Research

Applying the Role-Oriented Integrated Model to Treat Clients with Complex Trauma

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Complex trauma manifests through symptoms that suggest deep psychological distress, posing significant challenges for effective therapy. Through the lens of Moreno's Role Theory, the Role-Oriented Integrated (ROI) model addresses this complexity by integrating the role-based elements from three therapeutic approaches: the Therapeutic Spiral Model, Internal Family Systems, and Post-Induction Therapy. Enhanced by principles from the role method, and incorporating improvisational enactments from rehearsals for growth, the ROI model offers a unique, role-focused approach to treat complex trauma. This paper delineates the theoretical framework of the ROI Model, including its grounding in Moreno's concepts of role development and integration, and details its application in an 8-week structured group therapy program. It presents preliminary treatment outcomes from a small sample size, demonstrating notable effectiveness and underscores the need for further research with more robust methodologies to explore its wider clinical utility and efficacy. This study aims to contribute to the advancement of therapeutic methods for managing the diverse symptoms associated with complex trauma.

KEYWORDS: Complex trauma; role theory; Therapeutic Spiral Model; Internal Family Systems; Post-Induction Therapy.

Complex trauma, or complex post-traumatic stress disorder (C-PTSD), emerges from multiple traumatic events often occurring during crucial developmental stages, presenting unique challenges compared to PTSD. While PTSD typically results from single, acute events, such as natural disasters or physical assaults, C-PTSD develops through prolonged exposure to relational trauma, such as abuse or neglect during early life. This extended exposure leads to severe symptoms, including intense emotional dysregulation, significant dissociation, persistent somatic distress, and profound disruptions in personal identity and relationships (Ford & Courtois, 2020; Herman, 1992; O'Shea Brown, 2021).

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Traditional treatments for PTSD, such as trauma-focused cognitive behavioral therapy and exposure-based therapies, may not be fully effective for C-PTSD. They often fail to address the relational trauma and psychological impacts central to C-PTSD, thus increasing the risk of re-traumatization (Murray et al., 2022). Additionally, while somatic approaches, such as somatic experiencing and sensorimotor psychotherapy, focus on internal sensations to foster recovery (Levine, 2010; Ogden, 2020; van der Kolk, 2014), they may fall short in restoring disrupted identity and relational functions. Eye movement desensitization and reprocessing, although recommended for PTSD by the World Health Organization (WHO, 2013), may overwhelm clients with C-PTSD. This is due to the intense nature of the sessions, which can exceed the tolerance level of this population, as noted in Korn (2009).

This paper introduces the Role-Oriented Integrated (ROI) model, a novel approach specifically designed for C-PTSD. Drawing on Moreno's (2019) role theory, the ROI model integrates cognitive and somatic processes to manage safely and effectively the complex symptoms of C-PTSD. It specifically tackles identity confusion and relational dysfunctions by enhancing the quality, quantity, and flexibility of an individual's role repertoire, which aids in adaptation and recovery. The ROI model's comprehensive design not only addresses cognitive distortions and somatic distress but also accommodates the relational and psychological impacts of complex trauma. Preliminary results from an intensive outpatient group study indicate that the ROI model significantly improves treatment outcomes for individuals affected by C-PTSD.

THEORETICAL FOUNDATION OF THE ROI MODEL

While cognitive- or somatic-focused trauma treatments typically prioritize symptom alleviation, they may not fully resolve the deeper relational and identity disturbances essential for treating C-PTSD. Therefore, it is vital to adopt a comprehensive approach that goes beyond mere symptomatic relief to address the foundational disruptions and distortions caused by complex trauma. In this context, Moreno's (2019) role theory offers a robust theoretical foundation for understanding and treating C-PTSD.

In his seminal work, *Psychodrama* volume 1, Moreno (2019) presents the self as a system of roles organized into clusters with operational links (i.e., social atoms and cultural atoms), offering a dynamic perspective on personality development and interactions. He describes the progression of the self from the psychosomatic cluster, which encompasses bodily experiences, to the psychodramatic cluster that manages intrapersonal dynamics, culminating in the social cluster that facilitates interpersonal interactions. However, Moreno (2019) also notes that an imbalance between the psychosomatic and social roles can hinder self-development or create disturbances within the self. This imbalance is particularly significant, as it affects both how individuals perceive themselves and how they interact with others, potentially leading to ongoing internal conflicts and disrupted social relationships.

For individuals with C-PTSD, complex trauma often leads to heightened physiological responses and a disrupted sense of bodily safety, affecting what Moreno (2019) refers to as psychosomatic roles. This disruption can significantly hinder the ability to form and maintain healthy social connections, referred to as social roles. To address this misalignment, the psychodramatic cluster plays an essential role. Serving as an intermediary and conflict resolver, it bridges the internal, bodily-based experiences of psychosomatic cluster with the external, interpersonal interactions of social cluster. This mediation helps individuals integrate their internal states with their social environments, facilitating healthier interactions and personal development.

For example, consider a child who experiences neglect and resultant hunger, adopting a "hungry eater" role within the psychosomatic cluster. As the child uses imagination and role play to cope, this role may evolve into a "nourished provider" within the psychodramatic roles, empowering the child and introducing feelings of care absent in their real environment. As the child engages in social settings, such as school or peer groups, the "nourished provider" role can positively influence their social roles, reinforcing their social identity and capabilities. However, the persistent "hungry eater" role might conflict with these new social roles, causing feelings of insecurity or inadequacy in social situations involving food or nurturing. This conflict underscores the need for psychodramatic roles to reconcile these internal conflicts with external realities, facilitating a healthier integration of the child's psychosomatic and social identities.

In a clinical setting focused on complex trauma, role-oriented approaches can strengthen the operational links between imbalanced role clusters and develop a more integrated and adaptive role repertoire. Building on Moreno's (2019) concepts of role eager and counter-role, these approaches may facilitate the development of new, healthier roles unconstrained by trauma. For instance, transforming a role such as "hungry eater" into roles that embody agency, nourishment, and care can enhance the individual's sense of security and positively affect their interactions. Such transformations are crucial for fostering a healthier self-concept and more supportive relationships, demonstrating the profound impact of role adaptation in the healing process.

UNDERSTANDING COMPLEX TRAUMA THROUGH THE CORRESPONDING ROLES ACROSS THREE MODELS

As a role-oriented approach, the ROI model is deeply influenced by three established therapeutic frameworks that understand and treat trauma through a role-oriented lens. They are Internal Family Systems (IFS), Therapeutic Spiral Model (TSM), and Post-Induction Therapy (PIT), each utilizing a role-oriented perspective.

Contrasting with Moreno's (2019, p. 45) hypothesis that "the self emerges from roles," IFS views the self as inherently whole, surrounded by three parts: manager, firefighter, and exile (Schwartz, 2021). To harmonize these parts, IFS emphasizes eight C's of self-leadership: clarity, compassion, courage, confidence,

curiosity, creativity, calmness, and connectedness. Although IFS adopts philosophical stances that differ from Moreno's (2019) role perspective, the three parts and eight C's in IFS can be interpreted from a role perspective, where each part and C functions as a distinct role with unique viewpoints and qualities.

The exile role, typically harboring painful emotions or memories, remains hidden from consciousness to avoid discomfort. For individuals with C-PTSD, this role often manifests feelings of worthlessness, abandonment, and helplessness, echoing the "wounded child" role described in both TSM (Hudgins & Durost, 2022) and PIT (Mellody et al., 2003). During emotional turmoil, the protective roles of manager and firefighter in IFS, akin to the "adapted adult child" role from PIT and the internalized perpetrator and abandoning authority roles in TSM, engage in dysfunctional self-parenting through criticism, neglect, or indulgence, contingent on the emotional state of the exile. When the exile feels worthless, the manager may adopt a critical approach, reflecting TSM's internalized perpetrator role. Conversely, if the exile is overwhelmed and exhibits uncontrolled behaviors, the firefighter intervenes, often succumbing to addictive or numbing behaviors, which mirror the "abandoning authority" role in TSM. In contrast, the true self, similar to the "functional adult" in PIT and "appropriate authority" in TSM, employs affirming, nurturing, and boundary-setting strategies to support the exile. For a detailed comparison of corresponding trauma roles across the three models in the C-PTSD context, refer to Table 1.

Theoretically, symptom stabilization and reduction in clients are achievable through the reparenting strategies that replace dysfunctional coping mechanisms. However, implementing these strategies in practice is challenging, as dysfunctional behaviors are intricately linked to deeply entrenched roles. Merely replacing unhealthy coping strategies without addressing the underlying roles often fails to effect sustainable change.

Furthermore, it's crucial to recognize that these roles, whether in the IFS model or their equivalents in TSM and PIT, are not inherently negative. The exile role, for instance, emerges from trauma-induced feelings such as fear, sadness, and helplessness. For individuals experiencing complex trauma, the development of this role is a continuous and self-reinforcing process. Protective roles, such as the manager and firefighter in IFS, evolve as mechanisms to navigate traumatic experiences, particularly when escape or direct confrontation is not feasible.

In environments where trauma is pervasive and prolonged, the coping strategies of these protective roles can become maladaptive yet deeply ingrained, serving as survival mechanisms. This complexity underscores the need for a comprehensive approach that addresses both symptoms and their underlying causes in treating complex trauma.

AN OVERVIEW OF THE ROI MODEL

The ROI model tackles the fragmentation of self that often results from complex trauma, characterized by a collection of unintegrated roles that lead to conflicting internal emotions and external behaviors. This model asserts that individuals

Table 1. Corresponding trauma roles across the IFS, TSM, and PIT in the C-PTSD context.

Model	Inner child		Dysfunctional self-parenting		Functional reparenting	
	Corresponding roles	**Presenting issues**	**Corresponding roles**	**Dysfunctional self-parenting strategies**	**Corresponding roles**	**Functional reparenting strategies**
PIT	Wounded child	Feeling less than or worthless	Adapted adult child	Criticizing	Functional adult	Affirming
TSM	Victim		Perpetrator		Appropriate authority	
IFS	Exile		Manager		True self	
PIT	Wounded child	Feeling abandoned, wanting, and needy	Adapted adult child	Neglecting	Functional adult	Nurturing
TSM	Victim		Abandoned authority		Appropriate authority	
IFS	Exile		Manager/firefighter		True self	
PIT	Wounded child	Feeling out of control	Adapted adult child	Indulging	Functional adult	Setting boundaries
TSM	Victim		Abandoned authority		Appropriate authority	
IFS	Exile		Firefighter		True self	

The table structure is based on reparenting concept and strategies outlined in the Post Induction Therapy (PIT) model. Trauma roles from the Internal Family Systems (IFS) and Therapeutic Spiral Model (TSM) are correspondingly assigned to provide clear references. It is important to note that the presentations and functions of these roles are categorized specifically within the context of complex trauma and should not be generalized to other contexts.

with a history of complex trauma usually have a limited range of roles and a significant gap between their self-perception—shaped by unrecognized and distorted core beliefs—and their authentic selves. This misalignment is externally manifested through symptoms that impact behavior, cognition, emotions, and physiology, indicating the depth of the underlying trauma.

The ROI model provides a dynamic and iterative process that facilitates creativity and spontaneity in individuals with C-PTSDas they create, redefine, integrate, and balance their role repertoires. Drawing inspiration from Moreno's (2019) five stages of role development and the role method by Landy (1994), the model supports continuous personal development and healing. The steps of the model are flexible and can be revisited or applied in a nonlinear order as needed.

1. Identifying a role: This first step helps clients access their current role repertoire and identify an existing role within psychosomatic, social, or psychodramatic clusters.
2. Exploring the role: Here, clients examine the origin, quality, and adaptability of the role through dramatic interviewing. This step seeks to understand the role's history and function and evaluates the client's willingness and openness to adopt new, alternative, or complementary roles.
3. Developing a new role: Clients engage with Moreno's (2019) role development stages of role perception and role expectation. They define the desired attributes of the new role, utilizing the eight C's of IFS as a framework.
4. Role training: Incorporating Moreno's (2019) stages of role taking and role playing, this step begins with a proxy scene that challenges the new role, enhancing its capacity in a controlled and dramatic environment. This is followed by employing psychodrama to practice three reparenting strategies for the activated wounded child—affirming, nurturing, and setting boundaries—as per the techniques derived from PIT. TSM is integrated as a central intervention to ensure safe containment during these processes.
5. Integrating the role repertoire: The final step involves weaving the new role into the client's overall role repertoire and identifying operational links within it. This ensures that the new role aligns harmoniously with the existing roles, facilitating smoother transitions and interactions across various contexts.

Additionally, the model includes Rehearsals for Growth (RfG) by Wiener (1994), featuring a series of improved games and exercises that are especially effective in expanding clients' creative, expressive, and spontaneous capacities as they explore and develop their role repertoire.

APPLICATION OF THE ROI MODEL

The ROI model was initially implemented in a structured 8-week Intensive outpatient program, requiring clients to participate in 12 hours of group therapy and an additional hour of individual therapy each week. Participants typically presented with a variety of co-occurring disorders, manifesting symptoms

consistent with C-PTSD. To monitor their progress, clients were requested to fill out weekly self-report assessments. These assessments varied according to the individual's symptoms, but most clients routinely completed the Patient Health Questionnaire 9-item depression scale (PHQ-9), the Generalized Anxiety Disorder 7-Item (GAD-7) scale, and the Post-Traumatic Stress Disorder Checklist for DSM-5 (PCL-5; Blevins et al., 2015).

The PHQ-9 and GAD-7 are widely used tools to assess depression and generalized anxiety, respectively. The PCL-5, a 20-item self-report measure designed to assess the 20 DSM-5 symptoms of PTSD, is included to provide a comprehensive overview of severity and impact of PTSD on a client's life. This tool is widely used for screening, diagnosis, and monitoring of PTSD symptoms. Including these three measurements allows for efficient tracking of changes in symptoms over time, providing critical data to tailor therapeutic interventions and monitor client progress effectively.

Implementation of the ROI model in the clinic faced multiple challenges: constrained therapy session durations, the dynamic nature of an open group setting, diverse cultural backgrounds of participants, and the necessity to tailor therapy to each individual. Despite these challenges, participants commonly exhibited three predominant characteristics: an inadequate sense of self, a narrow and rigid range of roles they inhabit, and extensive histories of complex trauma. These shared traits underscored the relevanceof the ROI model, which employs a semi-structured framework designed to address effectively these common characteristics while accommodating individual needs.

The program's standard format includes 12 hours of group therapy spread over 4 days, with each session lasting for 3 hours. These sessions incorporate two 10-minute breaks, providing participants moments for rest and introspection. Each session is structured into five phases: check-in, warm-up, enactments, sharing, and closure. Typically, a group consists of eight participants, each engaging in an 8-week treatment cycle. As participants complete their treatment, new members join, facilitating a continuous transition within the group.

To illustrate the ROI model's practical application, a case study featuring a client referred to by the pseudonym "Lisa" is integrated into the weekly descriptions of the model in action, maintaining confidentiality while providing real-life context.

Week 1. Observing and Experimenting

In the first week, newcomers often experience anxiety when introduced to the group, especially those with histories of complex trauma where establishing trust is notably difficult. The unfamiliarity with role-oriented approaches, such as psychodrama and drama therapy, can further heighten anxiety levels. To ease the transition, newcomers are reassured that participation in dramatic enactments is voluntary, allowing gradual engagement within their comfort zones. Typically, members start by observing and then gradually increase their involvement in dramatic activities throughout the week. The inherent enjoyment found in RfG enactments proves effective in building early rapport within the group.

Concurrently, therapists assess client's readiness for further therapeutic engagement and begin to form a therapeutic alliance.

Lisa, a 26-year-old Caucasian cisgender woman, was referred for severe depression and social anxiety, conditions compounded by a significant history of suicidal ideation, attempts, and self-harm, with no prior experience in group therapy. On the first day, she was noticeably reserved and guarded. However, as the week progressed, the group's cohesiveness and the enjoyable atmosphere facilitated her gradual connection with other members.

Week 2. Identifying a Role

As newcomers begin to form bonds with the group and establish foundational trust with therapists, they are introduced to the first step of the ROI model: identifying a role. This phase aligns with the "invoking the role" and "naming the role" phases in the Role Method (Landy, 1994, p. 134), or the "inviting a character" in RfG exercises (Wiener, 1994, p. 138). The range of roles that clients may identify is extensive, from metaphorical to concrete, with the stipulation that these roles should mirror those the clients play in their everyday lives, touching upon somatic, affective, familial, and social dimensions. Clients then sculpt these roles, giving each a descriptive name comprising an adjective and a noun, and assigning a declarative line to each to help clarify their role identifications. Following this, clients are encouraged to contemplate the assembled sculptures and select one for further exploration.

For Lisa, the roles she identified were "Sabotaging Machine" in the somatic domain, "Non-stop Rabbit" in the affective domain, "Sad Clown" in the familial domain, and "Hopeless Loser" in the social domain. She chose to delve into the affective role of "Non-stop Rabbit," recognizing that her incessant, burrowing thoughts were at the root of her suicidal ideation and self-harm behaviors. She expressed feeling overwhelmed by the relentless nature of this role.

Week 3. Exploring the Role

During week 3, clients deepen their exploration of their identified roles, following step two of the ROI model. They begin by embodying their roles to narrate a story titled "How We Met." This exercise, inspired by a corresponding exercise in RfG, adds a unique twist by having the role itself narrate the story, revealing how it emerged and became a part of the client's life. The narrative unfolds in the first person, addressing four pivotal questions about the role's origin, catalyst, support, and messages conveyed to the client.

Clients may choose to share their story one-on-one or, preferably, within the group to foster a shared understanding. Following the storytelling, the role undergoes a group inquiry—or a therapist-led examination in individual sessions—to dissect the role's characteristics and malleability. The group naturally formulates questions, but therapists can also provide guiding prompts. These questions aim to explore the role's current relationship with the client, its perception of the client's feelings, the constancy or evolution of its messages, and its openness to accommodate an alternative or complementary role.

When Lisa embodied the "Non-stop Rabbit," she shared a poignant tale with the group. The "rabbit" appeared during Lisa's elementary school years; a time marred by bullying. It offered a rationale for the bullying—Lisa said "something stupid in the class"—and suggested Lisa stay inconspicuous to avoid further trouble. In the group interview, the "rabbit" confessed to knowing Lisa's weariness with its persistent caution and unnecessary burrowing, yet it felt compelled to protect Lisa from social blunders. Ultimately, the "rabbit" expressed a willingness to welcome a new ally, signaling openness to a complementary role to evolve and support Lisa in a healthier way.

Week 4. Developing a New Role

In the fourth week, clients who have shown a willingness to evolve beyond their established roles begin to shape new ones. Instead of adopting an entirely new role, many clients exhibit a reluctance to let go of their existing roles, despite recognizing a need for personal growth. However, they are open to introducing a complementary role that works in tandem with their existing roles to mitigate any limitations. This stage involves dramatic exercises that not only underscore the strengths inherent in their current roles but also articulate the anticipated advantages of adopting the complementary roles, all within the framework of the eight Cs of the IFS model that epitomizes the "true self." Through role-play, clients alternate between their old and new roles, fostering a conversation that defines how each will serve their future self.

Lisa, for instance, has welcomed the addition of a "Punctual Timer" role to balance out her "Non-Stop Rabbit." She recognized the rabbit's beneficial trait of curiosity and desired that the "Punctual Timer" would bring a sense of calm. Enacting both, Lisa engaged in a dialogue where the "timer" negotiated the containment of the rabbit's relentless activity without quelling its essential curiosity. This intricate exchange aided in shaping a vision for how the "Punctual Timer" can infuse Lisa's life with peace while honoring her inquisitive nature.

Week 5. Role Training, Part I—Proxy Scene

Week 5 shifts the treatment focus to role training, addressing the persistence of various trauma sub-roles developed over a lifetime. This phase involves engaging in dramatic enactments and psychodrama to foster self-reparenting strategies—affirming, nurturing, and setting boundaries—as endorsed by PIT. The ROI model incorporates the concept of a "proxy scene" from RfG to facilitate this training (Wiener, 2020, p. 64). Clients begin by identifying potential obstacles that the new role might encounter, and then engage in a proxy scene enactment. This allows the new role to confront these anticipated challenges and strengthen its capacity within a supportive environment created by the therapist and group members.

For example, Lisa identified several challenges for the "Punctual Timer" role: the "Non-stop Rabbit" is persistent and stubborn, and its ability to draw Lisa into rumination feels isolating. To address these issues, Lisa and the therapist designed a proxy scene where the "rabbit," played by another group

member, meets the "timer," played by Lisa, in a dream sequence akin to Alice's Wonderland. The "timer," guarding the queen's garden, confronts the "rabbit" digging without permission. Despite the rabbit's initial non-cooperation, the "timer" asserted her authority, threatening to exile the rabbit from the dreamland unless it ceases its digging. This enactment led Lisa to realize the importance of setting firm boundaries with the rabbit to maintain harmony within her internal family systems.

Week 6. Role Training Part II—Psychodrama of Reparenting

In week 6, the ROI model deepens the healing process by guiding clients through the latter stages of step four, the psychodrama of reparenting. Clients recount a recent episode where their "wounded child" role was activated and then "invite" their personal, interpersonal, and transpersonal strengths into the scene, following the protocols of TSM. These strengths collectively form a supportive circle around the client, who acts as the protagonist, thereby bolstering their resilience and ability to handle adversities through newly developed roles. Should the protagonist encounter obstacles reminiscent of past patterns, this circle of strengths is poised to offer guidance and support, helping the new role to navigate these challenges effectively.

For Lisa, a recent altercation with a friend triggered feelings of inadequacy and abandonment, leading to self-harm impulses. She recognized her curiosity as a personal strength, her brother as her interpersonal support, and the ocean as her transpersonal anchor. These elements were embodied by group members to form a circle of strength. As Lisa reenacted the conflict, she initially slipped into the "Non-stop Rabbit" role, echoing sentiments of being unloved and abandoned. However, the "Punctual Timer," bolstered by the strength circle, stepped in to interrupt the rabbit's negative spiral, steering her toward a state of tolerance. In the sharing session, Lisa expressed newfound tranquility and committed to embracing the "Punctual Timer" role in her everyday life.

Week 7. Integrating the New Role into the Role Repertoire

Following role training, clients transition to the fifth step of the ROI model. This stage requires a strategic dialogue between the newly acquired role, the existing role, and other roles, identified across four dimensions established in the first step. The aim is to encourage a collaborative negotiation, seeking to align the roles and resolve any conflicts. The process diverges depending on the role's nature: If it's an alternative role meant to supersede the existing one, a formal transition marks the old role's closure. If it's a complementary role, intended to work in concert with the existing one, the established role leads introduction to the role family. The client, serving as the role family leader, facilitates this meeting.

In Lisa's case, the "Punctual Timer" is a complementary role designed to collaborate with the "Non-stop Rabbit". Rather than acting as a replacement, this new role is meant to enhance the existing role family, which includes the "Sabotaging Machine" (somatic role), the "Sad Clown" (familial role), and

the "Hopeless Loser" (social role). Initially, the "Punctual Timer" anticipated seamless integration and substantial contribution. Yet, resistance from the established roles, ranging from skepticism to outright hostility, left Lisa feeling at an impasse. The therapist stepped in, proposing the group "doubling" for the "Punctual Timer." This technique sparked a brainstorm of ideas on how the "timer" can assist while valuing the other roles. In the ensuing discussion, Lisa articulated her commitment to supporting the "Punctual Timer" in becoming an integral part of the role family and planned to adapt the successful techniques (e.g., setting boundaries) used with the "Non-stop Rabbit" for other roles. This method fostered a thoughtful and inclusive strategy for role integration, taking into account the intricate emotional and psychological layers involved.

Week 8. Closure

Program constraints necessitate a timely exit, making an effective closure essential for preserving progress and facilitating ongoing self-discovery. An integral part of this closure is coordination with clients' therapists to strategize long-term treatment plans. Moreover, a graduation ceremony within the group acts as a poignant marker of accomplishment, fostering a sense of hope and achievement not just for the graduate but for all members.

In Lisa's case, her closure involved the "Presents" exercise from RfG (Wiener, 1994, p. 105), wherein group members bestowed imaginative, unseen gifts upon her new role, the "Punctual Timer." Leveraging their intimate knowledge of her role dynamics, particularly with the "Non-stop Rabbit," the group offered ingeniously tailored gifts. These symbolic presents essentially equipped the "Punctual Timer" with a toolkit to augment its function: a "Mindful Soup" to soothe the rabbit, a "Time Machine" for perspective-giving journeys, and more, each item thoughtfully designed to empower the timer's integration and efficacy within the role family.

DISCUSSION

Lisa commenced her treatment with significant symptoms: her depression score was 18 out of 27, anxiety score was 9 out of 21, and trauma symptoms were marked at 22 out of 30. Upon completing the program, Lisa's depression and anxiety scores impressively dropped to 0, indicating a 100% reduction, while her trauma symptoms decreased by 68.18%, to a score of 7. Notably, Lisa suffered from pronounced social anxiety initially, and the GAD-7 scale, primarily measuring generalized anxiety, did not fully capture her progress in this area. Nevertheless, an initial increase to 15 out of 21 in her anxiety score during the first week—rising by 6 points—was followed by a steep decline to 2 in the second week. Her anxiety score remained low, between 3 and 0, for the duration of her treatment, suggesting that the ROI model facilitated her rapid integration into the group and effectively alleviated her social anxiety.

The model also contributed to a significant reduction in her depression and trauma symptoms, although there was a slight fluctuation in her depression score in the sixth week.

Lisa's experience with the ROI model is part of a broader application across 24 clients with symptoms of C-PTSD. All were enrolled in a uniform treatment program that included 32 group therapy sessions and eight individual sessions over 8 weeks. Within the first month, two clients had to be moved to an alternative program to address more severe symptoms. Eight clients, requiring additional time to adjust to the model, extended their treatment by 4 weeks. Out of the remaining 14 who completed the program on schedule, six did not fulfill the requirement of weekly assessments. Consequently, the analysis was based on the eight clients who not only finished the treatment within 8 weeks but also consistently completed the PHQ-9, GAD-7, and PCL-5 scales. This group, ranging in age from 20 to 51 years with an average age of 34 years, exhibited marked improvements. On average, depression scores decreased by 77.27%, anxiety by 80.15%, and PTSD symptoms by 55.8%. These results underscore the therapeutic efficacy of the ROI model.

It must be noted, however, that these findings are limited to the scope of the scales used and the fact that the model was implemented solely by the developer. To provide a comprehensive understanding, Table 2 offers a statistical overview of the changes in symptoms. The *p*-values indicate significant reductions across all types of symptoms: 0.00013 for depression, 0.00016 for anxiety, and 0.00022 for trauma, underscoring the effectiveness of the treatment.

CONCLUSIONS

The preliminary implementation of the ROI model in group therapy settings shows promising potential for treating C-PTSD. However, several limitations exist that impact the generalizability and accuracy of the model's effectiveness. These limitations include a small dataset and the lack of a control group, which is crucial for establishing more definitive cause-and-effect relationships. Moreover, the model has been exclusively implemented by its developer, and its efficacy in individual therapy settings remains untested. Another concern is the variability in participant's completion of the model's cycles, with some individuals not completing and others undergoing multiple cycles, which may affect the consistency and reliability of results.

Despite these challenges, the positive outcomes observed among participants highlight the potential of the ROI model as an effective tool for managing the complex effects of C-PTSD. The observed benefits underscore the need for more extensive research. Future studies should utilize more robust research designs, including larger sample sizes and the use of randomized controlled trials, to provide a clearer assessment of the ROI model's therapeutic impact. Such studies would help clarify whether the benefits are due to general engagement in treatment or specific aspects of the ROI model, enhancing its credibility and potential for broader application in diverse clinical settings.

Table 2. Statistical analysis of symptom changes using the ROI model post-treatment (*N* = 8).

Symptoms types	Pre-score	Post-score	Change (%)	*t*-value	*p*-value	CI (95%)	*d*	*df*
Depression	18.25	4.25	77.27	7.56	0.00013*	9.62–18.38	2.67	7
Anxiety	14.625	2.875	80.15	7.34	0.00016*	7.96–15.54	2.60	7
Trauma	21.375	9.125	55.80	6.96	0.00022*	8.09–16.41	2.46	7

"Pre-score," "post-score," and "change (%)" represent mean score.
CI (95%): 95% confidence interval; *d*: Cohen's *d*; *df*: degrees of freedom. *$p < 0.05$ is statistically significant.

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APPENDIX: GLOSSARY OF ABBREVIATIONS FOR TERMS USED IN THE STUDY

GAD-7: Generalized Anxiety Disorder 7-Item scale, a brief self-report questionnaire commonly used to screen for and measure the severity of generalized anxiety disorder.

IFS: Internal Family Systems, a therapeutic approach developed by Richard Schwartz in the 1980s. It is based on the idea that the self is naturally multiple, and the three parts interact with an individual's internal systems in ways that mimic external family dynamics.

PCL-5: The abbreviated 5-item version of the Post-Traumatic Stress Disorder Checklist, a psychological assessment tool designed to identify symptoms of posttraumatic stress disorder (PTSD).

PHQ-9: Patient Health Questionnaire 9-item depression scale, a self-administered diagnostic tool for common mental health disorders, including depression.

PIT: Post-Induction Therapy, a therapeutic approach developed by Pia Mellody. It primarily focuses on treating the effects of trauma and the developmental immaturity that stems from childhood experiences, particularly those involving abuse, neglect, or other forms of dysfunctions within the family system.

RfG: Rehearsals for Growth, a therapeutic approach developed by Daniel J. Wiener in the late 1980s. It integrates drama therapy and theater improvisation techniques into the practice of psychotherapy to enhance personal growth and improve interpersonal relationships.

TSM: Therapeutic Spiral Model, an adaption of classical psychodrama developed by Kate Hudgins and Francesca Toscani. It is built on the foundation of psychodrama created by Jacob Moreno but tailored to ensure a safe and therapeutic environment for trauma survivors, minimizing the risks of re-traumatization and emotional overwhelm.