

“Stress, Trauma and PTSD”

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“Stress, Trauma and PTSD”

- **Understanding the Stress-Trauma response.**
- **Structures and functions of the human brain.**
- **Clinical points of reference.**
- **PTSD and information processing.**
- **Evidence based treatment and trauma.**

**All of the mysteries
of human behavior
are the result of just
one person!**

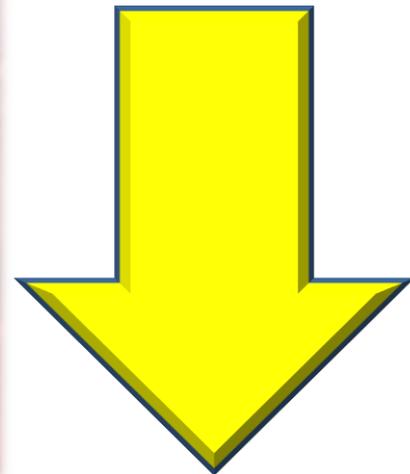
The “Paleolithic” Brain

- We possess a (300,000 year old) “**Paleolithic**” brain.
- Our current “**Executive**” brain is only 7,000 years old.
- Neurologically, age will always trump youth.
- Our brains are designed to process fear more effectively than pleasure, for reasons of survival.
- Our current response to danger is a consequence of our ancestral brain not evolving as fast as our modern world.

Understanding the Stress Response

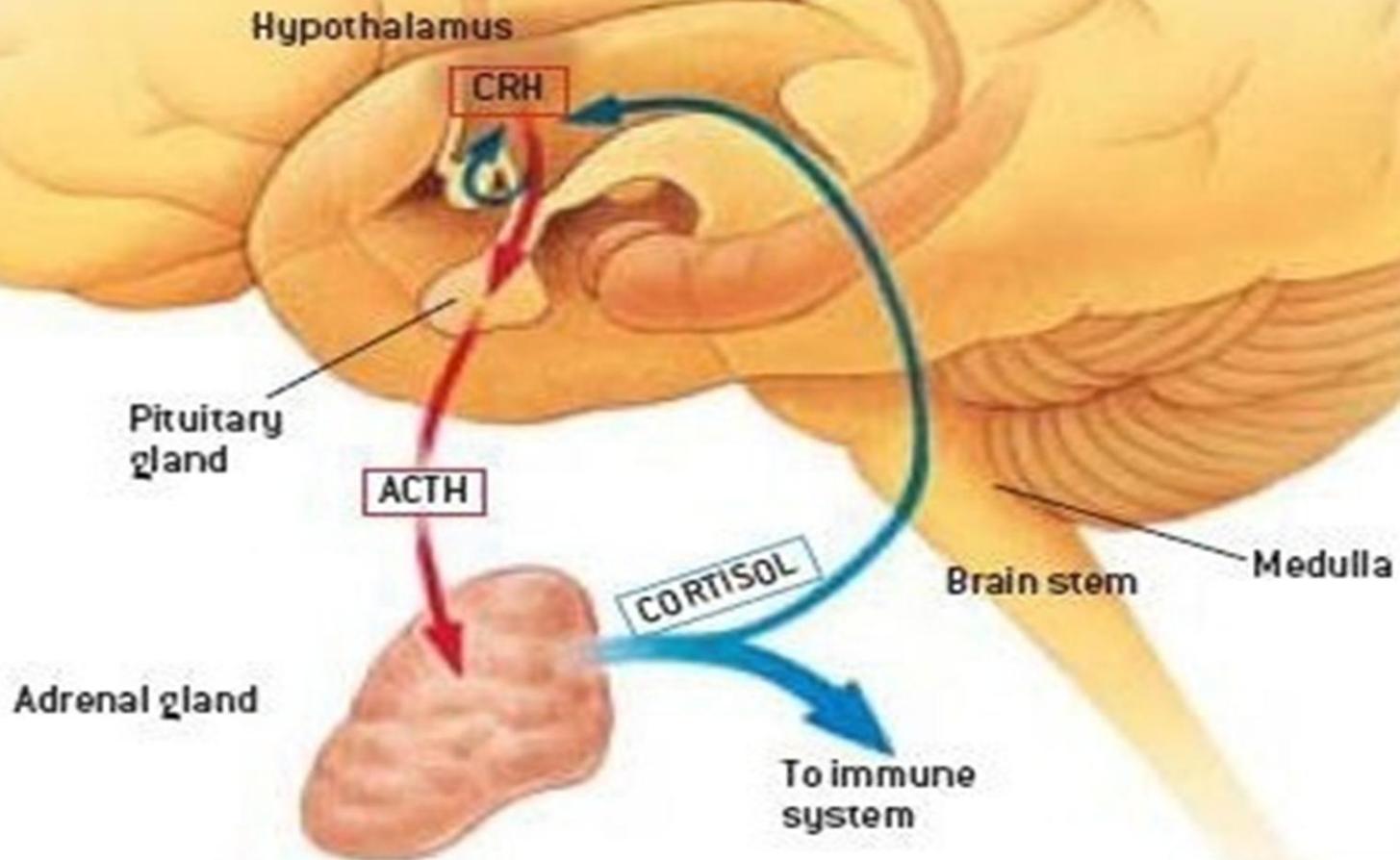
(How we define fear)

The trauma experience originates in the right hemisphere of the brain

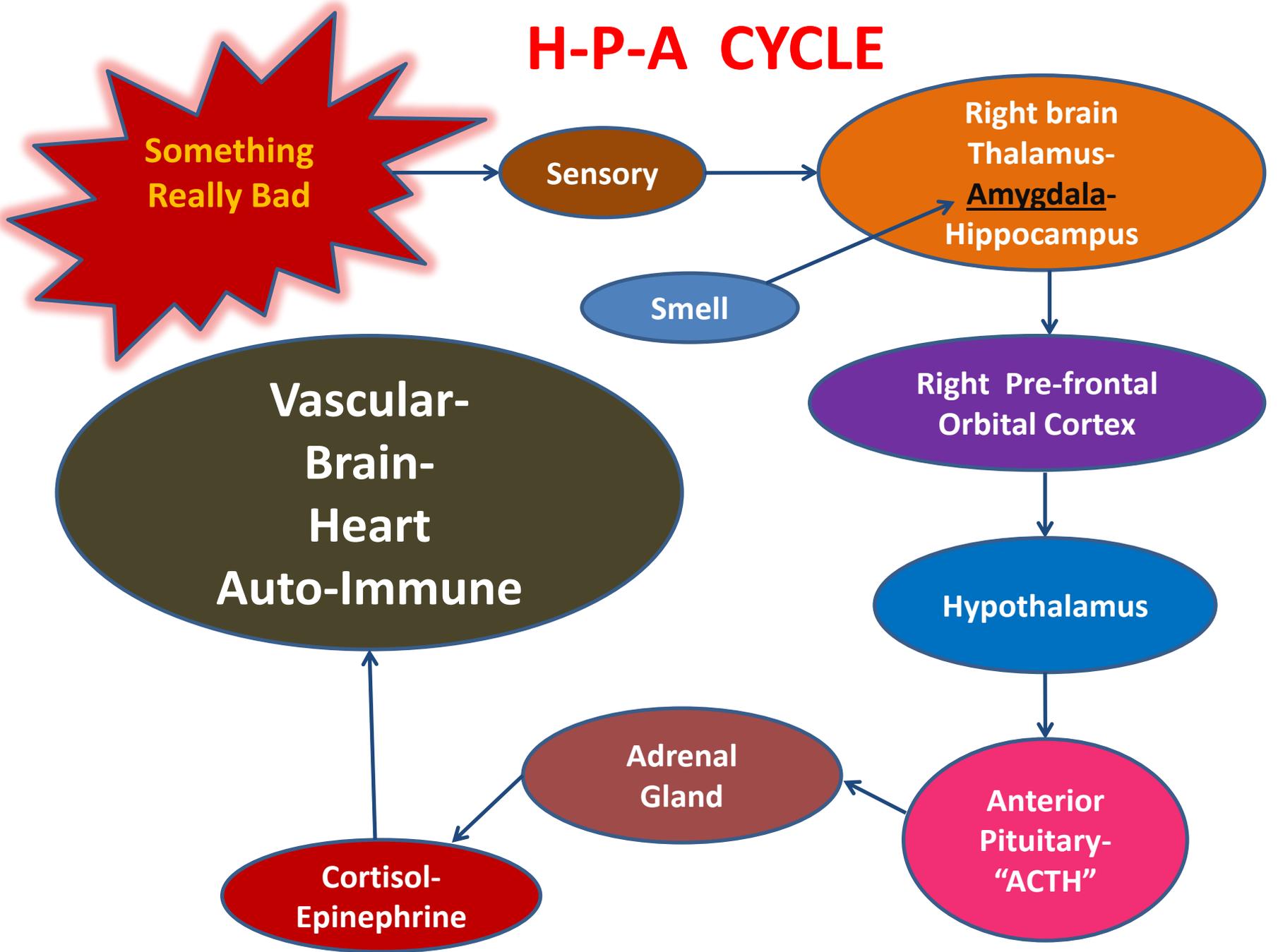


STRESS RESPONSE SYSTEM

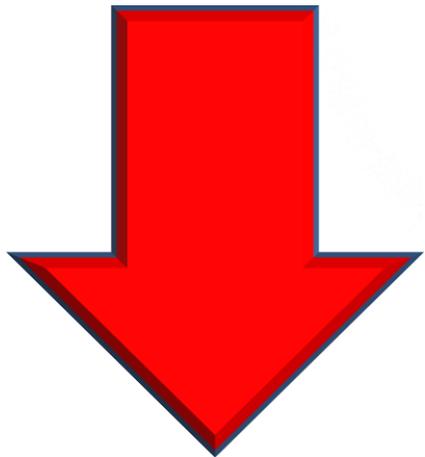
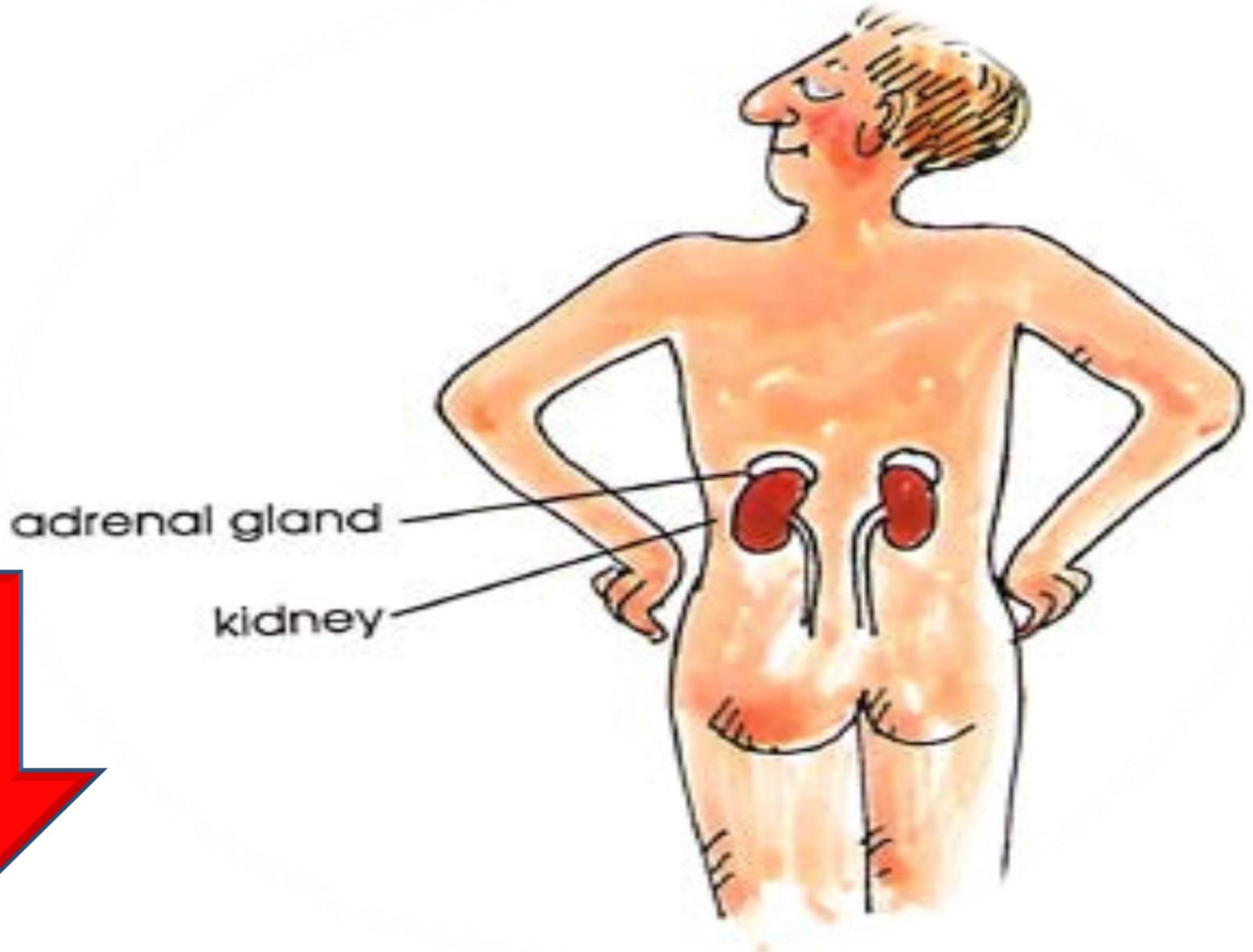
“H-P-A Axis”



H-P-A CYCLE

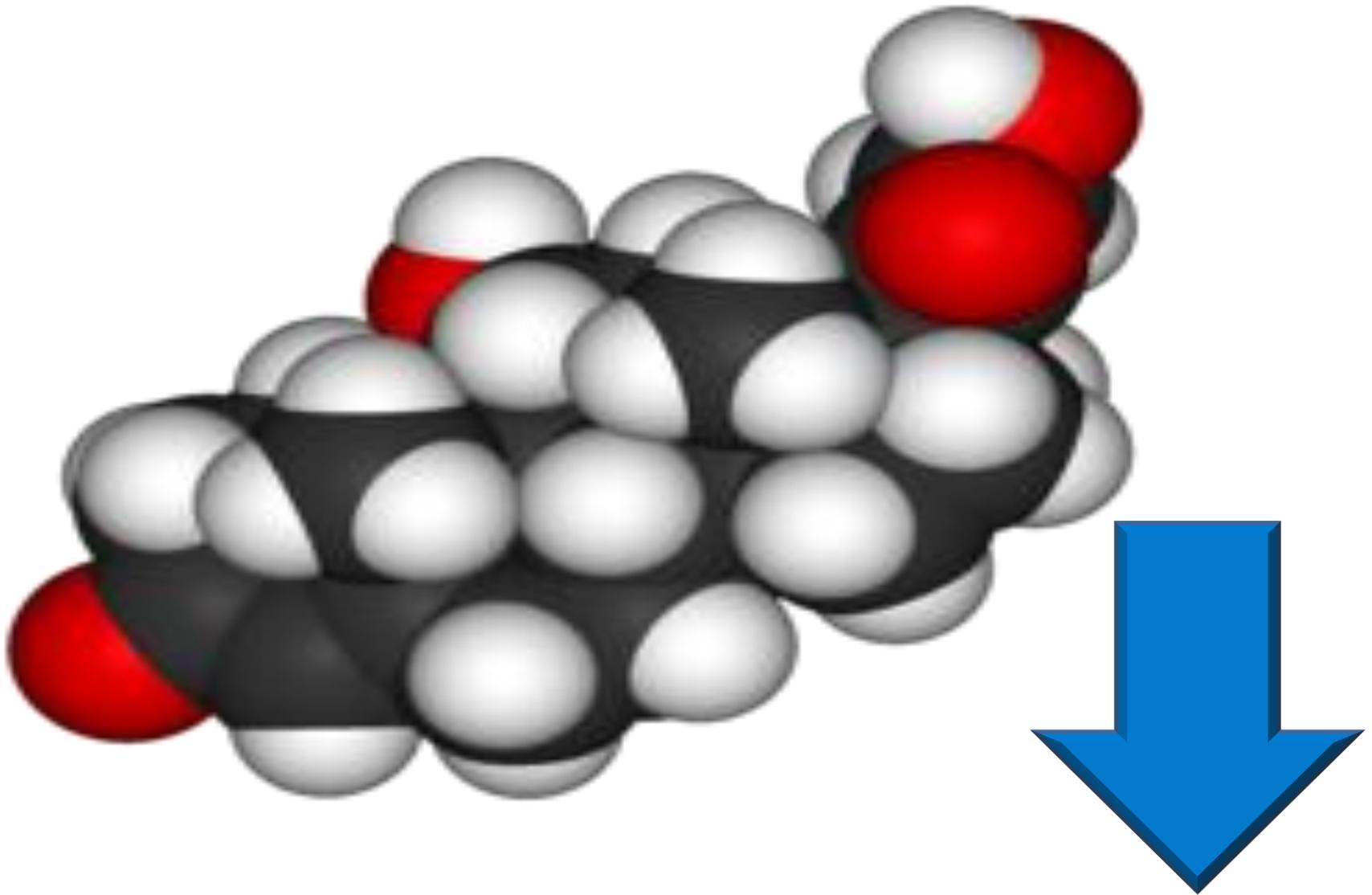


“CORTISOL” Our stress chemical to the rescue!

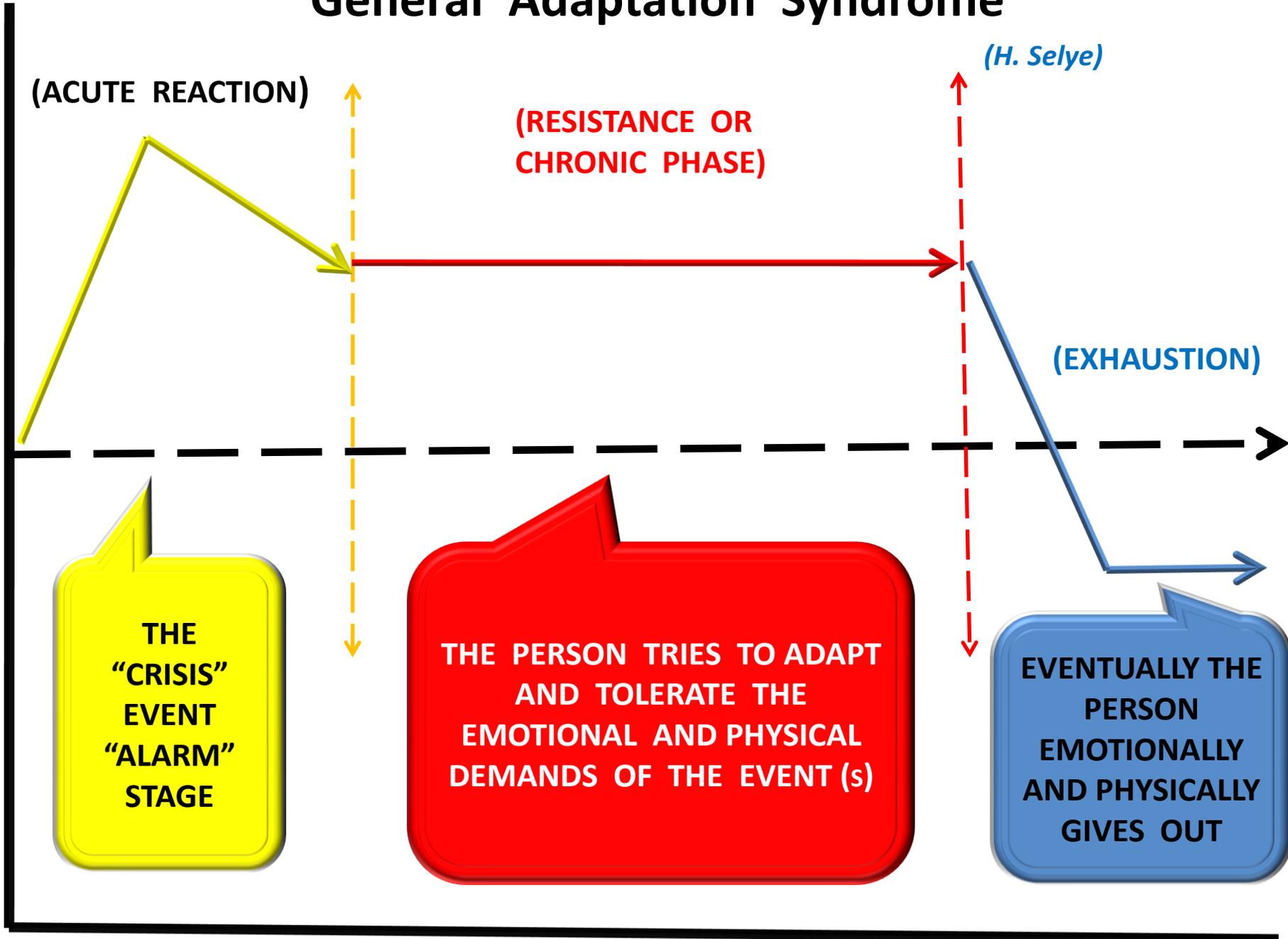


“CORTISOL”

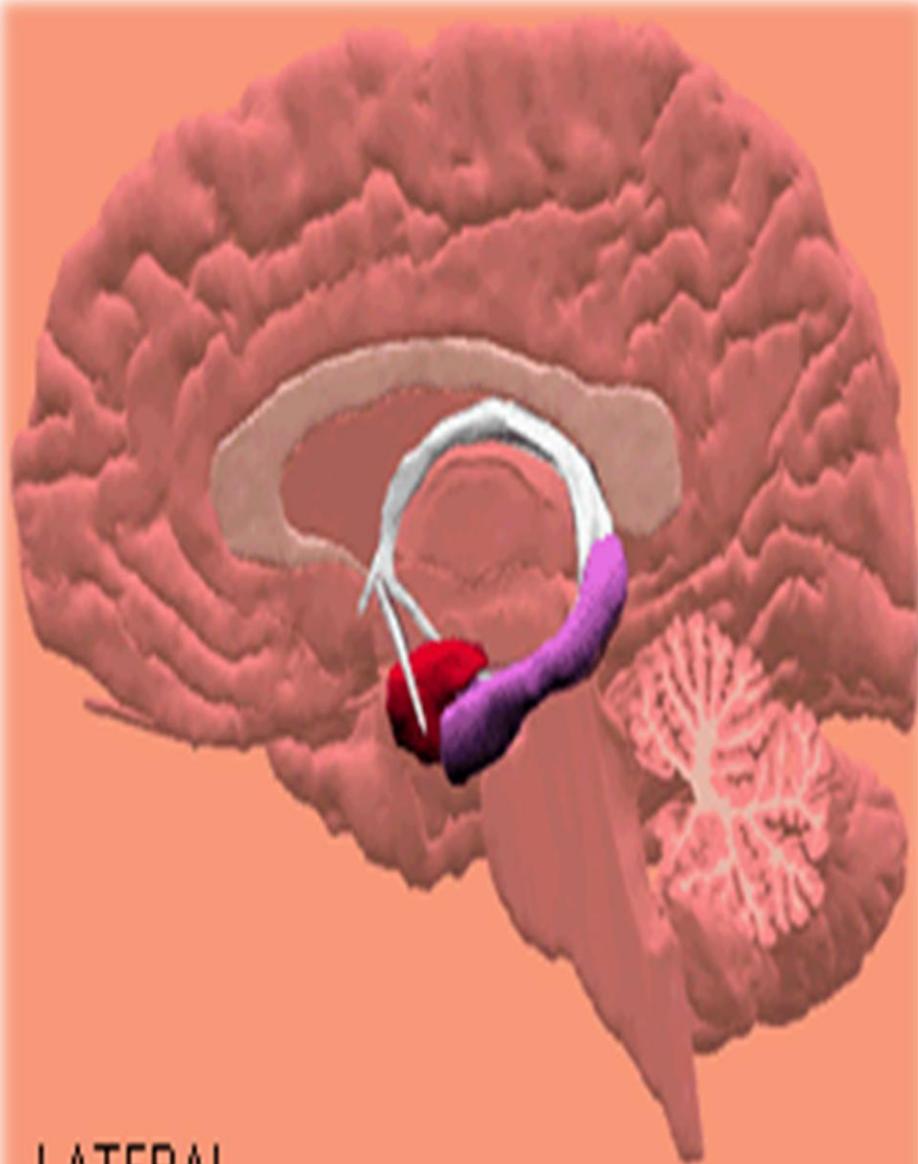
A GOOD Guy or BAD Guy?



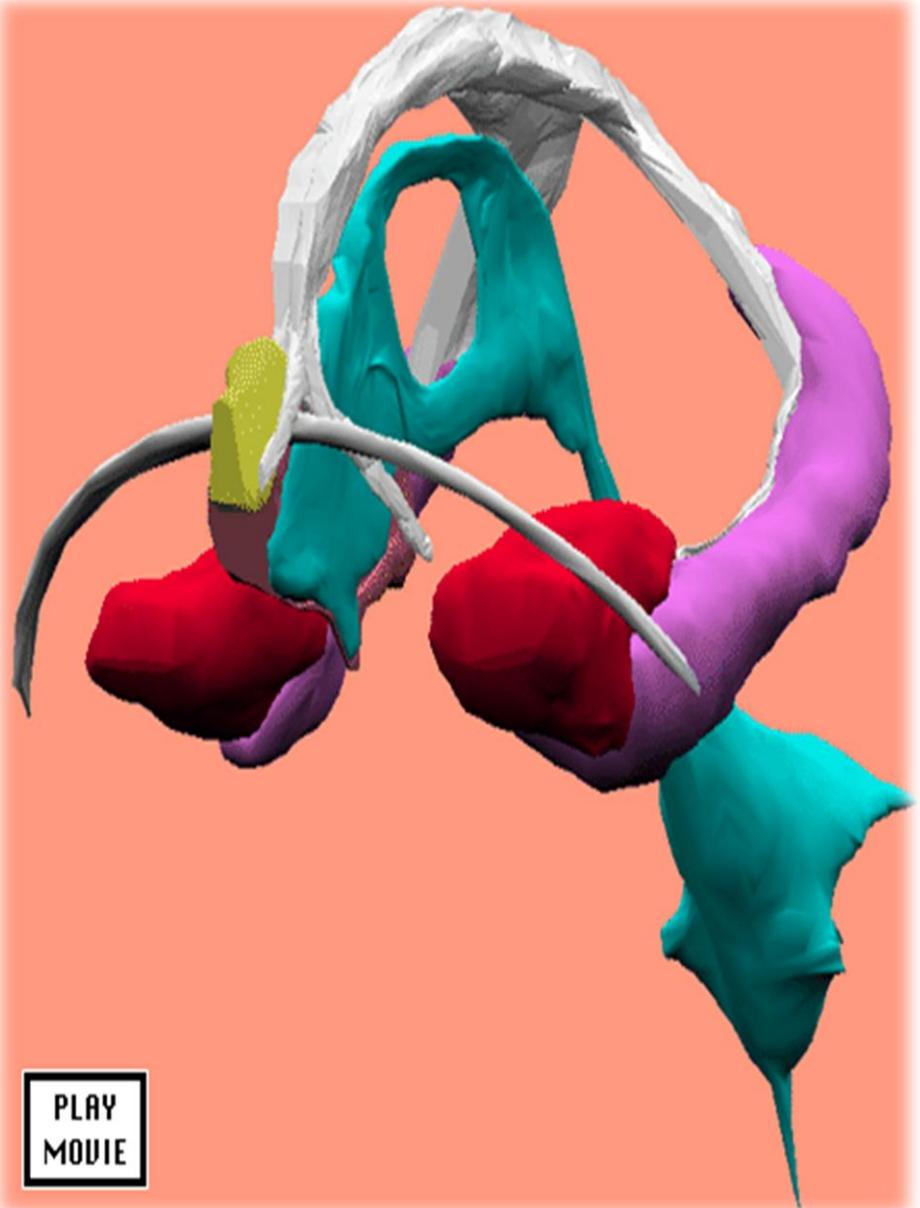
General Adaptation Syndrome



The amygdala and hippocampus have a high number of cortisol receptors

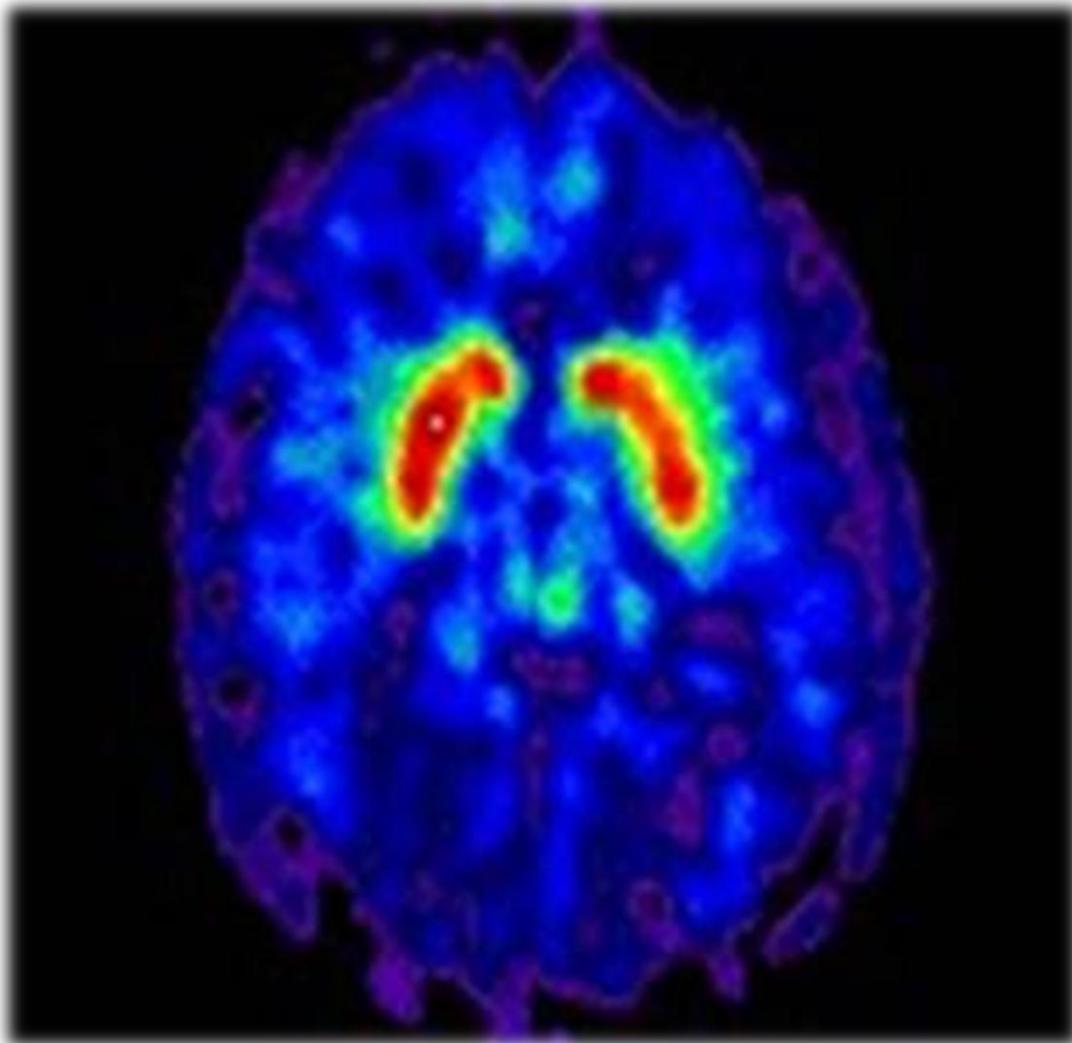


LATERAL



PLAY
MOVIE

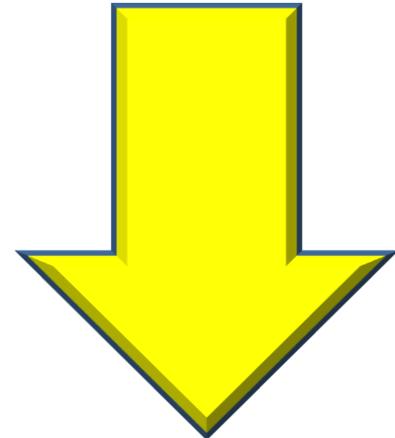
A PET scan image of the brains memory centers responding to an fearful and/or pleasurable event



Prolonged exposure to chronic stress (cortisol) has been associated with the cell death “ATROPHY” of the heart muscle and the brain’s hippocampus.

Hippocampal atrophy due to chronic exposure to “cortisol” has also been documented to occur in:

1. Adults that were abused as children.
2. Individuals that suffer with long term depressive illness or prolonged grief.
3. Individuals that struggle with evidence of PTSD.



General Overview

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**The Structures and Functions of the
Human Brain**

Your Brain

- Your brain is better at detecting patterns than distinguishing detailed information.
- Your brain enjoys predictive consistency and symmetry.
- Your brain wants closure and will strive to make sense of events, even if the conclusions are **false!**
- The struggle to integrate trauma into a meaningful event, is the goal of every trauma therapist.

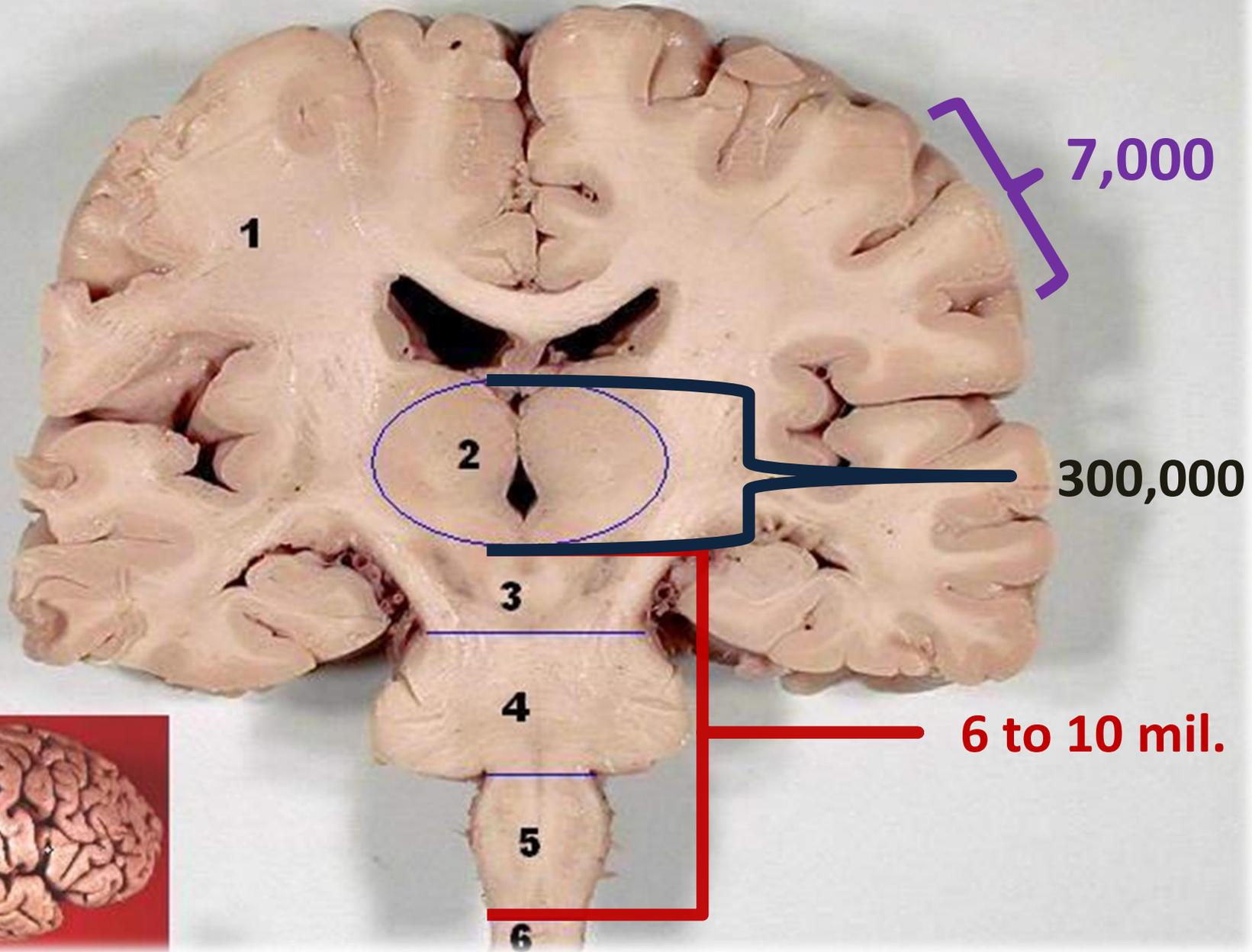
Basic facts and regions of the human brain



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The average human brain weights approx. **(3 Lbs.)** pounds, possess approx. **100 Billion Neurons** and produces approximately **15 watts of electricity.**

AGES OF THE BRAIN

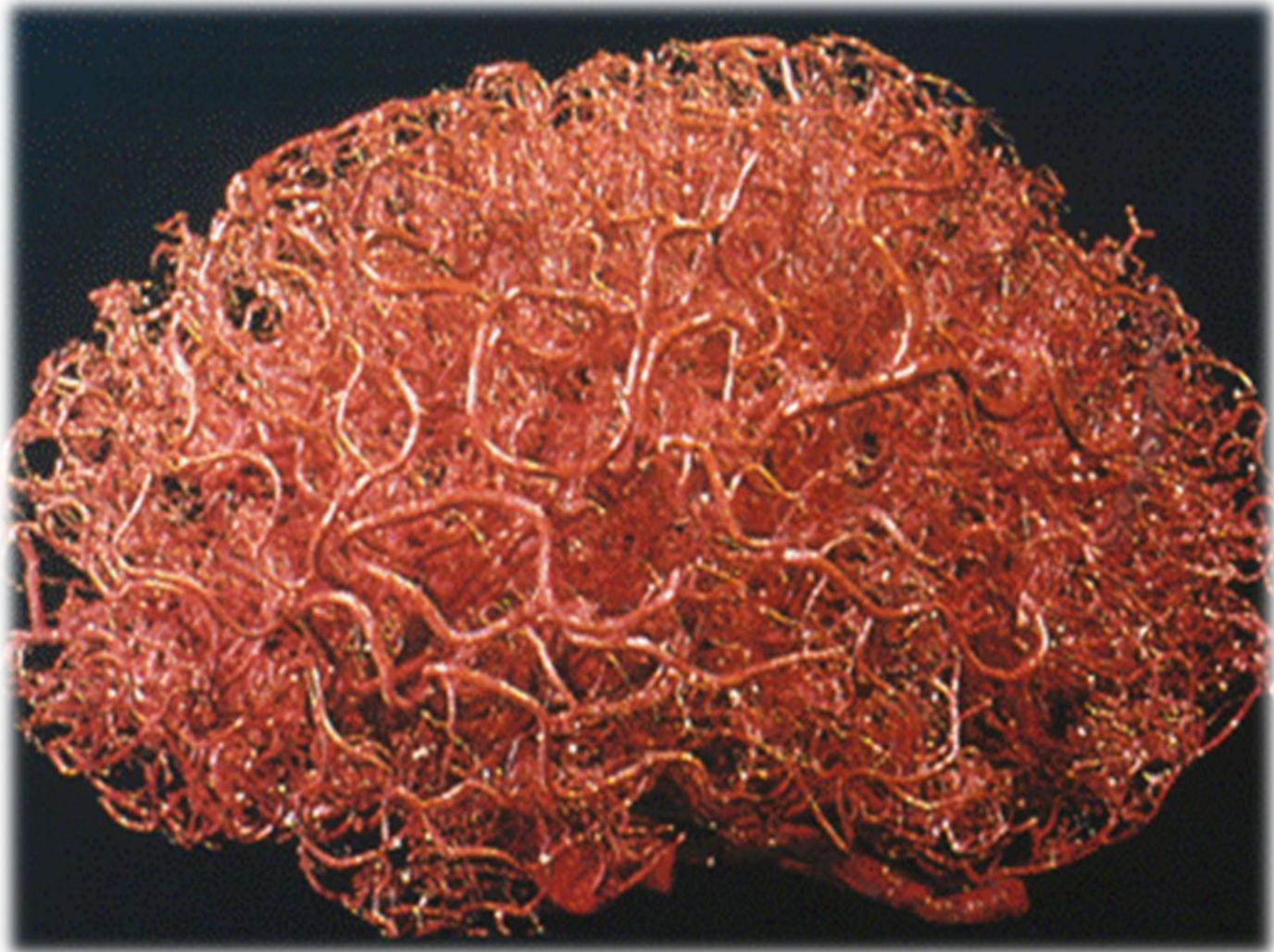


The brain has the same basic texture and consistency of

Jell-O



**THE BRAIN'S VASCULAR SYSTEM REQUIRES A CONSTANT
20% OF THE BODY'S BLOOD SUPPLY TO MAINTAIN NORMAL ACTIVITY**



Clinical Points of Reference

Clinical Points

Trauma appears to be more of a sensory memory phenomenon rather than an explicit memory problem!

Clinical Points

“FEAR” is the emotional experience,

..... while

“ANXIETY” is our physical reaction to fear.

Clinical Points

Stress-Trauma Disorders have been defined as:

**“Experiencing normal reactions to
abnormal events...that originated in reality”**

(Bessel A. Van der Kolk)

Clinical Points

My perception of my

“TRAUMA”

is my reality!

Clinical Points

Stress-Trauma Disorders are typically a consequence of feeling **“RESPONSIBLE”** for event(s), that we have

NO control over!

Clinical Points

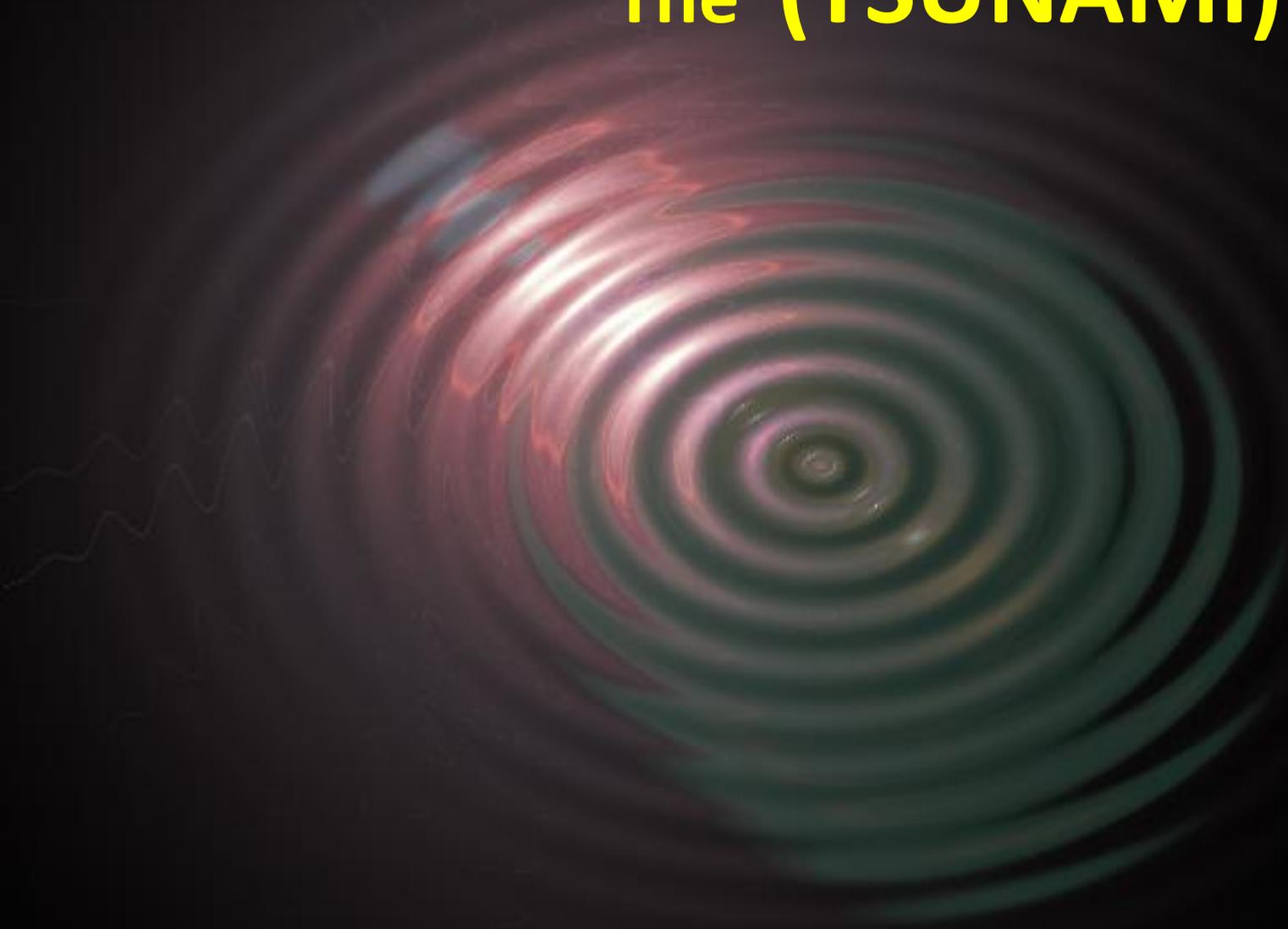
Stress-Trauma Disorders can be a result of a
“SINGLE” threatening (un-safe) event,

-or-

A consequence of accumulated

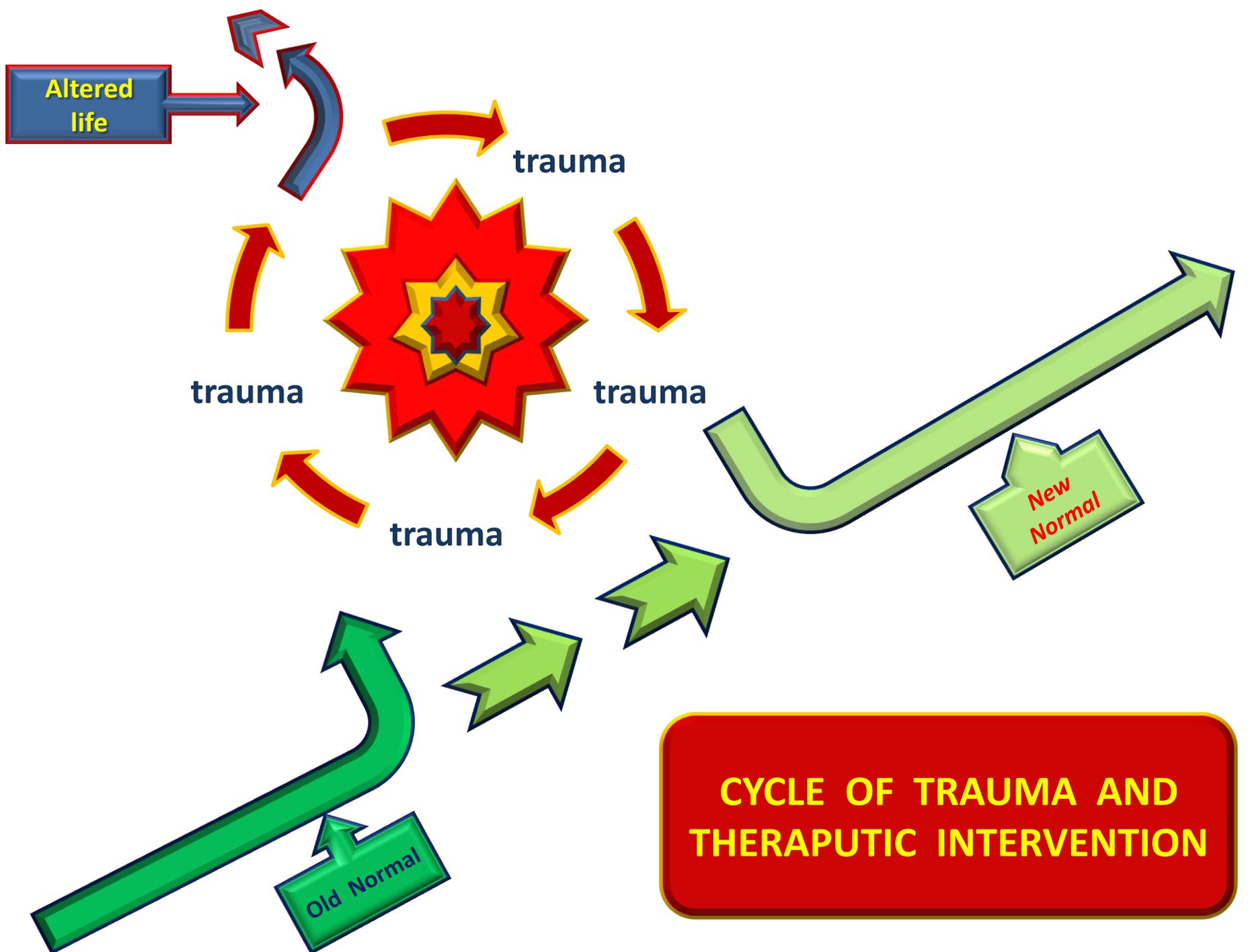
“LIFE-LONG” threatening (un-safe) events.

The (TSUNAMI) Effect



Clinical Points

Stress-Trauma survivors tend to redefine themselves...their identities, and their future life goals around the traumatic event(s).



Altered life

trauma

trauma

trauma

trauma

Old Normal

New Normal

CYCLE OF TRAUMA AND THERAPUTIC INTERVENTION

Clinical Points

Stress-Trauma Disorders have been estimated to occur in as high as “Sixty” (60%) to “Eighty” (80%) of the substance abusing population.

Clinical Points

Stress-Trauma Disorders
have been found to occur
“Two” (2) to “Three” (3)
times more in women than
in men, participating in
substance abuse treatment.

Clinical Points

Women substance abusers, with Stress-Trauma Disorders, report struggling more with “SHAME” or **“WHAT’S WRONG WITH ME !”**

Men substance abusers, with Stress-Trauma Disorders, struggle more with feelings of “GUILT” or **“I KNOW I DID SOMETHING WRONG!”**

Clinical Points

Once a victim of a traumatic event, many individuals continue to become victims of second, very similar events(s).

The occurrence of a second traumatic event, will typically cause the victim to relive and re-experience, unfinished part of the original or previous traumatic event(s).

Clinical Points

Women substance abusers report more often being victims of childhood physical and/or sexual trauma.

Men substance abusers report most often being victims of crime or war related events.

Clinical Points

Therapeutically it is important to determine the physical age of the individual or when their feeling **“UN-SAFE”** began.

That age becomes their therapeutic age, and where you want to begin treatment.

Clinical Points

A **“Trauma Bond”** occurs when the trauma victim creates a magical connection (bond) with the people, places or things, associated with the traumatic event.

Therefore, consider the **“Child”, “Adult-Child”,** and **“Co-Dependent”** individual as experiencing a **“Trauma Bond”** and/or a victim of trauma.

Clinical Points

Professional(s) consider that you are also likely to become a victim of
“Vicarious Trauma”, “Co-Dependency”,
“Compassion Fatigue” and
“Counter-Transference”

PTSD and Information Processing

The American Psychiatric Associations Identification of Stress and Trauma Disorders

**The DSM-5 (APA, 2013), currently identifies
Stress-Trauma Disorders under the heading:**

“TRAUMA AND STRESSOR-RELATED DISORDERS”

DSM-5

- Acute Stress Disorder (ASD):

The presence of a stress response appearing within **Three (3) days to One (1) month** following a traumatic event.

- Post Traumatic Stress Disorder (PTSD):

The presence of a stress response existing longer than **Three (3) months...or...the first occurrence of a symptom appear after Six (6) months** following the traumatic event(s).

PTSD and Information Processing

Van der Kolk (2007), identified **Six (6)** distinct signs and symptoms associated with PTSD victims.

1. **Intrusions**: Persistent intrusions of memories associated with the traumatic event.
2. **Compulsive Exposure to the Trauma**: A compulsive need to repeat the experience of the trauma, by exposing themselves to similar trauma producing events.

3. Avoiding and Numbing: PTSD victims may intentionally avoid traumatic memory activities or experience emotional numbing when unable to avoid specific memory or activities. “Freeze Response”

4. Inability to Modulate Arousal:

The PTSD victim typically over reacts (**hyper-arousal**) to mild or moderate degrees of generalized threat.

5. Attention, Distractibility, Stimulus Generalization and Discrimination:

PTSD victims may display attention-concentration problems, and have difficulty sorting out relevant from irrelevant stimulus information. Remember that during therapy.

6. Alterations in Defense Mechanisms and Personality Identity:

Following a traumatic event, the PTSD victim may feel less capable of engaging in personal self defense and find that they protect themselves by defining their world as dangerous and unpredictable. They become hyper-vigilant.

Once feeling incapable of predicting and controlling the events in their life, the victim's general sense of self-worth, self-esteem and personal empowerment are at risk.

Dissociation and the Trauma Victim

“Dissociation” Is an instinctual attempt, on the part of the trauma victim, to either emotionally detach or mentally separate themselves from the traumatic events(s).

Therapist: Evaluate for the presence of a Freeze Response and Discharge at the time of the trauma.

The occurrence of **“Dissociation”** at the time of the original trauma may predict later PTSD signs and symptoms.

THREE DEGREES OF DISSOCIATION

PRIMARY DISSOCIATION :

- 1. THE MOST COMMONLY OBSERVED CLINICAL FEATURE IN PTSD VICTIMS.**
- 2. SYMPTOMS ARE TYPICALLY PROVOKED BY A SENSORY STIMULI, RATHER THAN A COGNITIVE OR NARRATIVE EVENT.**
- 3. CHARACTERIZED BY THE PRESENCE OF INTRUSIVE MEMORIES, RECOLLECTIONS, NIGHTMARES, AND FLASHBACKS.**

- **SECONDARY DISSOCIATION :**

1. **REPORTED MOST OFTEN BY INCEST SURVIVORS, TRAFFIC ACCIDENT VICTIMS, AND COMBAT SOLDIERS.**
2. **CHARACTERIZED BY A FURTHER BREAKDOWN OF THE MEMORY EXPERIENCE.**
3. **VICTIMS ROUTINELY REPORT EXPERIENCING A SPECTATORS “DETACHMENT” VIEW OF THE TRAUMATIC EVENT(s) .**

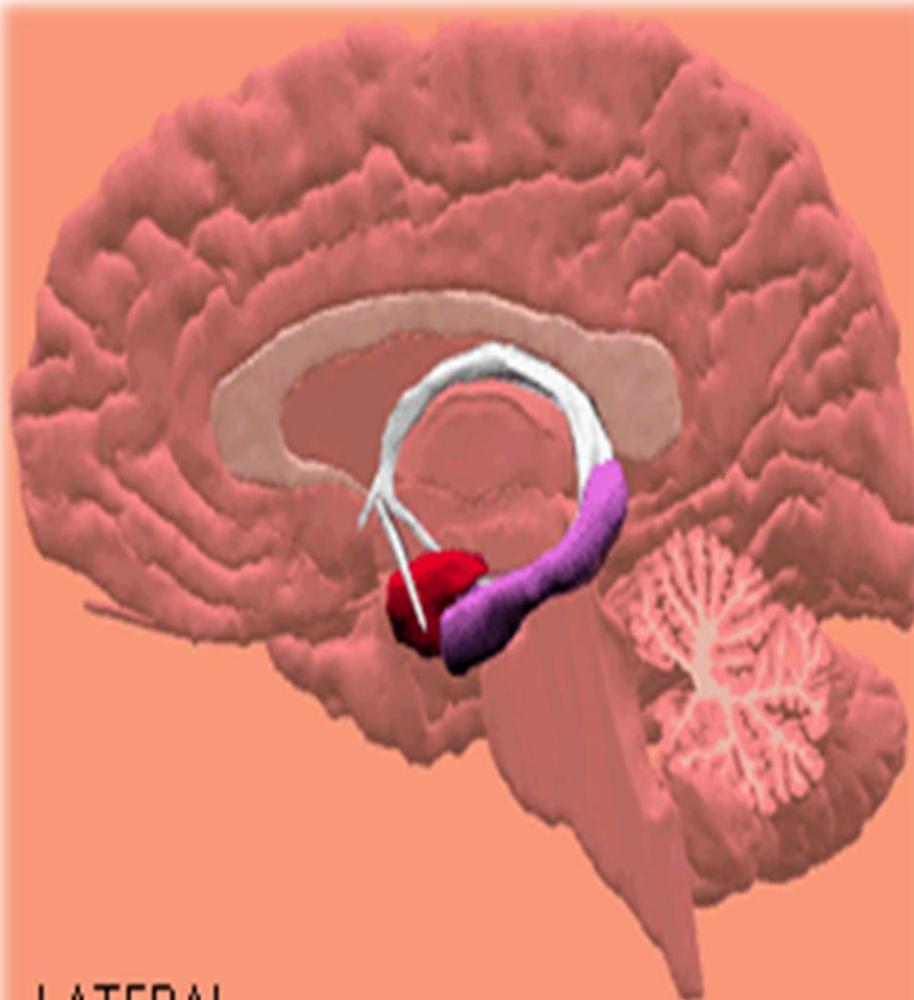
- **TERTIARY DISSOCIATION :**

1. FREQUENTLY REPORTED BY INDIVIDUALS THAT HAVE ENDURED CHRONIC AND EXTREME SEXUAL, PHYSICAL, AND PSYCHOLOGICAL ABUSE THAT BEGAN AT AN EARLY AGE.

2. CURRENTLY KNOWN AS DISSOCIATIVE IDENTITY DISORDER (DID), PREVIOUSLY KNOWN AS: MULTIPLE PERSONALLITY DISORDER (MPD)

Memory and Trauma

DURING A TRAUMATIC EVENT THE AMYGDALA WILL UP-REGULATE THE SENSORY EXPERIENCE, WHILE THE HIPPOCAMPUS WILL DOWN-REGULATE THE MEMORY EXPERIENCE . . . MAKING IT DIFFICULT FOR THE VICTIMS TO RECALL PARTS OF THE EVENT(S) .



LATERAL



PLAY
MOVIE

Yale Memory and Trauma Research findings

Yale researchers indicated that the ability to actually remember every detail is not as important as once thought.

Their research also indicated that most memory of the events will likely be inaccurate.

- **Yale's research recommends that you do not rely on memory or recall to be complete.**
- **They indicated memory of the events can and will change or fade over time..**
- **Their research also recommended that the therapist not worry about the accuracy of the information, **claiming that it is the process of the therapeutic relationship that is most important in the recovery from PTSD and trauma.****

Evidence Based Treatment Options

- **A brief review of psychotherapeutic technique**
- **What it means to be a “Therapist”**
- **Loss of control-predictability, the foundations of trauma**
- **Therapist “BEWARE”**
- **Components of evidence based trauma treatment**

A Brief Review of Psychotherapeutic Techniques

A Brief Review of Psychotherapeutic Techniques

- **Cognitive Behavioral Therapy (CBT):** Currently considered the first line recommendation for PTSD treatment.
- **Exposure Therapy:** A variation of CBT with the focus on re-experiencing traumatic circumstances, in a safe environment, in order to desensitize the PTSD symptoms.
- **Eye Movement Desensitization and Reprocessing (EMDR):** The belief is that the traumatic experience is “fixated” in specific areas of the brain and EMDR is permitting the “Fixated” portion of the brain to release the traumatic event for brain reprocessing.

THERAPIST

MY PERCEPTION OF
“TRAUMA” IS MY REALITY . . .

-

THEREFORE, ALWAYS BEGAN THERAPY WHERE
YOUR CLIENT IS . . .

**NOT WHERE YOU WANT
THEM TO BE!**

**PERCEIVED LOSS OF CONTROL AND
UNPREDICTABILITY ARE THE FOUNDATIONS
OF ALL TRAUMA(S).**

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**A MAIN OBJECTIVE IN THE THERAPEUTIC
PROCESS IS TO REBUILD A PERSONAL SENSE OF
SELF-CONTROL AND PREDICTABILITY.**

THE USE OF “CONTROL” IN THERAPY

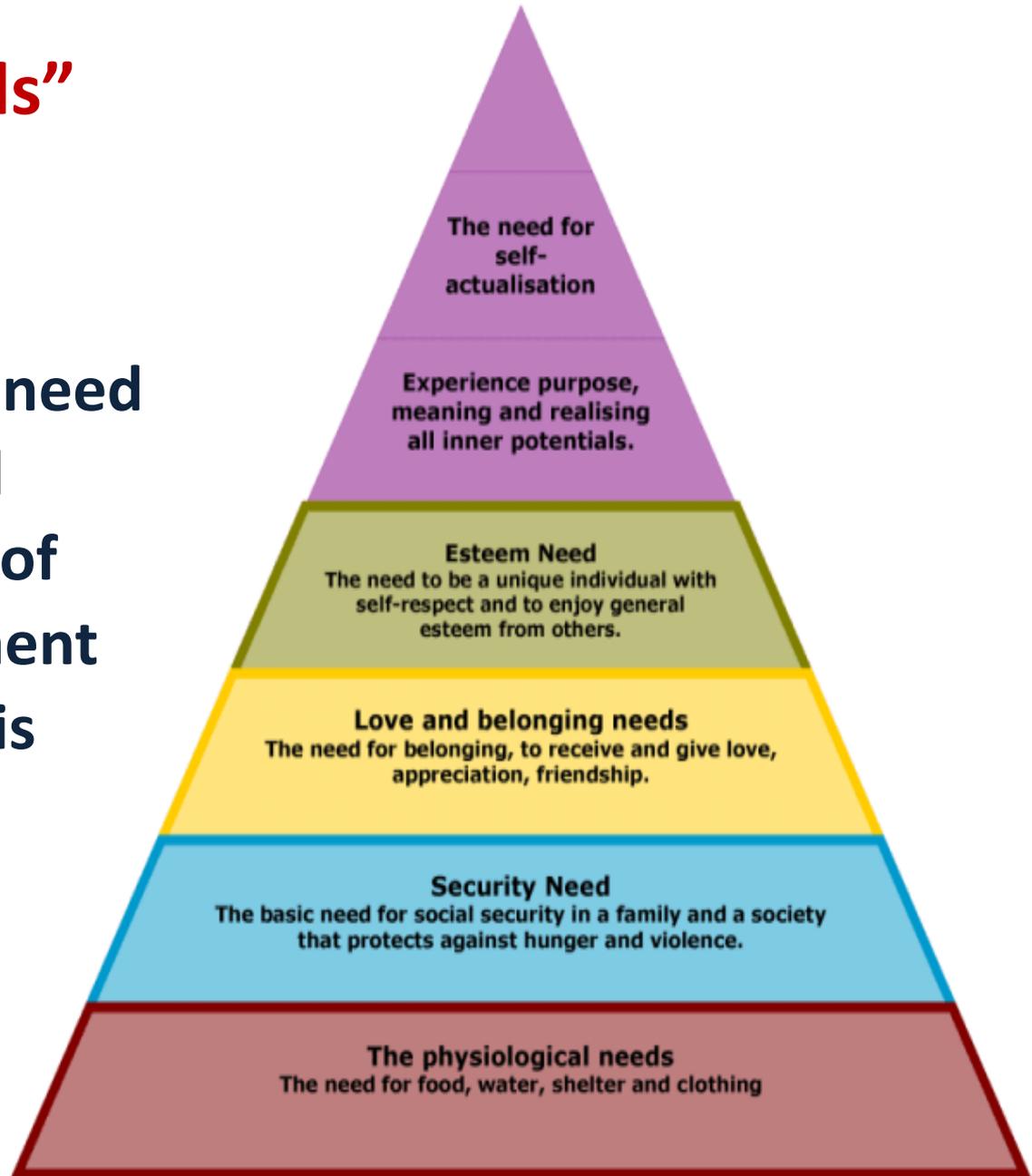
When counseling victims of mild to moderate stress and trauma, your therapeutic objective is to focus on how your client could have exercised some control over their circumstances.

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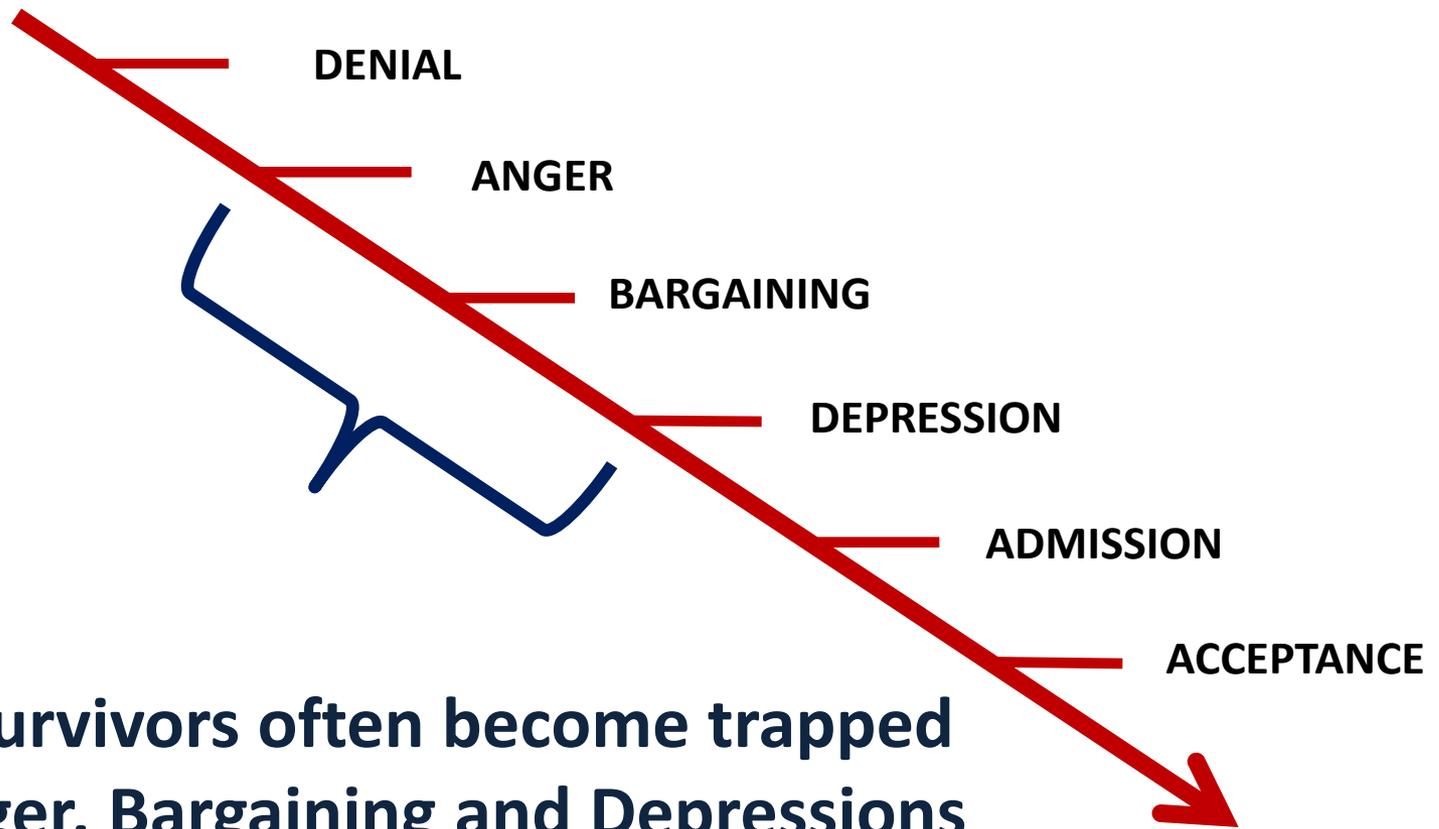
When counseling victims of extreme or horrific trauma your therapeutic objective is to reinforce the fact that they had No control over their circumstances.

Maslow's "Needs" and Trauma

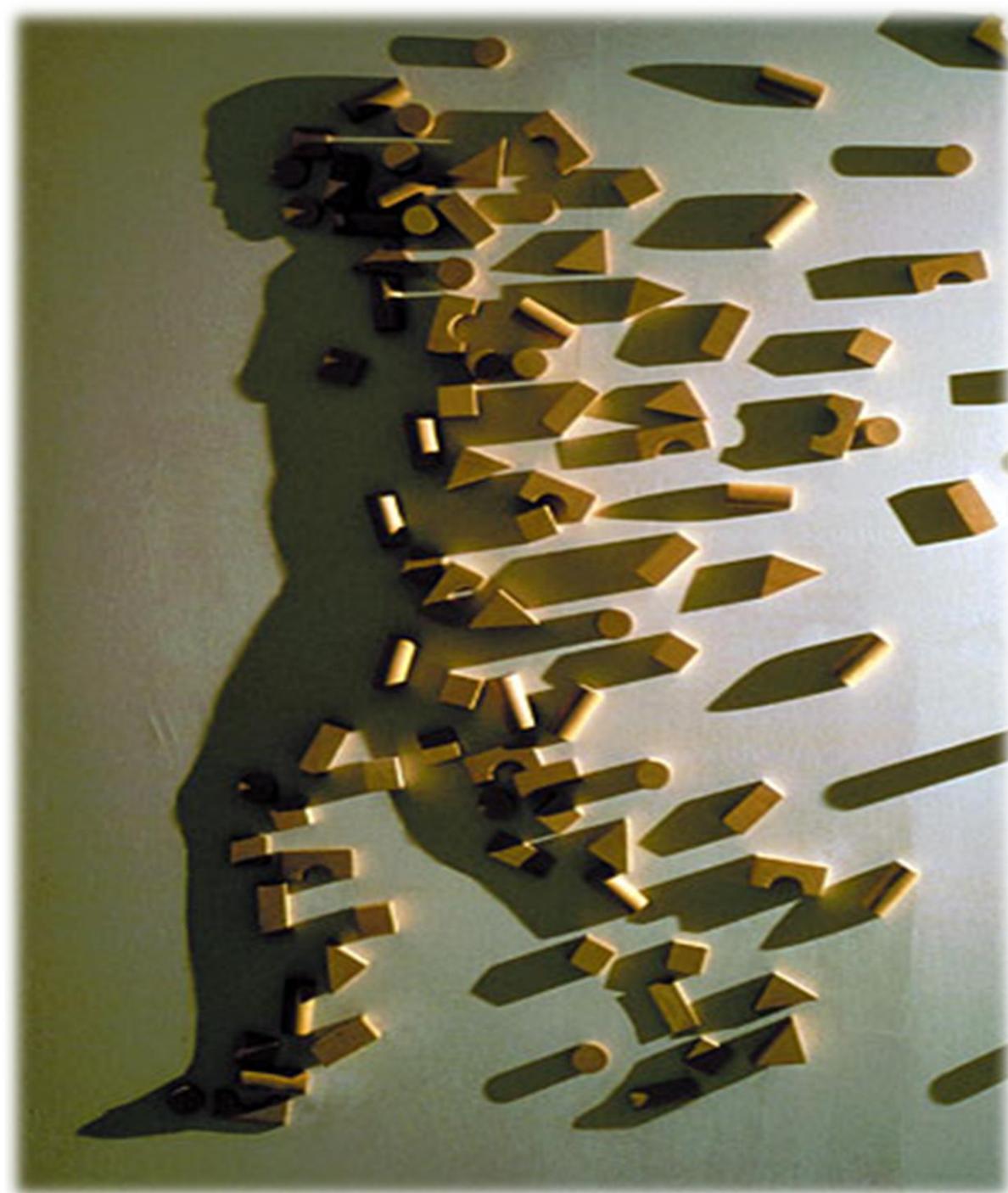
Trauma victims may need to re-experience and redefine each stage of emotional development before their healing is complete.



THE GRIEF PROCESS (E.K. ROSS)



Trauma survivors often become trapped in the Anger, Bargaining and Depressions stages of the grief process.



VICTIMS OF STRESS-TRAUMA, FIND IT DIFFICULT TO REMEMBER THEIR SUCCESSES IN LIFE AND IN THERAPY.

THE THERAPIST MAY NEED TO REMIND THEIR CLIENT(S) OF THEIR PROGRESS IN COUNSELING.

EACH SUCCESS IS SEEN AS AN ISOLATED EVENT AND ROUTINELY NOT ACCUMULATED FOR LATER REFERENCE.

Well Meaning Therapist Beware!

A therapist may do more harm than good by asking the individual to recall their trauma too early in therapy.

Asking the client to relive the experience too early, may only reinforce the traumatic memory and deepen the PTSD features.

THERAPIST: Asking your client to **“Tell Their Story”**

to early in treatment is not recommended for substance abusing-trauma victims.

THERAPIST BEWARE!

Research indicates that recovering substance abusing trauma victims will likely experience an increase in their traumatic symptoms during the early months of recovery.

THERAPIST BEWARE!

Research indicates that the therapist should be cautious when applying standard evidence based PTSD treatment techniques with the substance abusing trauma victim.

THERAPIST BEWARE!

TODAYS COUNSELOR, WORKING IN THE FIELD OF SUBSTANCE ABUSE AND TRAUMA, MUST BE CAUTIOUS WITH RESPECT TO OFFERING TOO MUCH SELF-DISCLOSURE OR THERAPEUTIC INTIMACY (CLOSENESS) WHEN WORKING WITH THE:

- 1. SEXUALLY TRAUMATIZED ... ABUSED CLIENT.**
- 2. PERSONALITY OR "CHARACTER" DISORDERED CLIENT INCLUDING TRUE:**
 - "NARRISCTIC" PERSONALITY DISORDERS.**
 - "BORDERLINE" PERSONALITY DISORDERS.**

THE NECESSARY COMPONENTS OF EVIDENCE BASED TRAUMA TREATMENT

THE FOUR (4) DON'TS OF THE SUBSTANCE ABUSING TRAUMA SURVIVOR

DON'T “TALK” “TRUST” “TOUCH” “FEEL”

BECOMES THE FOUR (4) DO'S DURING TREATMENT

THE (4) DON'TS BECOME THE THERAPEUTIC (4) DO'S ... " TALK "

DON'T "TALK" !

THEY WILL EITHER
TALK TOO MUCH ... AND SAY
NOTHING ... OR THEY WON'T
TALK AT ALL AND CONTINUE TO
MAINTAIN . . .

"A CONSPIRACY OF SILENCE"

DO PRACTICE "TALK" !

ENCOURAGE THEM TO
TALK. TALKING ALLOWS
THE CREATION OF A
"THERAPEUTIC" CONNECTION
(BOND) .

PRACTICE THE CONCEPT OF

"T. A. L. K."

“TRUST”

“TRUST” IS A PROCESS ... NOT AN EVENT

“TRUST” INVOLVES FOUR (4) BASIC ELEMENTS:

- 1. CONSISTENT,**
- 2. PREDICTABLE,**
- 3. BEHAVIOR,**
- 4. OVER TIME!**

DON'T "TRUST"

DON'T "TRUST"

THEY BELIEVE
"WHAT IS FAMILIAR
IS COMFORTABLE"!

**THEIR EXISTENCE
IS DEFINED BY
INCONSISTENCY!**

DO PRACTICE "TRUST"

REMEMBER: YOUR
CLIENT WILL TEST YOU.

BEING CONSISTENT AND
PREDICTABLE IN YOUR
RELATIONSHIP WITH YOUR
CLIENT ... REDUCES THEIR
TREATMENT RESISTANCE ...
AND BUILDS THERAPEUTIC
"COMPLIANCE" AND "TRUST".

DON'T ALLOW “TOUCH”

THEY MAY PRACTICE
THE “COME CLOSE-GET
AWAY” SYNDROME.

THE INDIVIDUAL MAY
AVOID ALL ATTEMPTS
TO DEVELOP CLOSENESS ...
OR MAY DISPLAY
DANGEROUS LOYALTY
TO THEIR PHYSICAL AND
SEXUAL PERPETRATORS.

DO PRACTICE
“SAFE” “TOUCH”

MANY TRAUMA VICTIMS
MAY VIEW YOUR ATTEMPTS
TO DEVELOP THERAPEUTIC
CLOSENESS AS DANGEROUS.

HELP TEACH THEM HOW TO
ESTABLISH ... AND MAINTAIN
HEALTHY BOUNDARIES, BY
EXAMPLE.

THE (4) DON'TS BECOME THE THERAPEUTIC (4) DO'S ... "FEEL"

OUR FEELINGS PROVIDE US
WITH OUR OWN UNIQUE DEFINITION
OF OUR WORLD AND OUR EXPERIENCES.

"FEELINGS" VALIDATE OUR EXISTENCE
AND OFFER SPECIAL MEANING AND PURPOSE
BY CONFIRMING AND TESTING OUR REALITY.

DON'T “FEEL”

FEELINGS ARE TOO
UNPREDICTABLE ... AND
THEREFORE, ... TOO
DANGEROUS.

THEY MAY HAVE NEVER
BEEN TAUGHT WHAT
FEELINGS ARE “NORMAL”!

DO PRACTICE “FEEL”

DISCUSS AND EXPLORE
“NORMAL” FEELINGS ...
AND THE EVENTS COMMONLY
ASSOCIATED WITH THEIR
PARTICULAR FEELINGS.

TEACH THEM FEELINGS BY

EXAMPLE!

In conclusion, research in the field of Trauma and Stress-Related Disorders indicate that effective treatment and rehabilitation may take **Three (3) to Five (5) years** of consistent involvement in counseling to establish a solid core of recovery.

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Recommend Readings

- **U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Public Health Service

Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

TREATMENT IMPROVEMENT PROTOCOL

(TIP) SERIES

Rockwall II, 5600 Fishers Lane

Rockville, MD 20857

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