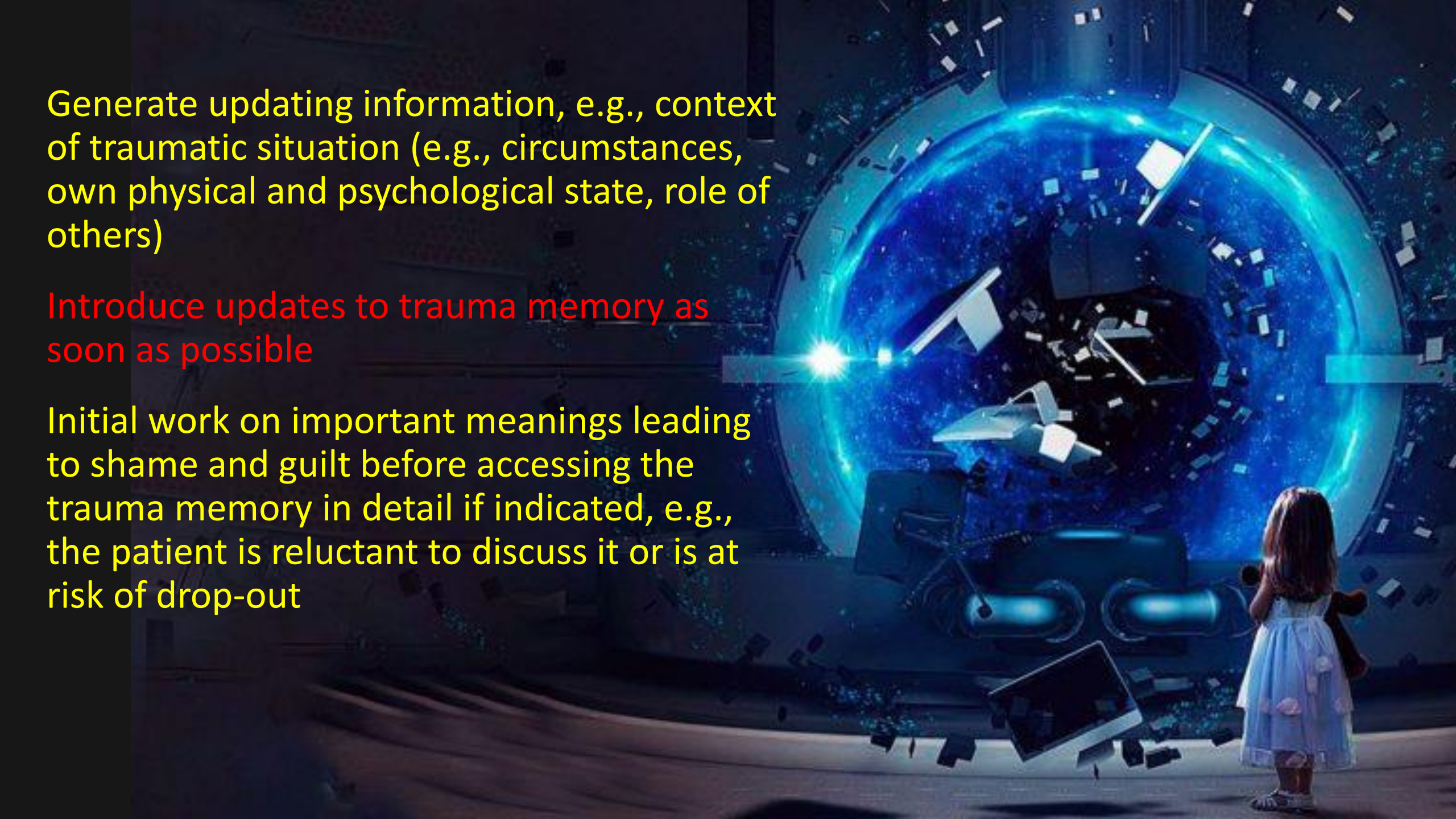
Reclaiming your life

- Incorporate reclaiming of values, self-identity and connections with others, self-care
- Address blocking beliefs, e.g. “I don’t deserve to be happy”

Generate updating information, e.g., context of traumatic situation (e.g., circumstances, own physical and psychological state, role of others)

Introduce updates to trauma memory as soon as possible

Initial work on important meanings leading to shame and guilt before accessing the trauma memory in detail if indicated, e.g., the patient is reluctant to discuss it or is at risk of drop-out



Working on meanings of the moral injury and/or trauma and its aftermath

Identify and address distorted appraisals using guided discovery, responsibility pie charts, contextualization, surveys, addressing thinking errors, psychoeducation, and seeking opinions of others

Accept responsibility for genuine fault

Consider costs and benefits of ongoing self-punishment and/or angry rumination

Work on moving forward through making amends via apologies and restitution, including in imagery

Trigger Discrimination

- Review re-experiencing to identify triggers, including ‘affect without recollection’
- Learn and practice ‘then versus now’ discrimination

SITE VISITS

- Consider earlier use if patients were dissociated at time of trauma or in a professional role
- Encourage patients to drop occupational role focus on visit
- Plan the visit ahead, particularly if it includes the patient's workplace
- Use virtual site visits where returning is impractical

ADDRESS MAINTAINING BEHAVIORS/COGNITIVE STRATEGIES

Explore costs and benefits of strategies and experiment with dropping them

Address substance use

Prioritize self-punishing behaviors and revenge rumination if presenting a risk

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