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# PTSD Revisited: Evolving Understanding & Best Practices in Trauma Treatment

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# About Me

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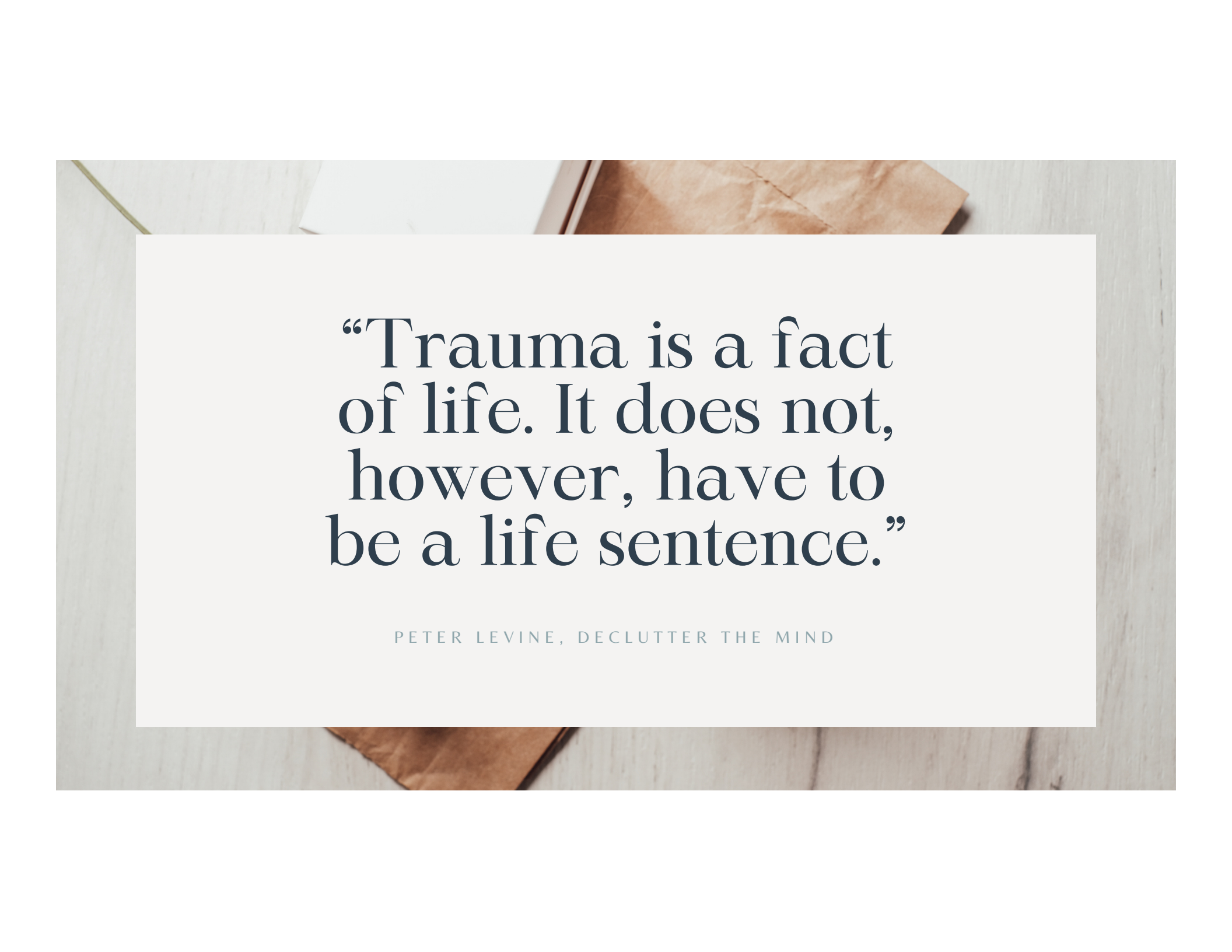
- LICENSED PROFESSIONAL COUNSELOR SUPERVISOR (LA)
- LICENSED PROFESSIONAL COUNSELOR (AZ)
- LICENSED CLINICAL MENTAL HEALTH COUNSELOR (NC)
- DOCTORATE STUDENT
- CERTIFIED CLINICAL TRAUMA PROFESSIONAL - LEVEL 2
- EMDR CERTIFIED THERAPIST
- LEVEL 2 IFS THERAPIST
- CERTIFIED MILITARY CLINICAL COUNSELOR
- CERTIFIED FIRST RESPONDER COUNSELOR



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# Learning Objectives

- 01 Participants will be able to better define the diagnostic criteria, neurobiological underpinnings, & symptomatology of PTSD.
- 02 Participants will learn about the potential barriers associated with trauma treatment and effectiveness and ways to overcome the barriers.
- 03 Participants will learn how to apply trauma-informed principles to enhance engagement, safety, and treatment efficacy across interdisciplinary behavioral health settings.
- 04 Participants will learn about the interplay between PTSD symptom clusters and common co-occurring conditions (e.g., dissociation, substance use, mood disorders) to inform differential diagnosis and individualized treatment planning.

The image features a quote by Peter Levine centered on a white rectangular card. The card is placed on a light-colored wooden surface. In the background, there are pieces of brown, textured paper, possibly from a book or a folder, adding a rustic or artistic feel to the composition. The quote is written in a dark, serif font and is enclosed in quotation marks.

“Trauma is a fact  
of life. It does not,  
however, have to  
be a life sentence.”

PETER LEVINE, DECLUTTER THE MIND



# Defining Trauma

- A **biological** disorder maintained by cognitions and behaviors. -(Dr. Shauna Springer)
- Something that is **too big** for the brain to assimilate into the memory system so it gets **stuck**.
- **Exposure** to actual or threatened death, serious injury, or sexual violence.
  - But what else?
- An **emotional response** to a terrible event like an accident, rape or natural disaster, etc.
- As **van der Kolk** notes, trauma is specifically an event that **overwhelms** the central nervous system, **altering** the way we process and recall memories.
  - "Trauma is not the story of something that happened back then," he adds, *"It's the current imprint of that pain, horror, and fear living inside people."*

"It's like a fate worse than death, like being trapped in hell." –  
Client



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# Posttraumatic Stress Disorder

Adults/Adolescents/Children 6+

**A** **Exposure** to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

- Directly experiencing the traumatic event(s).
- Witnessing, in person, the event(s) as it occurred to others.
- Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
- Experiencing repeated or extreme exposure to aversive details of the traumatic event(s).

**B** Presence of one (or more) of the following **intrusion** symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

- Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
- Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
- Dissociative reactions (flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring.
- Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)
- Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)

# Posttraumatic Stress Disorder

Adults/Adolescents/Children 6+

**C** Persistent **avoidance** of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

- Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
- Avoidance of or efforts to avoid external reminders that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

**D** **Negative alterations** in cognitions and mood associated with the traumatic event(s), beginning or worsening after the TE occurred, aeb 2 or more of the following:

- Inability to remember an important aspect of the traumatic event(s).
- Persistent & exaggerated negative beliefs of expectations about oneself, others, or the world.
- Persistent, distorted, cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame self or others.
- Persistent negative emotional states.
- Markedly diminished interest or participation in significant activities.
- Feelings of detachment or estrangement from others.
- Persistent inability to experience positive emotions.

# Posttraumatic Stress Disorder

Adults/Adolescents/Children 6+

**E** **Marked alterations** in arousal & reactivity associated with the TE(s), beginning or worsening after the TE(s) occurred, aeb 2 or more:

- Irritable behavior and angry outbursts.
- Reckless or self-destructive behavior.
- Hypervigilance.
- Exaggerated startle response.
- Problems with concentration.
- Sleep disturbance.

**F** **Duration** of the disturbance is *more than one month*.

**G** The disturbance causes clinically **significant distress or impairment**.

**H** The disturbance is not attributable to the physiological effects of a substance.

# Posttraumatic Stress Disorder Simplified

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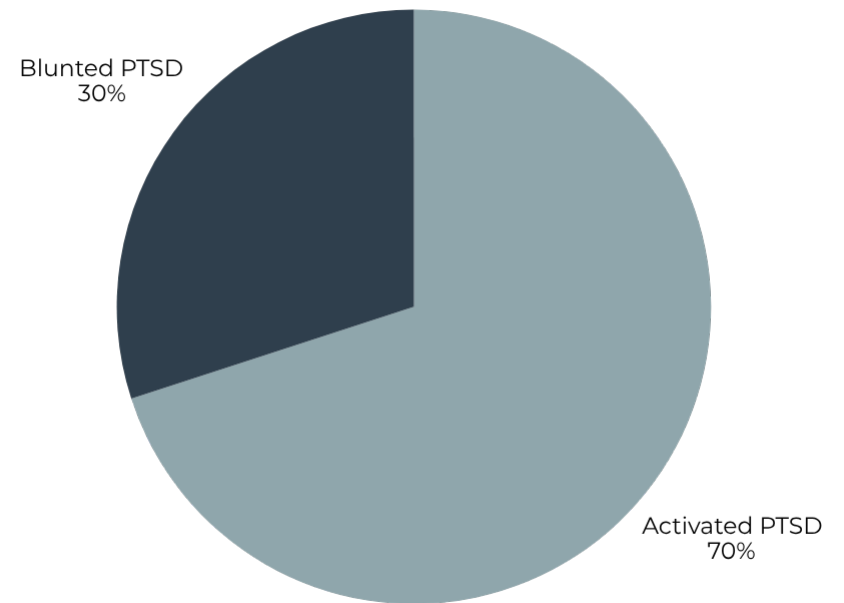
A	Exposure	D	Negative alterations in cognitions & mood
B	Intrusion Symptoms	E	Arousal & reactivity changes
C	Avoidance	F-H	> 1 month + functional impairment

# Activated vs. Blunted PTSD

**ACTIVATED PTSD:** Low activation of the PFC - inability of the PFC to calm down or inhibit the amygdala from firing - emotions are high, the body is activated, & cognitions are low.

**BLUNTED PTSD:** Increased reaction in the PFC & anterior cortex therefore cognition suppression is high while emotionality & physical sensations are low.

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# Types of Trauma

## type I



### SINGLE EVENT

Usually single-event trauma such as a car accident, one-time assault, etc. A sudden and distinct traumatic experience.

## type II



### COMPLEX TRAUMA

Persistent. Derives from repeated traumatic events. Three cardinal symptoms: Somatization (physical ailments), dissociation (divisions of personality), affect dysregulation (changes in impulse control, attention, perception, & significant relationships).

## type III



### COLLECTIVE

Shared traumatic experiences such as the COVID-19 pandemic, natural and human-made disasters. Natural disasters usually result in fewer cases of PTSD than human-made disasters.

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# Neurological Underpinnings

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## THE KEY POINTS

- ✓ TRAUMA & THE BRAIN
- ✓ CHEMICAL FACTORS
- ✓ MEMORY & TRAUMA

## Left Brain

- ✓ Thinking
- ✓ Logic/Facts
- ✓ Healed Trauma
- ✓ Non-traumatic Information
- ✓ Speech Center

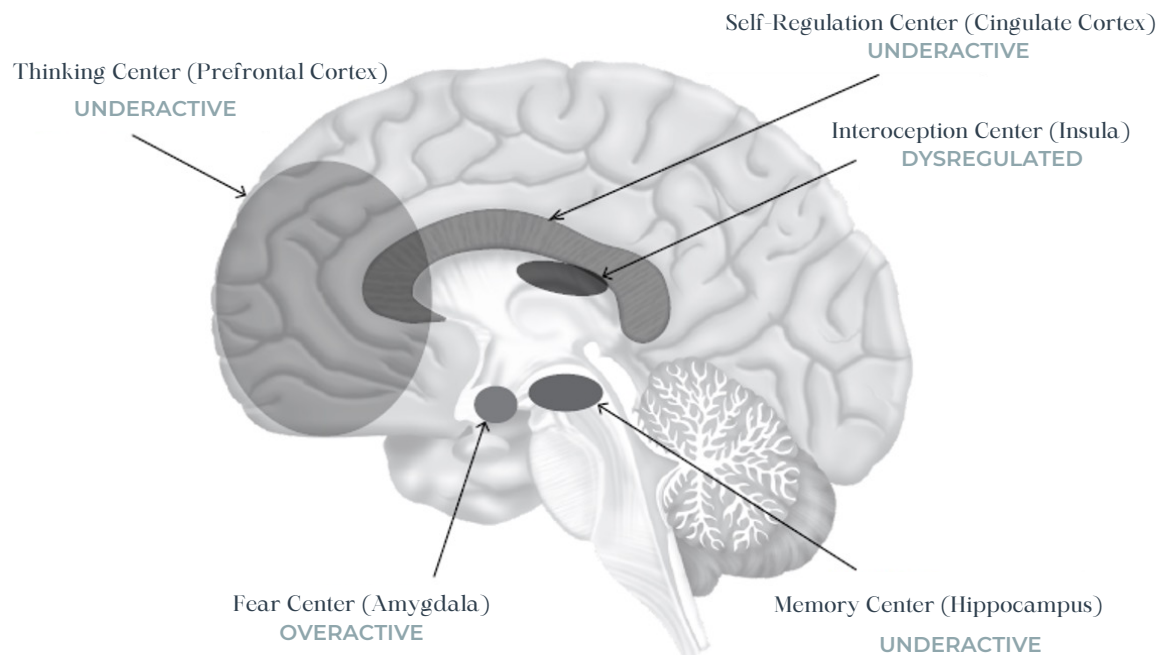
Reacts *after* right brain to an event

## Right Brain

- ✓ Trauma
- ✓ Triggers
- ✓ Old Feelings
- ✓ Old Sensations
- ✓ Old Beliefs
- ✓ Backlash

Reacts *first* to an event

# The Brain on Trauma



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## Amygdala

Quick & unconscious & crucial to helping us process emotions & extinguish fear. Is overly activated in a trauma brain.

## Prefrontal Cortex

Exhibits inhibitory control over the stress response & emotional reactivity. Suppresses the amygdala. Smaller PFC in trauma brain.

## Cingulate Cortex

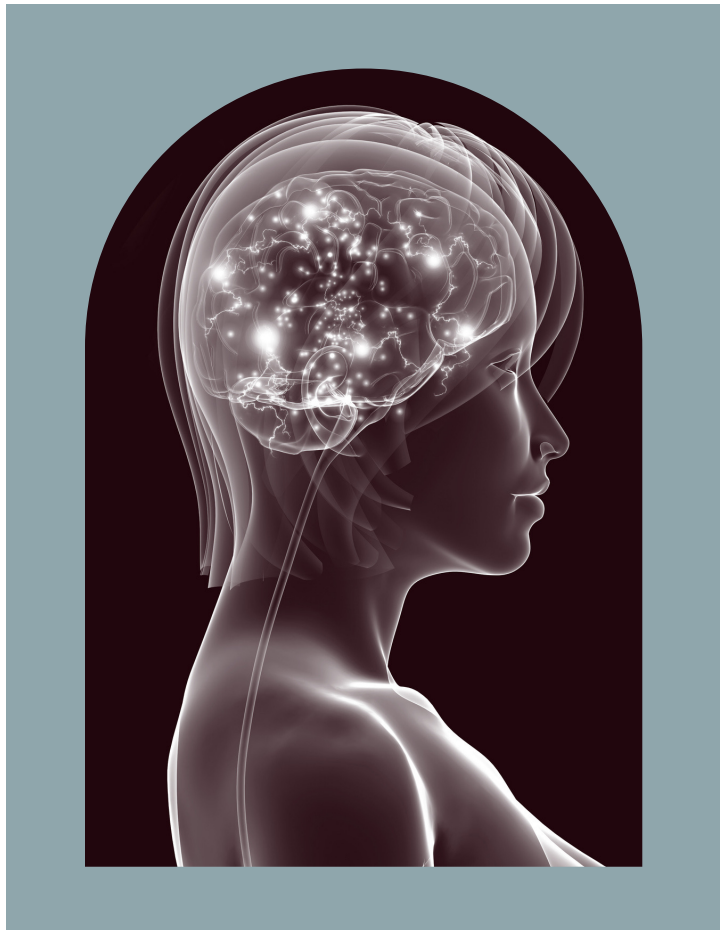
Important for emotion regulation, attention, decision-making, & suppression of fear responses. Helps to calm the amygdala.

## Hippocampus

Important for learning, memory, & the elimination of fear. Reduced volume in trauma brains.

## Insula

Integrates body sensation & emotional awareness & over-processes internal body signals associated with threat.



## Anatomical Factors

### HIPPOCAMPUS



Calms the amygdala firing. Reduced volume in PTSD. Underactive in PTSD.

### AMYGDALA



Increased glutamate & consolidates trauma memory. Increased excitability & reactivity as a result of PTSD. Stimulates the release of hormones & chemicals.

### PREFRONTAL CORTEX



Reduced volume of ventromedial PFC & anterior cingulate cortex in PTSD means it can't reduce the fear by inhibiting the amygdala.

AMYGDALA

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# Chemical Factors

01

## Reduced Serotonin

Leads to hypervigilance, increased aggression, impulsivity, enhanced formation of intrusive memories. SSRIs helpful & shown to restore PFC activity.

04

## Glutamate

Release is triggered by stress, contributes to the consolidation of traumatic memory & plays a central role in dissociation. Toxic in excess & contributes to the loss of nerve cells in the hippocampus and prefrontal cortex in PTSD.

02

## Released norepinephrine

Leads to increased fear, encoded emotional memory, enhanced arousal & vigilance. Typically prescribed propranolol or clonidine to decrease excitability & treat acute trauma.

05

## GABA

Main calming neurotransmitter in the brain. Stress known to alter GABA-benzodiazepine receptor complex.

03

## Increased Dopamine

Leads to increased chance of dissociation, development of anxiety, fear conditioning.

06

## Increased Cortisol

Helps us in moments of crisis by increasing emotional stability & mobilizing glucose or energy for survival responses. However, can be harmful when a surplus occurs.

# Memory & Trauma

## Implicit Memory

- Encoded within the first 18 months of life.
- Whenever something traumatic happens.
- Stored as perceptions, emotions, & bodily sensations.
- Primes us for future action.
- Unconscious, lacks awareness is from the past.

## Explicit Memory

- Starts developing at age 2.
- Requires focused attention.
- Linear, factual, conscious.
- Sense of time & narrative.
- Relies on the hippocampus.

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# Trauma Changes Our Core Beliefs

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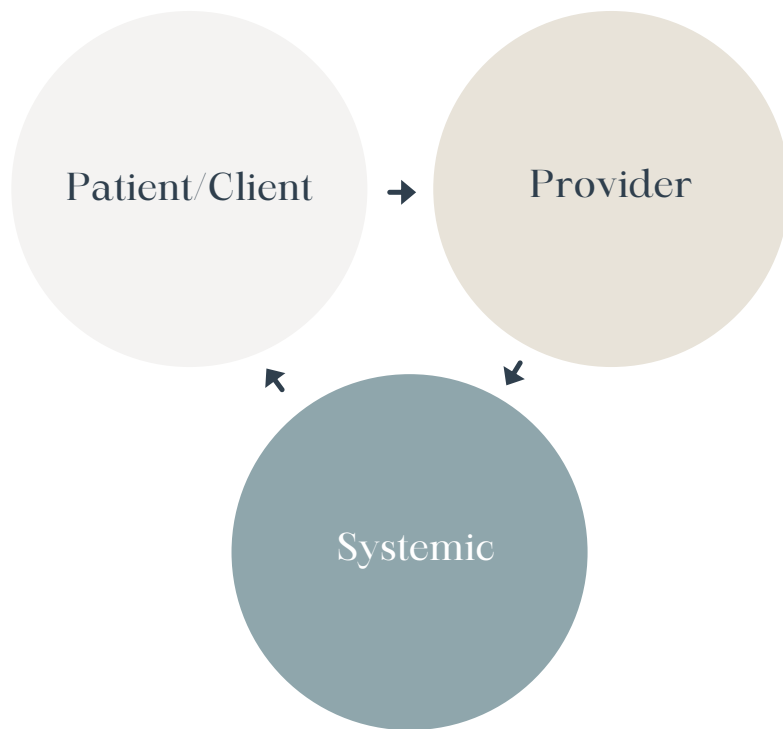
- ➔ The experience of trauma has the capacity to change the way we see **ourselves**, **others**, and/or the **world**.
- ➔ This can lead to negative cognitions or “stuck points” that dictate the way we show up in our day to day lives.



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# Barriers to Care



## Patient/Client Barriers


- Avoidance of trauma discussion
- Self-stigma & shame
- Limited trust in providers
- Logistical issues (time, cost, transportation)

## Provider Barriers

- Lack of specialized training
- Fear of or unintentional re-traumatization
- Compassion fatigue / vicarious trauma

## Systemic Barriers

- Fragmented care systems
- Inadequate reimbursement
- Rigid protocols in agencies

A close-up photograph of a white ceramic coffee cup filled with dark coffee, sitting on a matching saucer. The cup and saucer are placed on a light-colored, textured surface, possibly a tablecloth or paper. The background is slightly blurred, showing more of the same surface. Overlaid on the center of the image is a white rectangular box containing a quote in a serif font. The quote is: "Healing is not an overnight process. It is a daily cleansing of pain, it is a daily healing of your life." Below the quote, the name "LEON BROWN" is written in a smaller, all-caps serif font.

“Healing is not an  
overnight process. It  
is a daily cleansing of  
pain, it is a daily  
healing of your life.”

LEON BROWN

# Trauma Informed Care

"A STRENGTHS-BASED FRAMEWORK THAT REALIZES, RECOGNIZES, RESPONDS TO, AND RESISTS RE-TRAUMATIZATION." (SAMHSA, 2014)



## Realization

of the widespread impact of trauma and understand the potential paths for recovery.



## Recognition

of the signs and symptoms of trauma in clients, families, staff, and others involved with the system



## Responsive

by fully integrating knowledge about trauma into policies, procedures, and practices



## Resists Re-Traumatization

by not moving too fast and pushing a client before they are stable.



## Integrated Care

- ✓ HOLISTIC CARE - MIND, BODY, & SOCIAL
- ✓ ALIGNMENT OF MEDICAL, PSYCHIATRIC, & PSYCHOSOCIAL TREATMENTS
- ✓ USE VALIDATED SCREENING TOOLS
- ✓ COLLABORATION WITH OTHER TREATING PROVIDERS
- ✓ COLLABORATION WITH THE CLIENT (GIVING THEM AUTONOMY)

# Treatment Must Address the Biological Injury & the Cognitions & Behaviors that Maintain It



## COMPONENTS OF SUCCESSFUL TRAUMA TREATMENT

- STABILIZATION & PSYCHOEDUCATION
- COPING SKILLS DEVELOPMENT/RESOURCING
- REPROCESSING
- RELEASING/UNBURDENING
- INTEGRATION & RECONNECTION

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# Getting Started

- ✓ ESTABLISH RAPPORT
- ✓ CREATE A COMFORTABLE ENVIORNMENT
- ✓ SLOW IS SMOOTH & SMOOTH IS FAST
- ✓ ASSESS TRAUMA HISTORY SENSITIVELY
- ✓ BE TRANSPARENT

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# Common Co-Occurring Disorders

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01

## Dissociation

Common in complex trauma & may include depersonalization, derealization, amnesia, & identity disturbance. Is a protective / adaptive coping mechanism that requires stabilization.

04

## Anxiety & Depression

Anxiety & depression symptoms frequently show up with PTSD & often play into barriers for treatment, most specifically connected to avoidance.

02

## Substance Use

40-60% of PTSD clients will also meet for SUD. Usually "self-medication" to decrease hyperarousal, intrusive memories, &/or sleep disturbances. Integrated treatment most useful.

05

## Chronic Pain/Somatic

PTSD is known to heighten pain perception & often times chronic pain/somatic symptoms are encoded unresolved trauma memories.

03

## ADHD

PTSD can mimic or exacerbate symptoms including hyperarousal, impulsivity, &/or hyperactivity. Studies show individuals with ADHD are more likely to report childhood trauma.



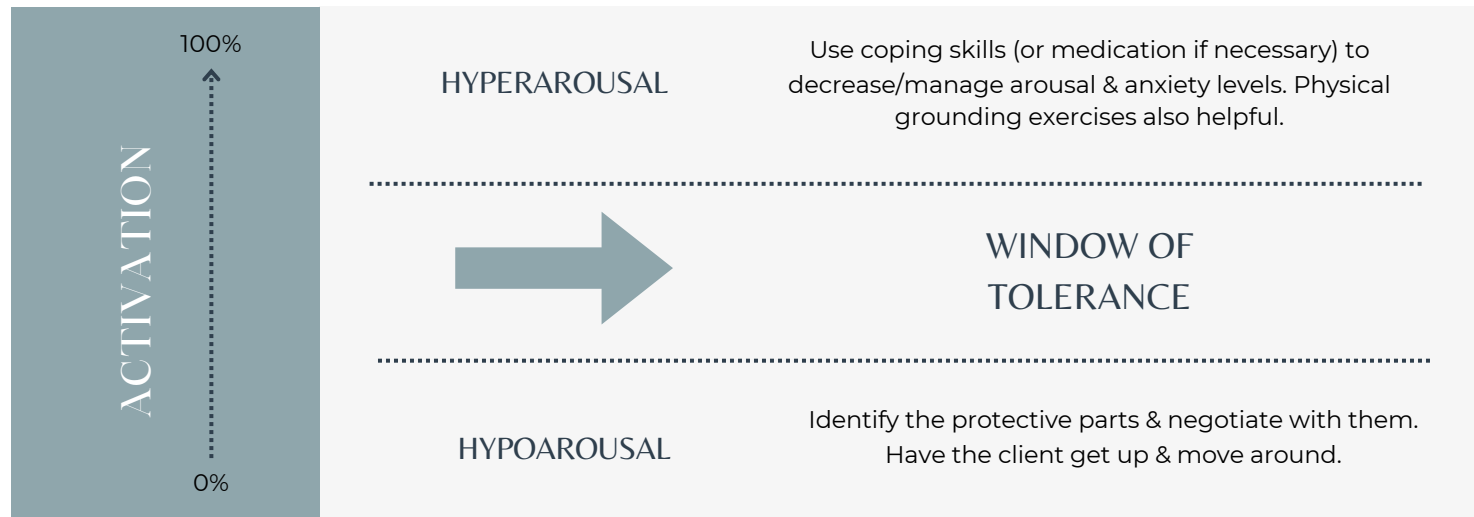
# Effective Treatment Modalities

- ✓ COGNITIVE PROCESSING THERAPY (CPT)
- ✓ PROLONGED EXPOSURE (PE)
- ✓ EYE MOVEMENT DESENSITIZATION & REPROCESSING (EMDR)
- ✓ INTERNAL FAMILY SYSTEMS (IFS)
- ✓ BRAINSPOTTING
- ✓ ACCELERATED RESOLUTION THERAPY (ART)
- ✓ DEEP BRAIN REORIENTING (DBR)
- ✓ SOMATIC EXPERIENCING (SE)

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# The Window of Tolerance



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# Trauma Informed Interventions



## SAFE SPACE IMAGERY

A space for "Self" to consolidate Self energy & get respite when needed.

01



## BUBBLE IMAGERY

Surround yourself with a bubble that's got all the feelings of your safe space in it.

02



## AFFECT DIAL

A dimmer switch used for controlling the intensity of feelings (use SUD scale).

03



## PICTURE IN PICTURE

Envisioning a tv screen with a smaller screen in the corner where the trauma is processed.

04

# Trauma Informed Interventions



## FOCUS AWAY, FOCUS NEAR

Focus first on just the facts, habituate. Then focus on emotional content, habituate.

05



## RESOURCING & GROUNDING

Container, Safe Space Imagery, Nurturing Figure, Grounding with Senses, Body Movement, etc.

06



## MERIDIAN TAPPING

An EFT tapping sequence shown to stimulate acupressure points & decrease fear &/or anxiety.

07



## TREE OF LIFE

Identify different aspects of a client's identity including past, future goals, strengths, & supports.

08

# Trauma Informed Interventions



## CONFERENCE TABLE

Inviting all parts involved in the trauma to come to a conference table.

09



## COPING SKILLS CARD

All coping skills are written down on a card, in the phone, etc. & kept readily available.

10



## TRAUMA TIMELINE

Start birth to present day & listen for client parts. Helpful for identifying trauma targets for EMDR.

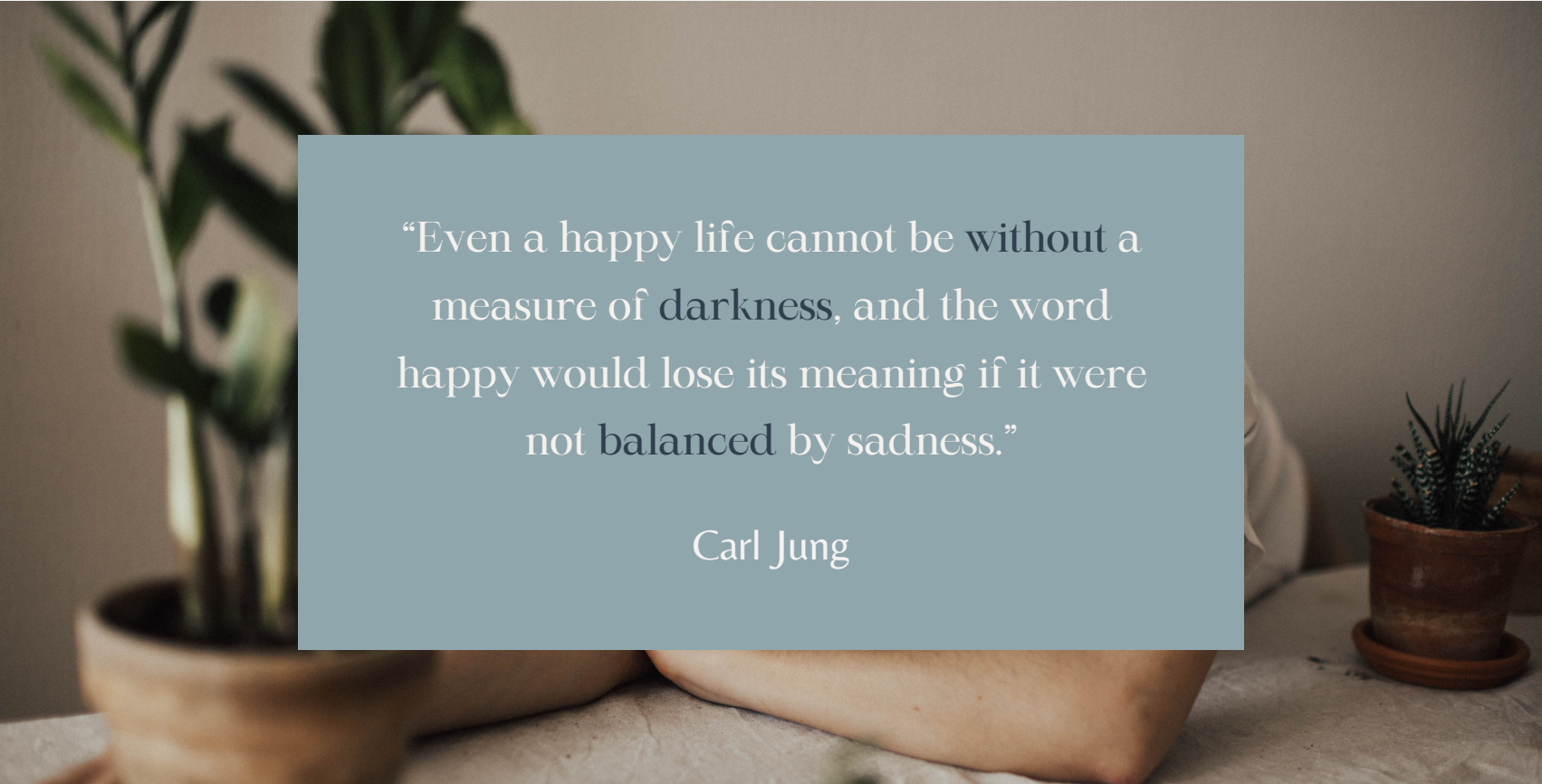
11



## STELLATE GANGLION BLOCK

SGB is an injection of a local anesthetic into the Stellate Ganglion, a nerve bundle in the neck to reduce PTS.

12

A still life photograph of potted plants on a table. In the foreground, a large, light-colored ceramic pot holds a green plant with long, slender leaves. To the right, a smaller, dark brown ceramic pot holds a small, spiky succulent. The background is a plain, light-colored wall. A semi-transparent teal rectangular box is overlaid in the center of the image, containing a quote in white serif font.

“Even a happy life cannot be without a  
measure of darkness, and the word  
happy would lose its meaning if it were  
not balanced by sadness.”

Carl Jung

# Discussion & Q&A

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