NUMINUS

# Applied PAT

## MODULE 6: POSTTRAUMATIC STRESS & COMPLEX CASES

# AGENDA

Welcome, agreements, L.A. 01

Overview of the program 02

Complex Trauma Consideration in PAT 03

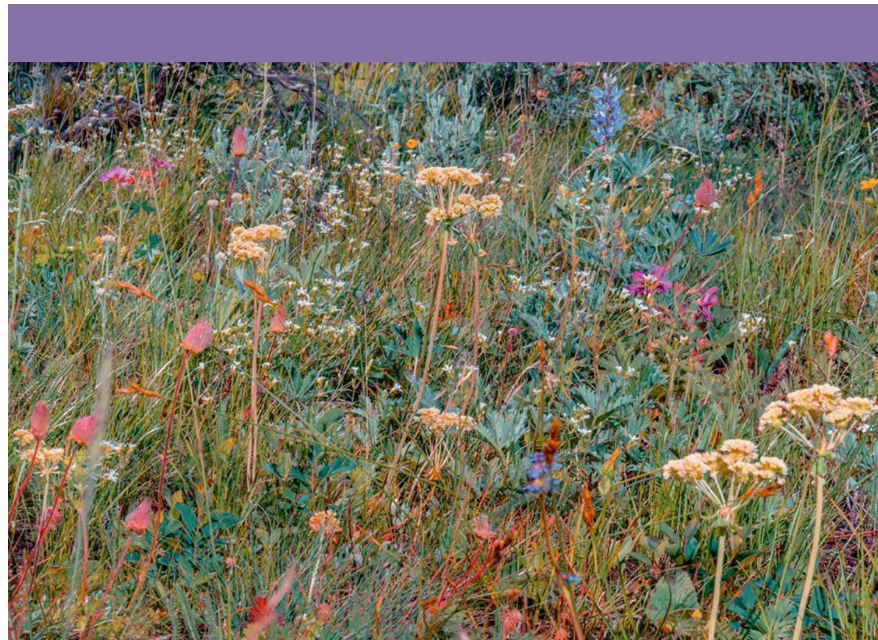
Case 04

Q&A 05

Closing 06

# GROUP AGREEMENTS

# CENTRE



Confidentiality

Engagement

Non-judgmental listening

# GROUP AGREEMENTS

# CENTRE

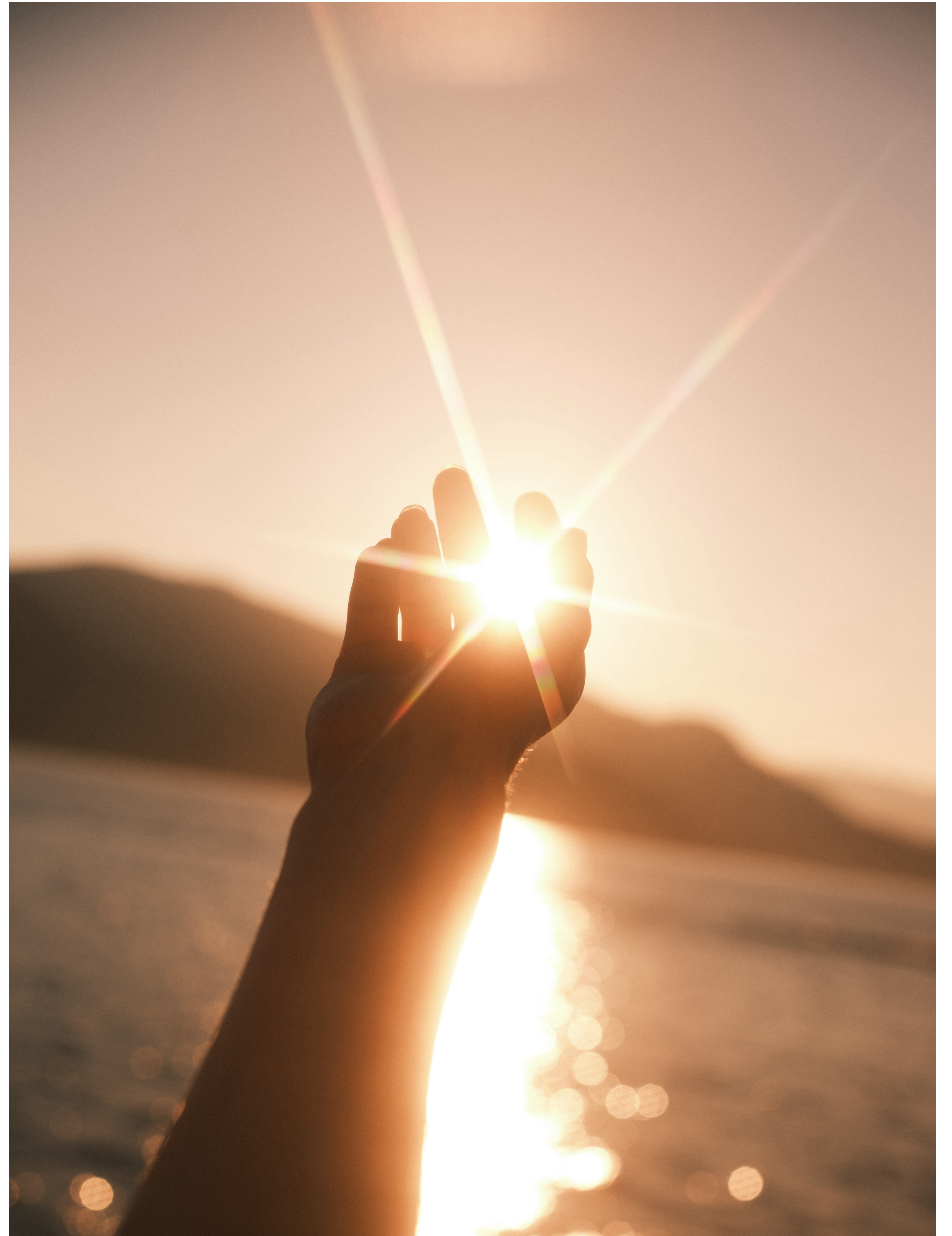
Timeliness

Right to pass

Equity

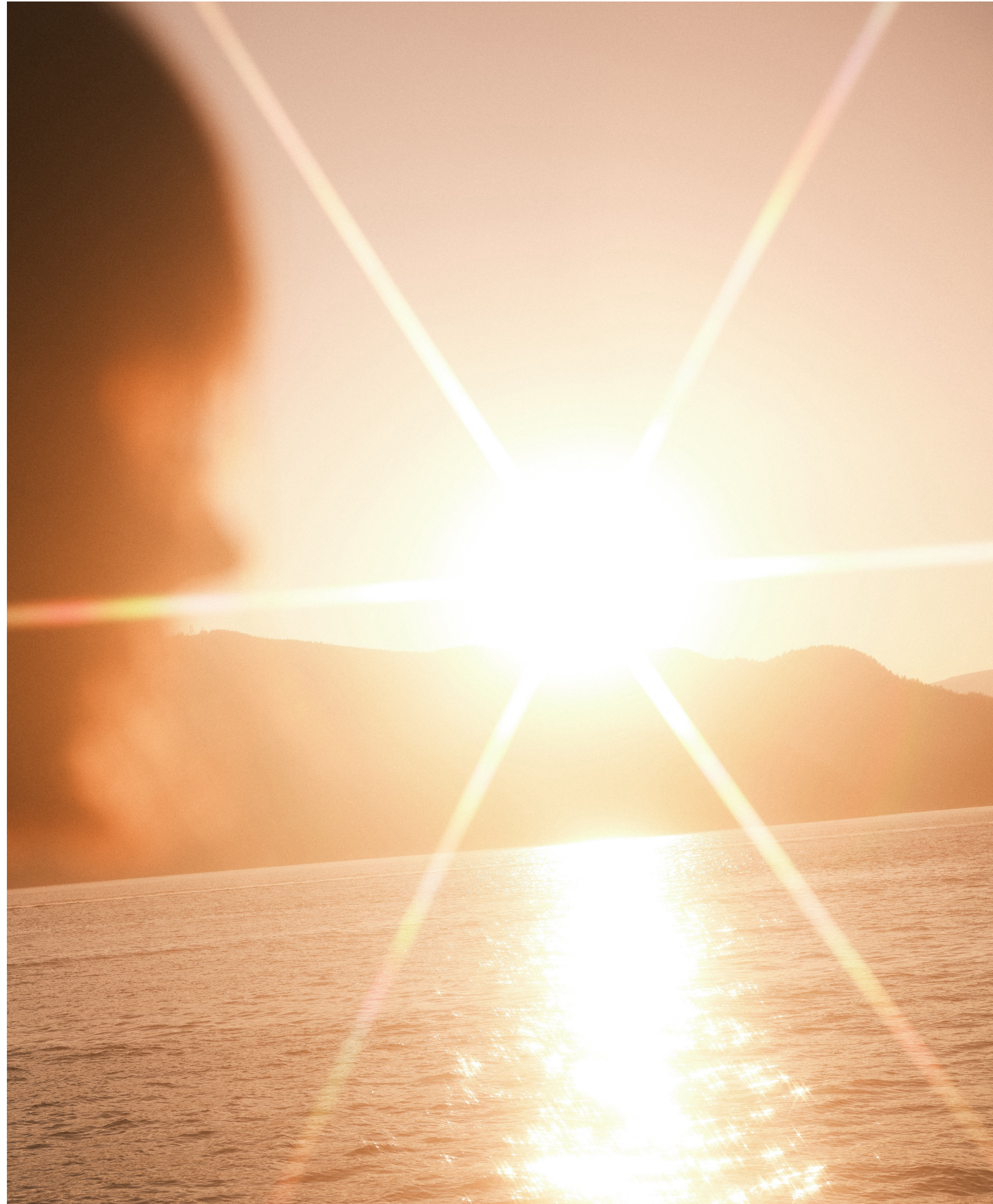
# Whole Person Care

- Therapist and client
- People are within a cultural context
- Intersecting identities
  - Power & privilege
  - Working across difference
- Our own personal histories and triggers
- Therapist risk tolerance & honouring our limits



# Life Course Theory

- Physical, environmental and socioeconomic exposures through development shape health
- Within and across generations
- Developmental: experiences at different sensitive periods shift health trajectories
- Structural: social identity and position disproportionally allocate risks and resources.



# Considerations for Working with Complex Trauma

- Therapist self-care
- Responsibility for the vulnerability and opening up of the client
- The art of boundaries
- Do thorough assessment
- Extended Preparation
- Rupture and repair – high level of sensitivity with working with high trauma loads
- Show up as a whole person
- Working with shame

# Chelsea: Part 1

- 40, F, cisgendered
- Neuropsych Hx: depression through adulthood, severe post-partum depression 16 years ago, depression on and off since, TBI 1 year ago, associated PTSD with worsening depression/SI
- Cycling accident one year ago, significant head trauma with residual TBI/PTSD symptoms which impair daily function
- Med hx: Rheumatoid arthritis, hypothyroidism
- Hx of childhood trauma: parents divorced, emotional neglect/abuse from mother, physical abuse from step-father. Felt parentified as the oldest of 4 siblings.
- Currently married, 16 years
- 4 children, ages 10-20, two from previous marriage
- Current member of local predominant religion, difficult relationship with religion.

## QUESTIONS

- *What risks and protective factors are relevant for the case conceptualization?*
- *What could be identified as goals of treatment? How might you help this client set an intention for a medicine session?*
- *What challenges can you anticipate given the complexities of this case?*
- *What is your initial treatment plan?*
- *How would you approach discussing the intersection of symptoms with a client who has this constellation of diagnoses in the context of expectation management?*

# Chelsea: Part 2

- 1st session: 100 mg ketamine lozenge follow by a 20 mg IM dose
- Escalating anxiety during the 'come up' phase, looping question of "Am I ok?"
- Became childlike during the session, giggling, talking in a distinct "little girl" voice
- Alleviation of chronic headache during the session
- Nausea/vomiting following the session
- In the 2 days following, no SI
- Increased stress tolerance
- 4th session: passing sirens provoke a panic response and then feelings of hatred toward herself
- Each session provides temporary relief of her chronic headache

1. *What supportive activities can you suggest to aid in prolonging the benefits of a session?*
2. *During the come up phase of every session she has feelings of being unsafe, asking for reassurance repeatedly. How might you guide her through this period of her session?*
   a. *How could you help her prepare for this given the predictability of these feelings arising?*
3. *How would you support this client through a panic attack?*
4. *How could this be used as an opportunity to work with this trigger?*
5. *What therapeutic tools could you use to navigate the self-narrative surrounding PTSD symptoms?*
6. *Do you have thoughts on the nature of her headaches?*

# Chelsea: Part 3

- Before the 6th session, she describes having a great day. Within the session crying about the relentless, constant nature of her pain, fear, depression
- She has a session during which she fully felt her anger related to being mistreated in her marriage
- In the sessions following separation from her spouse, she no longer experiences nausea

1. *Given what she told you before the session, how might you approach the belief/narrative that her symptoms are constant?*
2. *What suggestions could you give for integration?*
3. *How would you discuss anger with her? What questions could you ask to further explore this?*
4. *What are your thoughts on nausea in this client? How would you/do you approach discussing the potential of nausea/vomiting in PAT with any client?*