ROGERS
Behavioral Health

Expanding our horizons in evidence-based treatment of PTSD

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Disclosures

Nathan Butzen, PsyD, and **Patrick Michaels, PhD,** have declared that they do not, nor do their family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation.

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Learning objectives

Upon completion of the instructional program, participants should be able to:

1. Identify at least two components of the 2024 APA guidelines for best practices when working with adults who have complex trauma histories.
2. Describe at least one similarity and one difference between the emerging treatment of Written Exposure Therapy and established evidence-based treatment modalities for working with adults with PTSD.
3. Summarize how incorporating Behavioral Activation and wellness strategies promotes resilience, adaptability, and community belonging in adults with PTSD.

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What will be covered in this webinar

- Diagnosis and guiding principles in working with trauma in adults
- Trauma treatments: Select evidence-based pathways
- Recovery from trauma and promotion of resiliency factors

Please note:

Our focus for the content of this program is on the healthcare professional who is practicing in a clinical setting.

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Presenter subjectivities

Nathan Butzen, PsyD

Professional identities
- Director of Outpatient at Rogers-Atlanta
- Clinical Psychologist
- Veteran - US Army Reserve (USAR)

Personal identities
- He/him/his
- White, Able-bodied
- Father, Husband
- Once-divorced; Child of divorced parents

Patrick Michaels, PhD

Professional identities
- Regional Clinical Director
- Clinical Psychologist

Personal identities
- He/him/his
- White, Able-bodied
- Father, husband

We acknowledge that our experience, intersectionality, privilege – and lack thereof – informs what we each bring to our research, clinical practice, and teaching

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Diagnosis and guiding principles in working with trauma

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DSM-5 Diagnostic criteria for PTSD

A: **Exposure to trauma** (actual or threatened death, serious injury, or sexual violence), witnessing trauma, learning about trauma happening to friend/family, or indirect exposure (vicarious trauma)

B: **Intrusion / Re-experiencing (at least 1 symptom)**
- Distressing intrusive memories, recurrent distressing dreams, dissociative reactions or "flashbacks," distressed by internal/external reminder, physiological reactions to internal/external cues of trauma

C: **Avoidance (at least 1 symptom)**
- Avoid distressing memories, thoughts, or feelings related to the trauma; avoid external reminders (people, places, conversations, activities, objects, situations)

D: **Persistent Negative Alterations in Cognitions and Mood (2 symptoms)**
- Dissociative amnesia/memory issues, negative beliefs about self, others and the world, distorted cognitions about the cause/consequence of trauma that leads to inappropriately or excessively blaming self/others, persistent negative emotional state, anhedonia, feeling detached/estranged from others, and persistent inability to have positive emotions

E: **Increased Arousal / Reactivity (2 symptoms)**
- Irritable behavior and angry outbursts, hypervigilance, increased startle response, concentration problems, sleep disturbances

F: **Symptoms last more than one month**

G: **Symptoms create significant distress/functional impairment**

H: **Symptoms are not due to medications, substance use, or other illness**

****Diagnostic Specifiers:**
Dissociative: Depersonalization; Derealization;
Delayed Onset: Full criteria not met for 6 months

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Complex Trauma: ICD-11 vs. DSM-5

- **Prevalence rates differ by definition/study sample**
  - *ICD-11* includes both categories of PTSD and C-PTSD
    - C-PTSD is diagnosed when there is Disturbances in Self-Organization (DSO), which are significant difficulties with affect regulation, self-concept, and relationships
  - *DSM-5* integrated some C-PTSD criteria into new diagnostics
    - Persistent Negative Alterations in Cognitions and Mood (negative beliefs about self, persistent negative emotional state, feeling detached/estranged from others)
- **US epidemiological studies of PTSD Prevalence**
  - ***ICD-11 Criteria***: 7.2% lifetime prevalence, breakdown is 3.4% PTSD and 3.8% CPTSD
  - ***DSM-5 Criteria:*** *6% lifetime prevalence of PTSD*

(Brewin et al., 2017; Cloitre et al., 2021)

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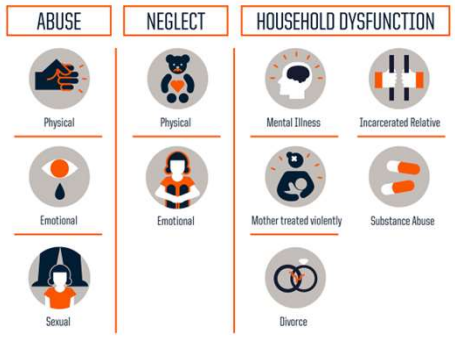
Do Adverse Childhood Events (ACES) matter?



Screening for ACES may be important in identifying the various types of trauma that clients, especially Veterans, have experienced

- In general, 3-4 trauma categories appear to be the tipping point for more severe long-term impact on someone's physical and mental health in research studies
- However, in Veterans, childhood emotional neglect and sexual abuse were tied to more negative outcomes as individual indicators

(Slavin, Fischer, & Pietrzak, 2025)

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Co-occurring conditions: Lifespan considerations

Physical Conditions	Mental Health Conditions	Maladaptive Behaviors

• Chronic Pain
• Gastrointestinal
  • GERD, IBS
• Neurological disorders
  • TBI
• Sleep disorders
  • Insomnia
  • OSA
	• ADHD
	• Anxiety Disorders
	  • GAD
	  • Social Phobia
	• Bipolar Disorder
	• Depressive disorders
	• Eating Disorders
	• Neurocognitive Disorders
	• OCD
	• Panic Disorder
	• Personality Disorders
	• Psychosis
	• Schizophrenia
		• Emotion Dysregulation
		• Impulsivity
		• Interpersonal Ineffectiveness
		  • Aggression
		  • Anger
		• Substance Use Disorders
		  • Alcohol
		  • Cannabis
		  • Tobacco
		• Suicidal Ideation / Homicidal Ideation
		• Self-Harm

(Hicks et al., 2024; Qassem, et al 2021)

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Assessment tools

- **Life Events Checklist (LEC-5)** - Establishes Criterion A
  - Self-report, extended self-report, or interview format
- **Clinician-Administered PTSD Scale (CAPS)**
- **PTSD Checklist for DSM-5 (PCL-5)** - also with LEC-5
  - Ongoing symptom monitoring and outcomes
- **QIDS, PHQ-9, BADS, Beck Inventories** for Depression
- Substance Use Disorder assessment and inventories
  - Brief Addiction Monitor – Revised (BAM-R)
  - ASAM Criteria
- **Subjective Well-Being** Scales and **Quality of Life** Inventories

RESOURCE: https://www.ptsd.va.gov/professional/assessment/list_measures.asp

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APA Guidelines for complex trauma history

H: ***Humanistic.*** Provide a safe-haven to support dignity/ self-compassion and ***foster personal agency***

I: ***Integrative.*** Tailor individualized care to whole person; balance past-focused evidence-based treatment ***with present needs and goals of the individual***

S: ***Sequence*** therapy based on **individual readiness/preferences**; impact on client's day-to-day functioning; and identified phases of treatment

T: ***Timeline.*** Impact of trauma history on timeline of an individual's lifespan; consider inter-generational and transgenerational risk factors; family history of trauma

O: ***Outcomes.*** Measurement-based care should assist with real-time identification of improvement/decline in functional domains and adapt treatment for effectiveness

R: ***Relationship.*** Secure therapeutic rapport; boundaries, exploration of self

Y: ***Why.*** Assist the client in making meaning of what happened, reappraisal of blame and responsibility, and exploring existential themes

(American Psychological Association, 2024)

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An episode of care for complex trauma

	Assessment	Treatment
H	Preferred pronouns/name Cultural and Values assessment Treatment preferences / goals	Recovery-oriented care (agency, empowerment, self-determination), Build trust, Strengths-based and recognition of resilience
I	Physical health (pain, sleep, eating), quality of relationships, need for other specialties	Medical monitoring, ongoing consideration of cultural/spiritual practices, ROI with outside entities
S	Diagnoses, SUD/ASAM, environmental stressors, readiness for various phases of treatment, ongoing life concerns	Proceeds in phases, transdiagnostic care (ACT, BA, CBT, DBT), balance current/past focus, monitor ongoing life concerns
T	Onset of trauma, attachment-style, social functioning, ACES, current safety risks (from self and others)	Understanding of trauma timeline, creation of relationship map/genogram, address avoidance, safety planning collaboration
O	Symptom monitoring beyond diagnostic tools to include self-harm, addictive bx, dissociation, physical health and pain	Teaching DBT skills for regulation, grounding and mindfulness, addressing harmful "secondary coping" and making outside referrals when needed
R	Therapeutic alliance; relational boundary-making, parallel process	Safe attachment; Interpersonal processing with client; relational repair as needed; shared decision-making
Y	Explore attribution of blame and responsibility; meaning-making	Narrative writing; Identifying new learnings about self and others and takeaways in moving forward.

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Trauma treatments: Select evidence-based pathways

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VA/DoD clinical practice guidelines for psychotherapy

Strong Recommendation:

- Cognitive Processing Therapy (CPT)
- Eye Movement Desensitization and Reprocessing (EMDR) ⚠
- Prolonged Exposure (PE) Therapy

Weak Recommendation:

- Written Exposure Therapy*
- Ehler's Cognitive Therapy for PTSD
- Present-Centered Therapy

*Would now move to "Strong" based on results of the 3rd published RCT study in 2023

(VA/DoD Clinical Practice Guideline, 2023)

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Therapy	Primary Interventions	Distinctive Components
Cognitive Processing Therapy (with or without trauma account) 12 sessions (50-60 minutes)	Impact Statement about WHY you believe the trauma occurred. Identify Stuck Points and implement cognitive strategies to address them.	Stuck points and Cognitive Errors (Over-Accommodated beliefs and Self-Blame Beliefs) - Cognitive Restructuring
Eye Movement Desensitization and Reprocessing Number of sessions varies, but lasts 60-90 minutes each 8 "phases" of treatment	Think/speak about traumatic event with bilateral stimulation until reported SUDS decrease to 0 or 1. Strengthen a chosen positive belief/cognition to counter a negative trauma belief at end of every session.	Teach relaxation techniques. Bilateral stimulation, *"thinking about"* trauma may be a form of exposure, strengthening of positive beliefs that counter negative trauma-related cognitions.
Prolonged Exposure 10-15 sessions (90 minutes)	In-vivo exposure hierarchy to reduce avoidance. Imaginal exposure is verbal recounting of the identified trauma in present tense.	Teach relaxation breathing. Record trauma story in present tense - "as if it were happening right now." Listen to audio recording repeatedly and measure SUDS.
Written Exposure Therapy 5 Sessions (45-60 minutes) 30 minutes of writing each session	Imaginal exposure is a written narrative about trauma in past tense, completed 5 times with scripted instructions.	Writing and thinking about trauma, but aspects of trauma not discussed verbally. Only discussion is about process of writing.

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Written Exposure Therapy: Systematic review

✓ **Written Exposure Therapy (WET) is both efficacious and effective for reducing PTSD symptoms per results of systematic review.**

1. Multiple studies found WET beneficial when delivered remotely with a video-conference platform and in a group format with a small group of participants.
2. Two studies reported beneficial outcomes with an adolescent population
3. Lower dropout rates in WET compared to PE and CPT, which is beyond the effects of just the shorter treatment suggesting that both the length and format are more tolerable.
   - ✓ 2018 - 6% vs. 40% (PE and CPT)
   - ✓ 2022 - 24% vs 45% (PE and CPT)
   - ✓ 2023 –13% vs. 36% (PE and CPT)
4. When VA/DOD guidelines were released in July 2023, only 2 RCT studies had been published for WET but one more study was published later in 2023 that meets the criteria for a 3rd RCT for WET.

(DeJesus, Trendel, & Sloan, 2024)

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CBT Functional assessment of trauma

- Index event (type, reaction, injuries)
- Fear cues
  - External stimuli (situations, people, places, objects)
  - Internal stimuli (PTSD SX heightened arousal, hypervigilance)
  - Intrusive thoughts (recurrent thoughts/images/memories)
- Feared consequences (harm, distress, reminders of event)
- Safety Behaviors
  - Avoidance patterns (traumatic event reminders, activities perceived as dangerous)
  - In-situation safety behaviors (safety checks, safe person nearby, weapon nearby)
  - ***Beliefs about safety behaviors*** (avoidance/safety behaviors prevent intrusive thoughts, increase perceived safety, prevent harm)

(Abramowitz, Deacon, & Whiteside, 2019)

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WET theory: Inhibitory learning

Imaginal Exposure Therapy

- Habituation to traumatic event via writing exercises
- Inhibitory Learning
  - Acknowledge fear-based cognitions not removed, remain intact
    - Not teaching to resist, control, or fix distress
    - Promote tolerance of anxiety/fear, such feelings are universal and safe
  - Goals
    - Develop new non-threatening cognitions
    - Activation of new safety-based cognitions in a wide variety of contexts over time
    - Strengthen fear tolerance as a part of new learning

(Abramowitz, Deacon, & Whiteside, 2019)

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Written Exposure Therapy (WET)

Structure of treatment:

- ✓ Psychoeducation about trauma and exposure therapy rationale in Session 1 prior to writing
- ✓ 30-minutes of quality writing about the trauma "as you look back upon it now" rather than the "right now" perspective of PE; no stopping/distractions permitted during writing
- ✓ Therapist uses script prompts verbatim from *Written Exposure Therapy for PTSD (2019)* and provides printed script to client for reference during writing session.
- ✓ SUDS rating used to assess client discomfort pre/post writing.
- ✓ Brief check-in about the experience of writing immediately after session.
- ✓ Read scripted material to participants with reminders of possible reactions post-session and the instruction to allow the experience of thoughts/feelings between sessions

- Recommended to complete LEC-5 and CAPS-5 before starting WET for thorough assessment of index trauma but other measures could be utilized as well.
- Imaginal exposure writing exercises are all focused on one identified index trauma
- Optimal symptom improvement is obtained in 5 writing sessions. Distress when writing decreases significantly by the third writing session

(Sloan & Marx, 2019)

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WET: Initial session

1. Provide psychoeducation about PTSD and rationale for exposure therapy immediately prior to the initial writing session. Training on using the SUDS scale and introduction to process of writing – answer questions as needed.
2. Read script verbatim for writing instructions on Session 1 and provide client with a printout of the script that was read to them and facilitate an uninterrupted 30-minute session for them to write about the identified index trauma.
3. After writing, therapist inquires how completing writing exposure went but does not process any written content with patient because the exposure activity is the trauma writing, which is completed.
4. No more than 10 mins discussing the process of writing. Finish with script on remaining open to thoughts, images, feelings that may come up about the trauma between sessions to reduce the tendency towards avoidance. Provide client with education about avoidance and potential increase in PTSD symptoms after session 1.
5. Therapist reads trauma narrative after client leaves office. Develop feedback for client about the quality of trauma writing to share prior to Session 2 Writing Time.

(Sloan & Marx, 2019)

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WET: Sessions 2, 3 and 4

Session 2: Evaluate if client followed writing instructions and wrote about index trauma. Determine if client focused on thoughts and feelings in initial writing. Assess whether client could think about the trauma since last session without pushing thoughts away. Writing session focused on **deepest feelings and thoughts.**

Session 3: Evaluate writing for feedback/improvement of writing. Ensure detailed trauma account was written. Check in and provide feedback. Writing session focused on **impact of trauma on client's view of life, meaning of life, and relationships**.

Session 4: Determine if client is following instructions for writing; if not, treatment may not be successful. Expect decrease in avoidance of places or activities. Writing session focused on the **most upsetting part of the trauma and how the trauma event has changed client's life.**

(Sloan & Marx, 2019)

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WET: Session 5

- Last session of protocol; generally positive feedback is given regarding the Session 4 narrative.
- Writing session focused on wrapping up the writing and writing about **how the traumatic experience is related to client's current life and future.**
- Post-writing: No feedback given to client about writing as this is a wrap-up session. Remind client they have learned a skill to cope with traumatic events.
- Ask client if treatment was successful. Avoidance of trauma by only writing about peripheral detail is a common reason for "no."
- For residual symptoms, continue to conduct WET or discuss another EBP.
- Determine if other symptoms persist that need treatment (e.g., depression, SUD, emotional dysregulation)

(Sloan & Marx, 2019)

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Rogers Behavioral Health's WET outcomes data

Sample (N=238) adults in a PHP or IOP from 1/1/25 to 9/30/25

Demographics
- 76.9% Caucasian
- 4.2% Black/African-American
- 1.25% Asian
- 1.25% Amer. Indian/Alaskan Native
- 16.4% Other/Unknown

Ethnicity
- 83.2% Not Hispanic or Latino
- 4.6% Hispanic/Latino
- 12.2% Not reported

Age
- 18-21 5.5%
- 21-29 33.2%
- 30-39 27.3%
- 40-49 21.0%
- 50-60 12.6%
- 60-70 0.4%

Marital Status
- Single 57.1%
- Married 24%
- Divorced 8.8%
- Separated 2.5%
- Unknown 7.6%

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Rogers Behavioral Health's WET outcomes data

- Average checked-in days until first WET session: 8.5 days
- Average length of treatment: 29 days in PHP and/or IOP
- Outcomes (3+ WET sessions): 80% of clients received 5+ sessions; all groups with 3+ sessions showed significant improvement (3, 4, 5, 5+)

Measure	N	Baseline	Post	Effect Size Cohens D
PCL-5	**236**	**46.13**	**33.67**	**0.83 (HIGH)**
QIDS	226	13.74	10.82	0.60
Quality of Life (QOL)	217	46.44	54.58	0.57
BADS	223	24.00	28.99	0.53

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Level of care considerations

When is a HLOC needed?

Widespread Functional Impairments

- Intrapersonal functioning
  - Self-care (sleep, nutrition, med adherence)
  - Maladaptive coping (SUD, SH)
  - Mental health (SI, suicide attempts)
  - Physical health
  - Avoidance, Isolation, rumination
- Interpersonal functioning
- Community participation
  - Household environment
  - Transportation
  - Work/Academic engagement

What are the differences in the delivery of EBTS at HLOC?

- WET depending on LOC
- Integrative protocol of ACT, BA, CBT, DBT, mindfulness, and self-compassion
- Restoring/habilitating clients to life goals and obligations
- Adapting EBTs to a setting that is not a research study
  - PTSD + SUD at residential level of care in a group setting (Schumacher et al, 2022)
  - WET in group format (Larsen et al, 2024)

Complex conditions need comprehensive solutions

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Recovery from trauma and promotion of resiliency factors

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Case example

- 22 y/o (they/them) college student recently unenrolled
- Diagnoses: PTSD; MDD, recurrent; OCD
- Disability/Physical Health: Insomnia; PCOS
- Religion and spirituality – Spiritual but not religious; "scientific"
- Ethnicity and race – White
- Sexual orientation – Pansexual (recent breakup with alcoholic partner)
- SES: raised middle class, trying to become independent from family so finances are a big concern
- Indigenous heritage: None known
- National Origin: United States
- Gender Identity: non-binary, they/them pronouns

Age and generation
Diagnosis status
Disability & physical health status
Religion and spirituality
Ethnicity and race
Sexual orientation
Socioeconomic status
Indigenous heritage
National origin
Gender identity

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Case example: Outcomes monitoring

Functional improvements:

Intrapersonal functioning
- Improved ADLs and sleep, med adherence

Interpersonal functioning
- Family relations improvement due to limits/boundaries
- Diversified social interactions; planned roommate (friend) for next semester
- Ended the co-dependent relationship

Community participation
- Re-enrolled in college
- Attending Al-Anon meetings

Measurement-based care:

Measure	Baseline	Post	Interpretation
PCL-5	59	31	Severe to subclinical trauma symptoms
QIDS	13	6	Moderate to Mild depressive symptoms
Quality of Life	29	77	Significantly low to the Normal range
BADS	14	40	Very minimal activation/ high avoidance to high activation/ little avoidance

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Behavioral activation and wellness strategies

- Action-oriented; promotes healthy coping/adaptation
- Targets: avoidance, isolation, and rumination
- Client's context evaluated and functionally understood
  - ADLS/Routine Activities
  - Enjoyable/Pleasurable Activities
  - Values (short-term and long-term goals)
- Co-create healthy behavioral patterns
  - Value-behavior congruence
  - Diverse, stable patterns or activities

(Martell, Dimidjian, & Herman-Dunn, 2022; Kanter, Busch, & Rusch, 2009)

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1. T = Triggers

Stressful Life Events, Changes:
- Problematic romantic relationships
- Bad grades or negative feedback at work
- Divorce
- Lack of social life/close friendship

2. R = (Emotional) **Responses**

Painful feelings:
- Feeling depressed
- Lonely
- Embarrassed
- Neglected
- Scared of the future
- Frustrated

3. AP = Avoidance patterns

Behavioral responses:
- Use smartphone or video games to avoid
- Call in sick to school/work
- Avoid family interaction
- Stop following daily schedule
- Increased sleep

DEPRESSION

Main point: Your depression *makes sense.*

(Adapted from Martell, Dimidjian, & Herman-Dunn, 2022; Kanter, Busch, & Rusch, 2009)

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Wellness Wheel:
Fostering resilience, adaptability, and community inclusion

Realm	Building Wellness
Physical	Sleep, nutrition, movement, touch, physical safety
Emotional	Emotional identification, understanding, labeling, expressing, and regulating
Intellectual	Creativity, knowledge, learning, memory, self-management
Social	Identities, relationships,
Environment	Engaging in the world around us, growth and security, service to others, play, connection with others
Occupational	Contribution, responsibilities
Financial	Access to tools, money, resources
Spiritual	Meaning, purpose, values

(Hanley-Dafoe, 2023)

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Time for questions and answers

- Please use the Q&A button to submit your question.
- If we don't get to your question, please feel free to send an email to **webinars@rogersbh.org** and we will follow up with you.

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Recommended resources

1. **APA Guidelines for Working with Adults with Complex Trauma Histories:**
   https://www.apa.org/practice/guidelines/adults-complex-trauma-histories.pdf
2. **PTSD Assessment Tools:**
   https://www.ptsd.va.gov/professional/assessment/list_measures.asp
3. **Free Database of PTSD articles:**
   https://www.ptsd.va.gov/PTSD/ptsdpubs/search_ptsdpubs.asp

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About the presenters

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Patrick Michaels, PhD, is a licensed clinical psychologist based at Rogers' Nashville location who serves as a regional clinical director

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