A TREATMENT IMPROVEMENT PROTOCOL

Trauma-Informed Care in Behavioral Health Services

TIP 57

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TIP 57

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

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Rockville, MD 20857

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Disclaimer

The views, opinions, and content expressed herein are the views of the consensus panel members and do not necessarily reflect the official position of SAMHSA or HHS. No official support of or endorsement by SAMHSA or HHS for these opinions or for the instruments or resources described are intended or should be inferred. The guidelines presented should not be considered substitutes for individualized client care and treatment decisions.

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What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific best practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts of various forms of treatment and prevention. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at http://store.samhsa.gov.

Although each consensus-based TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that behavioral health is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. If research supports a particular approach, citations are provided.

Foreword

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA's mission to improve prevention and treatment of substance use and mental disorders by providing best practices guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particular area of expertise until they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIP panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

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How This TIP Is Organized

This Treatment Improvement Protocol (TIP) is divided into three parts:

- Part 1: *A Practical Guide for the Provision of Behavioral Health Services*
- Part 2: *An Implementation Guide for Behavioral Health Program Administrators*
- Part 3: *A Review of the Literature*

Part 1 is for behavioral health service providers and consists of six chapters. Recurring themes include the variety of ways that substance abuse, mental health, and trauma interact; the importance of context and culture in a person's response to trauma; trauma-informed screening and assessment tools, techniques, strategies, and approaches that help behavioral health professionals assist clients in recovery from mental and substance use disorders who have also been affected by acute or chronic traumas; and the significance of adhering to a strengths-based perspective that acknowledges the resilience within individual clients, providers, and communities.

Chapter 1 lays the groundwork and rationale for the implementation and provision of trauma-informed services. It provides an overview of specific trauma-informed intervention and treatment principles that guide clinicians, other behavioral health workers, and administrators in becoming trauma informed and in creating a trauma-informed organization and workforce. Chapter 2 provides an overview of traumatic experiences. It covers types of trauma; distinguishes among traumas that affect individuals, groups, and communities; describes trauma characteristics; and addresses the socioecological and cultural factors that influence the impact of trauma. Chapter 3 broadly focuses on understanding the impact of trauma, trauma-related stress reactions and associated symptoms, and common mental health and substance use disorders associated with trauma. Chapter 4 provides an introduction to screening and assessment as they relate to trauma and is devoted to screening and assessment processes and tools that are useful in evaluating trauma exposure, its effects, and client intervention and treatment needs. Chapter 5 covers clinical issues that counselors and other behavioral health professionals may need to know and address when treating clients who have histories of trauma. Chapter 6 presents information on specific treatment models for trauma, distinguishing integrated models (which address substance use disorders, mental disorders, and trauma simultaneously) from those that treat trauma alone.

Advice to Counselors and/or Administrators boxes in Part 1 provide practical information for providers. Case illustrations, exhibits, and text boxes further illustrate information in the text by offering practical examples.

Part 2 provides an overview of programmatic and administrative practices that will help behavioral health program administrators increase the capacity of their organizations to deliver

trauma-informed services. Chapter 1 examines the essential ingredients, challenges, and processes in creating and implementing trauma-informed services within an organization. Chapter 2 focuses on key development activities that support staff members, including trauma-informed training and supervision, ethics, and boundaries pertinent to responding to traumatic stress, secondary trauma, and counselor self-care.

Advice to Administrators and/or Supervisors boxes in Part 2 highlight more detailed information that supports the organizational implementation of trauma-informed care (TIC). In addition, case illustrations, organizational activities, and text boxes reinforce the material presented within this section.

Part 3 is a literature review on TIC and behavioral health services and is intended for use by clinical supervisors, interested providers, and administrators. Part 3 has three sections: an analysis of the literature, links to select abstracts of the references most central to the topic, and a general bibliography of the available literature. To facilitate ongoing updates (performed periodically for up to 3 years from first publication), the literature review is only available online at the Substance Abuse and Mental Health Services Administration (SAMHSA) Publications Ordering Web page (http://store.samhsa.gov).

Terminology

Behavioral health: Throughout the TIP, the term "behavioral health" is used. Behavioral health refers to a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like serious mental illness and substance use disorders, which are often chronic in nature but from which people can and do recover. The term is also used in this TIP to describe the service systems encompassing the promotion of emotional health, the prevention of mental and substance use disorders, substance use and related problems, treatments and services for mental and substance use disorders, and recovery support. Because behavioral health conditions, taken together, are the leading causes of disability burden in North America, efforts to improve their prevention and treatment will benefit society as a whole. Efforts to reduce the impact of mental and substance use disorders on America's communities, such as those described in this TIP, will help achieve nationwide improvements in health.

Client/consumer: In this TIP, the term "client" means anyone who seeks or receives mental health or substance abuse services. The term "consumer" stands in place of "client" in content areas that address consumer participation and determination. It is not the intent of this document to ignore the relevance and historical origin of the term "consumer" among individuals who have received, been subject to, or are seeking mental health services. Instead, we choose the word "client," given that this terminology is also commonly used in substance abuse treatment services. Note: This TIP also uses the term "participant(s)" instead of "client(s)" for individuals, families, or communities seeking or receiving prevention services.

Complex trauma: This manual adopts the National Child Traumatic Stress Network (NCTSN) definition of complex trauma. The term refers to the pervasive impact, including developmental

consequences, of exposure to multiple or prolonged traumatic events. According to the NCTSN Web site (http://www.nctsn.org/trauma-types), complex trauma typically involves exposure to sequential or simultaneous occurrences of maltreatment, "including psychological maltreatment, neglect, physical and sexual abuse, and domestic violence…. Exposure to these initial traumatic experiences—and the resulting emotional dysregulation and the loss of safety, direction, and the ability to detect or respond to danger cues—often sets off a chain of events leading to subsequent or repeated trauma exposure in adolescence and adulthood" (NCTSN, 2013).

Co-occurring disorders: When an individual has one or more mental disorders as well as one or more substance use disorders (including substance abuse), the term "co-occurring" applies. Although people may have a number of health conditions that co-occur, including physical problems, the term "co-occurring disorders," in this TIP, refers to substance use and mental disorders.

Cultural responsiveness and cultural competence: This TIP uses these terms interchangeably, with "responsiveness" applied to services and systems and "competence" applied to people, to refer to "a set of behaviors, attitudes, and policies that…enable a system, agency, or group of professionals to work effectively in cross-cultural situations" (Cross, Bazron, Dennis, & Isaacs, 1989, p. 13). Culturally responsive behavioral health services and culturally competent providers "honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services…. [C]ultural competence is a dynamic, ongoing developmental process that requires a long-term commitment and is achieved over time" (U.S. Department of Health and Human Services, 2003, p. 12).

Evidence-based practices: There are many different uses of the term "evidence-based practices." One of the most widely accepted is that of Chambless and Hollon (1998), who say that for a treatment to be considered evidence based, it must show evidence of positive outcomes based on peer-reviewed randomized controlled trials or other equivalent strong methodology. A treatment is labeled "strong" if criteria are met for what Chambless and Hollon term "well-established" treatments. To attain this level, rigorous treatment outcome studies conducted by independent investigators (not just the treatment developer) are necessary. Research support is labeled "modest" when treatments attain criteria for what Chambless and Hollon call "probably efficacious treatments." To meet this standard, one well-designed study or two or more adequately designed studies must support a treatment's efficacy. In addition, it is possible to meet the "strong" and "modest" thresholds through a series of carefully controlled single-case studies. An evidence-based practice derived from sound, science-based theories incorporates detailed and empirically supported procedures and implementation guidelines, including parameters of applications (such as for populations), inclusionary and exclusionary criteria for participation, and target interventions.

Promising practices: Even though current clinical wisdom, theories, and professional and expert consensus may support certain practices, these practices may lack support from studies that are scientifically rigorous in research design and statistical analysis; available studies may be limited in number or sample size, or they may not be applicable to the current setting or population. This TIP refers to such practices as "promising."

Recovery: This term denotes a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Major dimensions that support a life in recovery, as defined by SAMHSA, include:

- ***Health:*** overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way.
- ***Home:*** a stable and safe place to live.
- ***Purpose:*** meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.
- ***Community:*** relationships and social networks that provide support, friendship, love, and hope.

Resilience: This term refers to the ability to bounce back or rise above adversity as an individual, family, community, or provider. Well beyond individual characteristics of hardiness, resilience includes the process of using available resources to negotiate hardship and/or the consequences of adverse events. This TIP applies the term "resilience" and its processes to individuals across the life span.

Retraumatization: In its more literal translation, "retraumatization" means the occurrence of traumatic stress reactions and symptoms after exposure to multiple events (Duckworth & Follette, 2011). This is a significant issue for trauma survivors, both because they are at increased risk for higher rates of retraumatization, and because people who are traumatized multiple times often have more serious and chronic trauma-related symptoms than those with single traumas. In this manual, the term not only refers to the effect of being exposed to multiple events, but also implies the process of reexperiencing traumatic stress as a result of a current situation that mirrors or replicates in some way the prior traumatic experiences (e.g., specific smells or other sensory input; interactions with others; responses to one's surroundings or interpersonal context, such as feeling emotionally or physically trapped).

Secondary trauma: Literature often uses the terms "secondary trauma," "compassion fatigue," and "vicarious traumatization" interchangeably. Although compassion fatigue and secondary trauma refer to similar physical, psychological, and cognitive changes and symptoms that behavioral health workers may encounter when they work specifically with clients who have histories of trauma, vicarious trauma usually refers more explicitly to specific cognitive changes, such as in worldview and sense of self (Newell & MacNeil, 2010). This publication uses "secondary trauma" to describe trauma-related stress reactions and symptoms resulting from exposure to another individual's traumatic experiences, rather than from exposure directly to a traumatic event. Secondary trauma can occur among behavioral health service providers across all behavioral health settings and among all professionals who provide services to those who have experienced trauma (e.g., healthcare providers, peer counselors, first responders, clergy, intake workers).

Substance abuse: Throughout the TIP, the term "substance abuse" has been used to refer to both substance abuse and substance dependence. This term was chosen partly because behavioral health professionals commonly use the term substance abuse to describe any excessive use of addictive substances. In this TIP, the term refers to the use of alcohol as well as other substances of abuse. Readers should attend to the context in which the term occurs to determine what possible range of meanings it covers; in most cases, it will refer to all varieties of substance-related

disorders as found in *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (American Psychiatric Association, 2013a).

Trauma: In this text, the term "trauma" refers to experiences that cause intense physical and psychological stress reactions. It can refer to "a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual well-being" (SAMHSA, 2012, p. 2). Although many individuals report a single specific traumatic event, others, especially those seeking mental health or substance abuse services, have been exposed to multiple or chronic traumatic events. See the "What Is Trauma" section in Part 1, Chapter 1, for a more indepth definition and discussion of trauma.

Trauma-informed: A trauma-informed approach to the delivery of behavioral health services includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. It involves viewing trauma through an ecological and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic. In May 2012, SAMHSA convened a group of national experts who identified three key elements of a trauma-informed approach: "(1) realizing the prevalence of trauma; (2) recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and (3) responding by putting this knowledge into practice" (SAMHSA, 2012, p 4).

Trauma-informed care: TIC is a strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper, Bassuk, & Olivet, 2010, p. 82). It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services.

Trauma-specific treatment services: These services are evidence-based and promising practices that facilitate recovery from trauma. The term "trauma-specific services" refers to prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders (including substance use and mental disorders) that developed during or after trauma.

Trauma survivor: This phrase can refer to anyone who has experienced trauma or has had a traumatic stress reaction. Knowing that the use of language and words can set the tone for recovery or contribute to further retraumatization, it is the intent of this manual to put forth a message of hope by avoiding the term "victim" and instead using the term "survivor" when appropriate.

Part 1: A Practical Guide for the Provision of Behavioral Health Services

1 Trauma-Informed Care: A Sociocultural Perspective

IN THIS CHAPTER

- Scope of the TIP
- Intended Audience
- Before You Begin
- Structure of the TIP
- What Is Trauma?
- Trauma Matters in Behavioral Health Services
- Trauma Informed Intervention and Treatment Principles
- As You Proceed

Many individuals who seek treatment in behavioral health settings have histories of trauma, but they often don't recognize the significant effects of trauma in their lives; either they don't draw connections between their trauma histories and their presenting problems, or they avoid the topic altogether. Likewise, treatment providers may not ask questions that elicit a client's history of trauma, may feel unprepared to address trauma-related issues proactively, or may struggle to address traumatic stress effectively within the constraints of their treatment program, the program's clinical orientation, or their agency's directives.

By recognizing that traumatic experiences and their sequelae tie closely into behavioral health problems, front-line professionals and community-based programs can begin to build a trauma-informed environment across the continuum of care. Key steps include meeting client needs in a safe, collaborative, and compassionate manner; preventing treatment practices that retraumatize people with histories of trauma who are seeking help or receiving services; building on the strengths and resilience of clients in the context of their environments and communities; and endorsing trauma-informed principles in agencies through support, consultation, and supervision of staff.

This Treatment Improvement Protocol (TIP) begins by introducing the scope, purpose, and organization of the topic and describing its intended audience. Along with defining trauma and trauma-informed care (TIC), the first chapter discusses the rationale for addressing trauma in behavioral health services and reviews trauma-informed intervention and treatment principles. These principles serve as the TIP's conceptual framework.

Scope of the TIP

Many individuals experience trauma during their lifetimes. Although many people exposed to trauma demonstrate few or no lingering symptoms, those individuals who have experienced repeated, chronic, or multiple traumas are more likely to exhibit pronounced symptoms and consequences, including substance abuse, mental illness, and health problems. Subsequently, trauma can significantly affect how an individual engages in major life areas as well as treatment.

This TIP provides evidence-based and best practice information for behavioral health service providers and administrators who want to work more effectively with people who have been exposed to acute and chronic traumas and/or are at risk of developing traumatic stress reactions. Using key trauma-informed principles, this TIP addresses trauma-related prevention, intervention, and treatment issues and strategies in behavioral health services. The content is adaptable across behavioral health settings that service individuals, families, and communities—placing emphasis on the importance of coordinating as well as integrating services.

Intended Audience

This TIP is for behavioral health service providers, prevention specialists, and program administrators—the professionals directly responsible for providing care to trauma survivors across behavioral health settings, including substance abuse and mental health services. This TIP also targets primary care professionals, including physicians; teams working with clients and communities who have experienced trauma; service providers in the criminal justice system; and researchers with an interest in this topic.

Before You Begin

This TIP endorses a trauma-informed model of care; this model emphasizes the need for behavioral health practitioners and organizations to recognize the prevalence and pervasive impact of trauma on the lives of the people they serve and develop trauma-sensitive or trauma-responsive services. This TIP provides key information to help behavioral health practitioners and program administrators become trauma aware and informed, improve screening and assessment processes, and implement science-informed intervention strategies across settings and modalities in behavioral health services. Whether provided by an agency or an individual provider, trauma-informed services may or may not include trauma-specific services or trauma specialists (individuals who have advanced training and education to provide specific treatment interventions to address traumatic stress reactions). Nonetheless, TIC anticipates the role that trauma can play across the continuum of care—establishing integrated and/or collaborative processes to address the needs of traumatized individuals and communities proactively.

Individuals who have experienced trauma are at an elevated risk for substance use disorders, including abuse and dependence; mental health problems (e.g., depression and anxiety symptoms or disorders, impairment in relational/social and other major life areas, other distressing symptoms); and physical disorders and conditions, such as sleep disorders. This TIP focuses on specific types of prevention (Institute of Medicine et al., 2009): selective prevention, which targets people who are at risk for developing social, psychological, or other conditions as a result of trauma or who are at greater risk for experiencing trauma due to behavioral health disorders or conditions; and indicated prevention, which targets people who display early signs of trauma-related

symptoms. This TIP identifies interventions, including trauma-informed and trauma-specific strategies, and perceives treatment as a means of prevention—building on resilience, developing safety and skills to negotiate the impact of trauma, and addressing mental and substance use disorders to enhance recovery.

This TIP's target population is adults. Beyond the context of family, this publication does not examine or address youth and adolescent responses to trauma, youth-tailored trauma-informed strategies, or trauma-specific interventions for youth or adolescents, because the developmental and contextual issues of these populations require specialized interventions. Providers who work with young clients who have experienced trauma should refer to the resource list in Appendix B. This TIP covers TIC, trauma characteristics, the impact of traumatic experiences, assessment, and interventions for persons who have had traumatic experiences. Considering the vast knowledge base and specificity of individual, repeated, and chronic forms of trauma, this TIP does not provide a comprehensive overview of the unique characteristics of each type of trauma (e.g., sexual abuse, torture, war-related trauma, murder). Instead, this TIP provides an overview supported by examples. For more information on several specific types of trauma, please refer to TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (Center for Substance Abuse Treatment [CSAT], 2000b), TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT, 1997b), TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT, 2009d), and the planned TIP, *Reintegration-Related Behavioral Health Issues in Veterans and Military Families* (Substance Abuse and Mental Health Services Administration [SAMHSA], planned f).

This TIP, *Trauma-Informed Care in Behavioral Health Services*, is guided by SAMHSA's Strategic Initiatives described in *Leading Change: A Plan for SAMHSA's Roles and Actions 2011–2014* (SAMHSA, 2011b). Specific to Strategic Initiative #2, Trauma and Justice, this TIP addresses several goals, objectives, and actions outlined in this initiative by providing behavioral health practitioners, supervisors, and administrators with an introduction to culturally responsive TIC.

Specifically, the TIP presents fundamental concepts that behavioral health service providers can use to:

- Become trauma aware and knowledgeable about the impact and consequences of traumatic experiences for individuals, families, and communities.
- Evaluate and initiate use of appropriate trauma-related screening and assessment tools.
- Implement interventions from a collaborative, strengths-based approach, appreciating the resilience of trauma survivors.
- Learn the core principles and practices that reflect TIC.
- Anticipate the need for specific trauma-informed treatment planning strategies that support the individual's recovery.
- Decrease the inadvertent retraumatization that can occur from implementing standard organizational policies, procedures, and interventions with individuals, including clients and staff, who have experienced trauma or are exposed to secondary trauma.
- Evaluate and build a trauma-informed organization and workforce.

The consensus panelists, as well as other contributors to this TIP, have all had experience as substance abuse and mental health counselors, prevention and peer specialists, supervisors, clinical directors, researchers, or administrators working with individuals, families, and

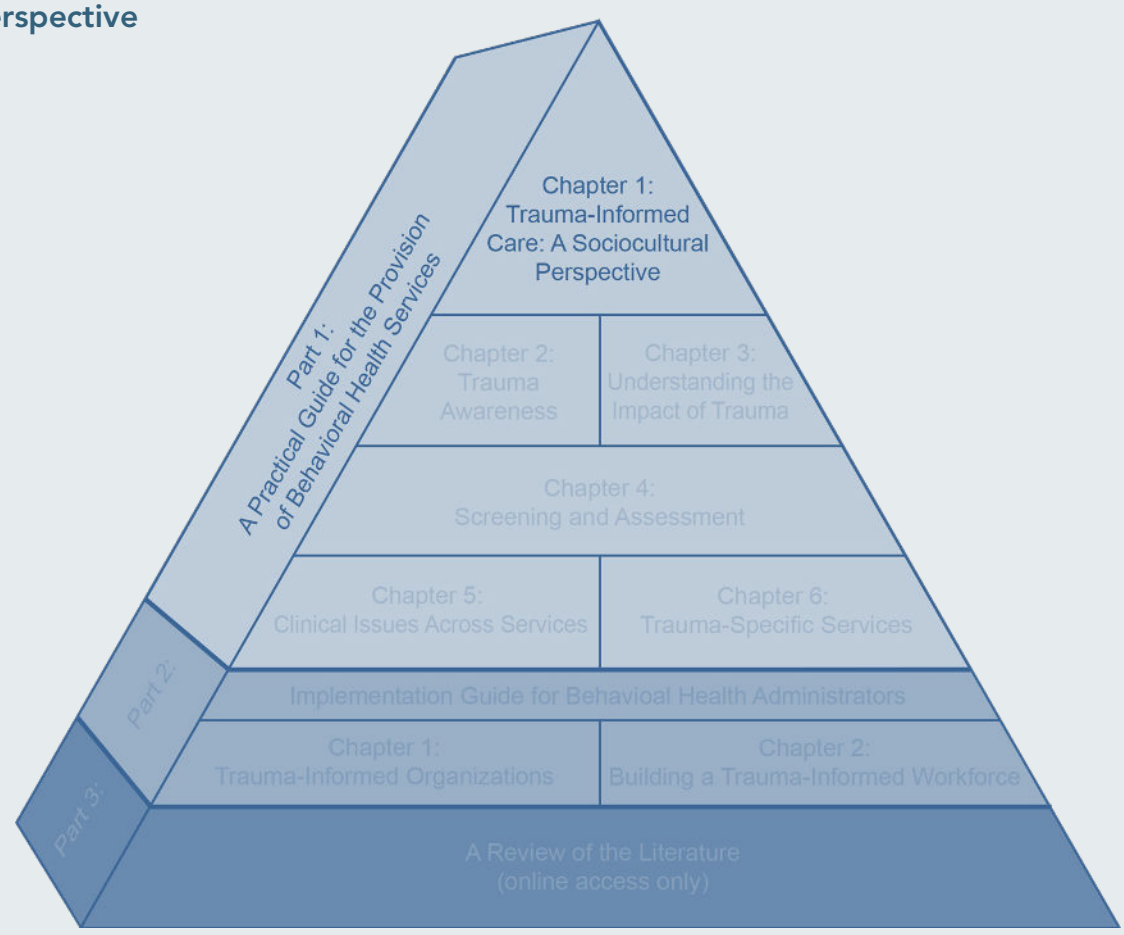
communities who have experienced trauma. The material presented in this TIP uses the wealth of their experience in addition to the available published resources and research relevant to this topic. Throughout the consensus process, the panel members were mindful of the strengths and resilience inherent in individuals, families, and communities affected by trauma and the challenges providers face in addressing trauma and implementing TIC.

Structure of the TIP

Using a TIC framework (Exhibit 1.1-1), this TIP provides information on key aspects of trauma, including what it is; its consequences; screening and assessment; effective prevention, intervention, and treatment approaches; trauma recovery; the impact of trauma on service providers; programmatic and administrative practices; and trauma resources.

Note: To produce a user-friendly but informed document, the first two parts of the TIP include minimal citations. If you are interested in the citations associated with topics covered in Parts 1 and 2, please consult the review of the literature provided in Part 3 (available online at http://store.samhsa.gov). Parts 1 and 2 are easily read and digested on their own, but it is highly recommended that you read the literature review as well.

Exhibit 1.1-1: TIC Framework in Behavioral Health Services—Sociocultural Perspective



What Is Trauma?

According to SAMHSA's Trauma and Justice Strategic Initiative, "trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being" (SAMHSA, 2012, p. 2). Trauma can affect people of every race, ethnicity, age, sexual orientation, gender, psychosocial background, and geographic region. A traumatic experience can be a single event, a series of events, and/or a chronic condition (e.g., childhood neglect, domestic violence). Traumas can affect individuals, families, groups, communities, specific cultures, and generations. It generally overwhelms an individual's or community's resources to cope, and it often ignites the "fight, flight, or freeze" reaction at the time of the event(s). It frequently produces a sense of fear, vulnerability, and helplessness.

See Appendix C to read about the history of trauma and trauma interventions.

Often, traumatic events are unexpected. Individuals may experience the traumatic event directly, witness an event, feel threatened, or hear about an event that affects someone they know. Events may be human-made, such as a mechanical error that causes a disaster, war, terrorism, sexual abuse, or violence, or they can be the products of nature (e.g., flooding, hurricanes, tornadoes). Trauma can occur at any age or developmental stage, and often, events that occur outside expected life stages are perceived as traumatic (e.g., a child dying before a parent, cancer as a teen, personal illness, job loss before retirement).

It is not just the event itself that determines whether something is traumatic, but also the individual's experience of the event. Two people may be exposed to the same event or series of events but experience and interpret these events in vastly different ways. Various biopsychosocial and cultural factors influence an individual's immediate response and long-term reactions to trauma. For most, regardless of the severity of the trauma, the immediate or enduring effects of trauma are met with resilience—the ability to rise above the circumstances or to meet the challenges with fortitude.

For some people, reactions to a traumatic event are temporary, whereas others have prolonged reactions that move from acute symptoms to more severe, prolonged, or enduring mental health consequences (e.g., posttraumatic stress and other anxiety disorders, substance use and mood disorders) and medical problems (e.g., arthritis, headaches, chronic pain). Others do not meet established criteria for posttraumatic stress or other mental disorders but encounter significant trauma-related symptoms or culturally expressed symptoms of trauma (e.g., somatization, in which psychological stress is expressed through physical concerns). For that reason, even if an individual does not meet diagnostic criteria for trauma-related disorders, it is important to recognize that trauma may still affect his or her life in significant ways. For more information on traumatic events, trauma characteristics, traumatic stress reactions, and factors that heighten or decrease the impact of trauma, see Part 1, Chapter 2, "Trauma Awareness," and Part 1, Chapter 3, "Understanding the Impact of Trauma."

Trauma Matters in Behavioral Health Services

The past decade has seen an increased focus on the ways in which trauma, psychological distress, quality of life, health, mental illness,

and substance abuse are linked. With the attacks of September 11, 2001, and other acts of terror, the wars in Iraq and Afghanistan, disastrous hurricanes on the Gulf Coast, and sexual abuse scandals, trauma has moved to the forefront of national consciousness.

Trauma was once considered an abnormal experience. However, the first National Comorbidity Study established how prevalent traumas were in the lives of the general population of the United States. In the study, 61 percent of men and 51 percent of women reported experiencing at least one trauma in their lifetime, with witnessing a trauma, being involved in a natural disaster, and/or experiencing a life-threatening accident ranking as the most common events (Kessler et al., 1999). In Wave 2 of the National Epidemiologic Survey on Alcohol and Related Conditions, 71.6 percent of the sample reported witnessing trauma, 30.7 percent experienced a trauma that resulted in injury, and 17.3 percent experienced psychological trauma (El-Gabalawy, 2012). For a thorough review of the impact of trauma on quality of life and health and among individuals with mental and substance use disorders, refer to Part 3 of this TIP, the online literature review.

Rationale for TIC

Integrating TIC into behavioral health services provides many benefits not only for clients, but also for their families and communities, for behavioral health service organizations, and for staff. Trauma-informed services bring to the forefront the belief that trauma can pervasively affect an individual's well-being, including physical and mental health. For behavioral health service providers, trauma-informed practice offers many opportunities. It reinforces the importance of acquiring trauma-specific knowledge and skills to meet the specific needs of clients; of recognizing that individuals may be affected by trauma regardless of its acknowledgment; of understanding that trauma likely affects many clients who are seeking behavioral health services; and of acknowledging that organizations and providers can retraumatize clients through standard or unexamined policies and practices. TIC stresses the importance of addressing the client individually rather than applying general treatment approaches.

TIC provides clients more opportunities to engage in services that reflect a compassionate perspective of their presenting problems. TIC can potentially provide a greater sense of safety for clients who have histories of trauma and a platform for preventing more serious consequences of traumatic stress (Fallot & Harris, 2001). Although many individuals may not identify the need to connect with their histories, trauma-informed services offer clients a chance to explore the impact of trauma, their strengths and creative adaptations in managing traumatic histories, their resilience, and the relationships among trauma, substance use, and psychological symptoms.

Two Influential Studies That Set the Stage for the Development of TIC

The Adverse Childhood Experiences Study (Centers for Disease Control and Prevention, 2013) was a large epidemiological study involving more than 17,000 individuals from United States; it analyzed the long-term effects of childhood and adolescent traumatic experiences on adult health risks, mental health, healthcare costs, and life expectancy.

The Women, Co-Occurring Disorders and Violence Study (SAMHSA, 2007) was a large multisite study focused on the role of interpersonal and other traumatic stressors among women; the interrelatedness of trauma, violence, and co-occurring substance use and mental disorders; and the incorporation of trauma-informed and trauma-specific principles, models, and services.

Implementing trauma-informed services can improve screening and assessment processes, treatment planning, and placement while also decreasing the risk for retraumatization. The implementation may enhance communication between the client and treatment provider, thus decreasing risks associated with misunderstanding the client's reactions and presenting problems or underestimating the need for appropriate referrals for evaluation or trauma-specific treatment. Organizational investment in developing or improving trauma-informed services may also translate to cost effectiveness, in that services are more appropriately matched to clients from the outset. TIC is an essential ingredient in organizational risk management; it ensures the implementation of decisions that will optimize therapeutic outcomes and minimize adverse effects on the client and, ultimately, the organization. A key principle is the engagement of community, clients, and staff. Clients and staff are more apt to be empowered, invested, and satisfied if they are involved in the ongoing development and delivery of trauma-informed services.

An organization also benefits from work development practices through planning for, attracting, and retaining a diverse workforce of individuals who are knowledgeable about trauma and its impact. Developing a trauma-informed organization involves hiring and promotional practices that attract and retain individuals who are educated and trained in trauma-informed practices on all levels of the organization, including board as well as peer support appointments. Trauma-informed organizations are invested in their staff and adopt similar trauma-informed principles, including establishing and providing ongoing support to promote TIC in practice and in addressing secondary trauma and implementing processes that reinforce the safety of the staff. Even though investing in a trauma-informed workforce does not necessarily guarantee trauma-informed practices, it is more likely that services will evolve more proficiently to meet client, staff, and community needs.

Advice to Counselors: The Importance of TIC

The history of trauma raises various clinical issues. Many counselors do not have extensive training in treating trauma or offering trauma-informed services and may be uncertain of how to respond to clients' trauma-related reactions or symptoms. Some counselors have experienced traumas themselves that may be triggered by clients' reports of trauma. Others are interested in helping clients with trauma but may unwittingly cause harm by moving too deeply or quickly into trauma material or by discounting or disregarding a client's report of trauma. Counselors must be aware of trauma-related symptoms and disorders and how they affect clients in behavioral health treatment.

Counselors with primary treatment responsibilities should also have an understanding of how to recognize trauma-related reactions, how to incorporate treatment interventions for trauma-related symptoms into clients' treatment plans, how to help clients build a safety net to prevent further trauma, how to conduct psychoeducational interventions, and when to make treatment referrals for further evaluations or trauma-specific treatment services. All treatment staff should recognize that traumatic stress symptoms or trauma-related disorders should not preclude an individual from mental health or substance abuse treatment and that all co-occurring disorders need to be addressed on some level in the treatment plan and setting. For example, helping a client in substance abuse treatment gain control over trauma-related symptoms can greatly improve the client's chances of substance abuse recovery and lower the possibility of relapse (Farley, Golding, Young, Mulligan, & Minkoff, 2004; Ouimette, Ahrens, Moos, & Finney, 1998). In addition, assisting a client in achieving abstinence builds a platform upon which recovery from traumatic stress can proceed.

Trauma and Substance Use Disorders

Many people who have substance use disorders have experienced trauma as children or adults (Koenen, Stellman, Sommer, & Stellman, 2008; Ompad et al., 2005). Substance abuse is known to predispose people to higher rates of traumas, such as dangerous situations and accidents, while under the influence (Stewart & Conrod, 2003; Zinzow, Resnick, Amstadter, McCauley, Ruggiero, & Kilpatrick, 2010) and as a result of the lifestyle associated with substance abuse (Reynolds et al., 2005). In addition, people who abuse substances and have experienced trauma have worse treatment outcomes than those without histories of trauma (Driessen et al., 2008; Najavits et al., 2007). Thus, the process of recovery is more difficult, and the counselor's role is more challenging, when clients have histories of trauma. A person presenting with both trauma and substance abuse issues can have a variety of other difficult life problems that commonly accompany these disorders, such as other psychological symptoms or mental disorders, poverty, homelessness, increased risk of HIV and other infections, and lack of social support (Mills, Teesson, Ross, & Peters, 2006; Najavits, Weiss, & Shaw, 1997). Many individuals who seek treatment for substance use disorders have histories of one or more traumas. More than half of women seeking substance abuse treatment report one or more lifetime traumas (Farley, Golding, Young, Mulligan, & Minkoff, 2004; Najavits et al., 1997), and a significant number of clients in inpatient treatment also have subclinical traumatic stress symptoms or posttraumatic stress disorder (PTSD; Falck, Wang, Siegal, & Carlson, 2004; Grant et al., 2004; Reynolds et al., 2005).

Trauma and Mental Disorders

People who are receiving treatment for severe mental disorders are more likely to have histories of trauma, including childhood physical and sexual abuse, serious accidents, homelessness, involuntary psychiatric hospitalizations, drug overdoses, interpersonal violence, and other forms of violence. Many clients with severe mental disorders meet criteria for PTSD; others with serious mental illness who have histories of trauma present with psychological symptoms or mental disorders that are commonly associated with a history of trauma, including anxiety symptoms and disorders, mood disorders (e.g., major depression, dysthymia, bipolar disorder; Mueser et al., 2004), impulse control disorders, and substance use disorders (Kessler, Chiu, Demler, & Walters, 2005).

Traumatic stress increases the risk for mental illness, and findings suggest that traumatic stress increases the symptom severity of mental illness (Spitzer, Vogel, Barnow, Freyberger & Grabe, 2007). These findings propose that traumatic stress plays a significant role in perpetuating and exacerbating mental illness and suggest that trauma often precedes the development of mental disorders. As with trauma and substance use disorders, there is a bidirectional relationship; mental illness increases the risk of experiencing trauma, and trauma increases the risk of developing psychological symptoms and mental disorders. For a more comprehensive review of the interactions among traumatic stress, mental illness, and substance use disorders, refer to Part 3 of this TIP, the online literature review.

Trauma-Informed Intervention and Treatment Principles

TIC is an intervention and organizational approach that focuses on how trauma may affect an individual's life and his or her response to behavioral health services from prevention through treatment. There are many definitions of TIC and various models for incorporating it across organizations, but a "trauma-informed approach incorporates three key elements: (1) *realizing* the prevalence of trauma; (2) *recognizing* how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and (3) *responding* by putting this knowledge into practice" (SAMHSA, 2012, p. 4).

TIC begins with the first contact a person has with an agency; it requires all staff members (e.g., receptionists, intake personnel, direct care staff, supervisors, administrators, peer supports, board members) to recognize that the individual's experience of trauma can greatly influence his or her receptivity to and engagement with services, interactions with staff and clients, and responsiveness to program guidelines, practices, and interventions. TIC includes program policies, procedures, and practices to protect the vulnerabilities of those who have experienced trauma and those who provide trauma-related services. TIC is created through a supportive environment and by redesigning organizational practices, with consumer participation, to prevent practices that could be retraumatizing (Harris & Fallot, 2001c; Hopper et al., 2010). The ethical principle, "first, do no harm," resonates strongly in the application of TIC.

> "A program, organization, or system that is trauma informed realizes the widespread impact of trauma and under stands poten tial paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings."
>
> (SAMHSA, 2012, p. 4)

TIC involves a commitment to building competence among staff and establishing programmatic standards and clinical guidelines that support the delivery of trauma-sensitive services. It encompasses recruiting, hiring, and retaining competent staff; involving consumers, trauma survivors, and peer support specialists in the planning, implementation, and evaluation of trauma-informed services; developing collaborations across service systems to streamline referral processes, thereby securing trauma-specific services when appropriate; and building a continuity of TIC as consumers move from one system or service to the next. TIC involves reevaluating each service delivery component through a trauma-aware lens.

The principles described in the following subsections serve as the TIP's conceptual

Advice to Counselors: Implementing Trauma-Informed Services

Recognizing that trauma affects a majority of clients served within public health systems, the National Center for Trauma-Informed Care (NCTIC) has sought to establish a comprehensive framework to guide systems of care in the development of trauma-informed services. If a system or program is to support the needs of trauma survivors, it must take a systematic approach that offers trauma-specific diagnostic and treatment services, as well as a trauma-informed environment that is able to sustain such services, while fostering positive outcomes for the clients it serves. NCTIC also offers technical assistance in the implementation of trauma-informed services. For specific administrative information on TIC implementation, refer to Part 2, Chapters 1 and 2, of this TIP.

framework. These principles comprise a compilation of resources, including research, theoretical papers, commentaries, and lessons learned from treatment facilities. Key elements are outlined for each principle in providing services to clients affected by trauma and to populations most likely to incur trauma. Although these principles are useful across all prevention and intervention services, settings, and populations, they are of the utmost importance in working with people who have had traumatic experiences.

Promote Trauma Awareness and Understanding

Foremost, a behavioral health service provider must recognize the prevalence of trauma and its possible role in an individual's emotional, behavioral, cognitive, spiritual, and/or physical development, presentation, and well-being. Being vigilant about the prevalence and potential consequences of traumatic events among clients allows counselors to tailor their presentation styles, theoretical approaches, and intervention strategies from the outset to plan for and be responsive to clients' specific needs. Although not every client has a history of trauma, those who have substance use and mental disorders are more likely to have experienced trauma. Being trauma aware does not mean that you must assume everyone has a history of trauma, but rather that you anticipate the possibility from your initial contact and interactions, intake processes, and screening and assessment procedures.

Even the most standard behavioral health practices can retraumatize an individual exposed to prior traumatic experiences if the provider implements them without recognizing or considering that they may do harm. For example, a counselor might develop a treatment plan recommending that a female client—who has been court mandated to substance abuse treatment and was raped as an adult—attend group therapy, but without considering the implications, for her, of the fact that the only available group at the facility is all male and has had a low historical rate of female participation. Trauma awareness is an essential strategy for preventing this type of retraumatization; it reinforces the need for providers to reevaluate their usual practices.

> "Trauma informed care embraces a perspective that highlights adaptation over symptoms and resilience over pathology."
>
> (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005, p. 467)

Becoming trauma aware does not stop with the recognition that trauma can affect clients; instead, it encompasses a broader awareness that traumatic experiences as well as the impact of an individual's trauma can extend to significant others, family members, first responders and other medical professionals, behavioral health workers, broader social networks, and even entire communities. Family members frequently experience the traumatic stress reactions of the individual family member who was traumatized (e.g., angry outbursts, nightmares, avoidant behavior, other symptoms of anxiety, overreactions or underreactions to stressful events). These repetitive experiences can increase the risk of secondary trauma and symptoms of mental illness among the family, heighten the risk for externalizing and internalizing behavior among children (e.g., bullying others, problems in social relationships, health-damaging behaviors), increase children's risk for developing posttraumatic stress later in life, and lead to a greater propensity for traumatic stress reactions across generations of the family. Hence, prevention and intervention services can provide education and age-appropriate programming tailored to develop coping skills and support systems.

So too, behavioral health service providers can be influenced by exposure to trauma-related affect and content when working with clients. A trauma-aware workplace supports supervision and program practices that educate all direct service staff members on secondary trauma, encourages the processing of trauma-related content through participation in peer-supported activities and clinical supervision, and provides them with professional development opportunities to learn about and engage in effective coping strategies that help prevent secondary trauma or trauma-related symptoms. It is important to generate trauma awareness in agencies through education across services and among all staff members who have any direct or indirect contact with clients (including receptionists or intake and admission personnel who engage clients for the first time within the agency). Agencies can maintain a trauma-aware environment through ongoing staff training, continued supervisory and administrative support, collaborative (i.e., involving consumer participation) trauma-responsive program design and implementation, and organizational policies and practices that reflect accommodation and flexibility in attending to the needs of clients affected by trauma.

Recognize That Trauma-Related Symptoms and Behaviors Originate From Adapting to Traumatic Experiences

A trauma-informed perspective views trauma-related symptoms and behaviors as an individual's best and most resilient attempt to manage, cope with, and rise above his or her experience of trauma. Some individuals' means of adapting and coping have produced little difficulty; the coping and adaptive strategies of others have worked in the past but are not working as well now. Some people have difficulties in one area of life but have effectively negotiated and functioned in other areas.

Individuals who have survived trauma vary widely in how they experience and express traumatic stress reactions. Traumatic stress reactions vary in severity; they are often measured by the level of impairment or distress that clients report and are determined by the multiple factors that characterize the trauma itself, individual history and characteristics, developmental factors, sociocultural attributes, and available resources. The characteristics of the trauma and the subsequent traumatic stress reactions can dramatically influence how individuals respond to the environment, relationships, interventions, and treatment services, and those same characteristics can also shape the assumptions that clients/consumers make about their world (e.g., their view of others, sense of safety), their future (e.g., hopefulness, fear of a foreshortened future), and themselves (e.g., feeling resilient, feeling incompetent in regulating emotions). The breadth of these effects may be observable or subtle.

Once you become aware of the significance of traumatic experiences in clients' lives and begin to view their presentation as adaptive, your identification and classification of their presenting symptoms and behaviors can shift from a "pathology" mindset (i.e., defining clients strictly from a diagnostic label, implying that something is wrong with them) to one of resilience—a mindset that views clients' presenting difficulties, behaviors, and emotions as responses to surviving trauma. In essence, you will come to view traumatic stress reactions as *normal* reactions to *abnormal* situations. In embracing the belief that trauma-related reactions are adaptive, you can begin relationships with clients from a hopeful, strengths-based stance that builds upon the belief that their responses to traumatic experiences reflect creativity, self-preservation, and determination.

This will help build mutual and collaborative therapeutic relationships, help clients identify what has worked and has not worked in their attempts to deal with the aftermath of trauma from a nonjudgmental stance, and develop intervention and coping strategies that are more likely to fit their strengths and resources. This view of trauma prevents further retraumatization by not defining traumatic stress reactions as pathological or as symptoms of pathology.

View Trauma in the Context of Individuals' Environments

Many factors contribute to a person's response to trauma, whether it is an individual, group, or community-based trauma. Individual attributes, developmental factors (including protective and risk factors), life history, type of trauma, specific characteristics of the trauma, amount and length of trauma exposure, cultural meaning of traumatic events, number of losses associated with the trauma, available resources (internal and external, such as coping skills and family support), and community reactions are a few of the determinants that influence a person's responses to trauma across time. Refer to the "View Trauma Through a Sociocultural Lens" section later in this chapter for more specific information highlighting the importance of culture in understanding and treating the effects of trauma.

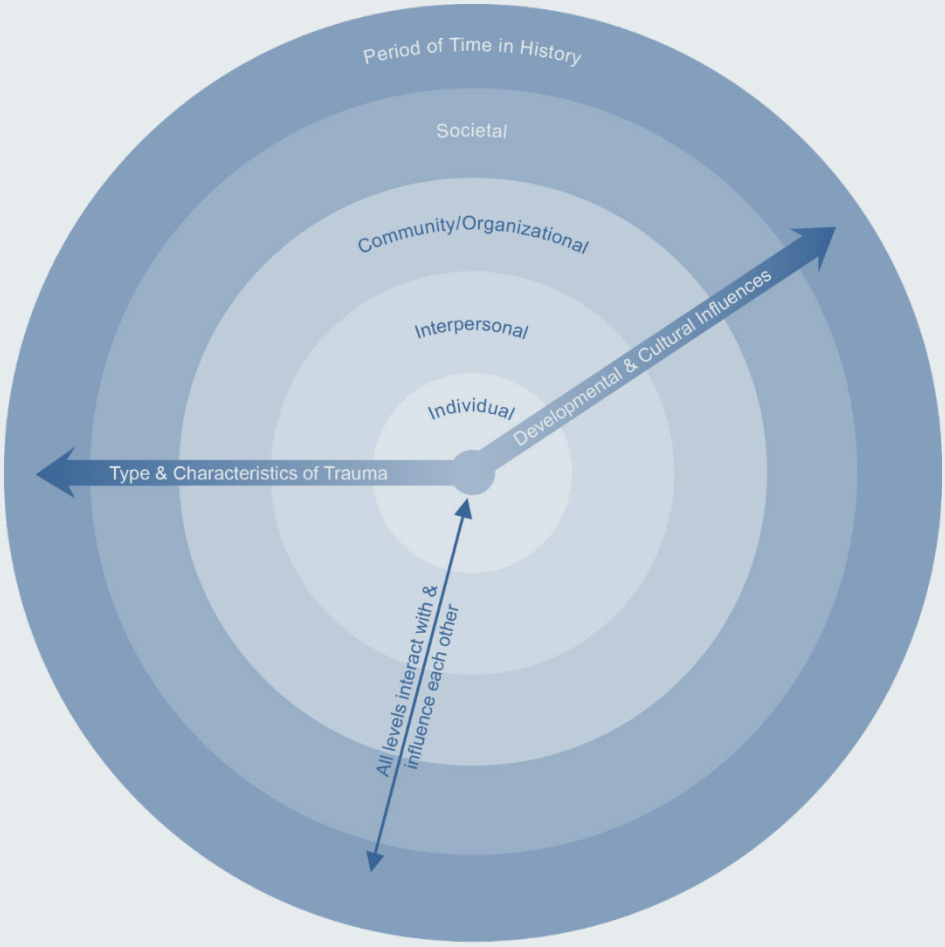
Trauma cannot be viewed narrowly; instead, it needs to be seen through a broader lens—a contextual lens integrating biopsychosocial, interpersonal, community, and societal (the degree of individualistic or collective cultural values) characteristics that are evident preceding and during the trauma, in the immediate and sustained response to the event(s), and in the short- and long-term effects of the traumatic event(s), which may include housing availability, community response, adherence to or maintenance of family routines and structure, and level of family support.

To more adequately understand trauma, you must also consider the contexts in which it occurred. Understanding trauma from this angle helps expand the focus beyond individual characteristics and effects to a broader systemic perspective that acknowledges the influences of social interactions, communities, governments, cultures, and so forth, while also examining the possible interactions among those various influences. Bronfenbrenner's (1979) and Bronfenbrenner and Ceci's (1994) work on ecological models sparked the development of other contextual models. In recent years, the social-ecological framework has been adopted in understanding trauma, in implementing health promotion and other prevention strategies, and in developing treatment interventions (Centers for Disease Control and Prevention, 2009). Here are the three main beliefs of a social-ecological approach (Stokols, 1996):

- Environmental factors greatly influence emotional, physical, and social well-being.
- A fundamental determinant of health versus illness is the degree of fit between individuals' biological, behavioral, and sociocultural needs and the resources available to them.
- Prevention, intervention, and treatment approaches integrate a combination of strategies targeting individual, interpersonal, and community systems.

This TIP uses a social-ecological model to explore trauma and its effects (Exhibit 1.1-2). The focus of this model is not only on negative attributes (risk factors) across each level, but also on positive ingredients (protective factors) that protect against or lessen the impact of trauma. This model also guides the inclusion of certain targeted interventions in this text, including selective and indicated

Exhibit 1.1-2: A Social-Ecological Model for Understanding Trauma and Its Effects



prevention activities. In addition, culture, developmental processes (including the developmental stage or characteristics of the individual and/or community), and the specific era when the trauma(s) occurred can significantly influence how a trauma is perceived and processed, how an individual or community engages in help-seeking, and the degree of accessibility, acceptability, and availability of individual and community resources.

Depending on the developmental stage and/or processes in play, children, adolescents, and adults will perceive, interpret, and cope with traumatic experiences differently. For example, a child may view a news story depicting a traumatic event on television and believe that the trauma is recurring every time they see the scene replayed. Similarly, the era in which one lives and the timing of the trauma can greatly influence an individual or community response. Take, for example, a pregnant woman who is abusing drugs and is wary of receiving medical treatment after being beaten in a domestic dispute. She may fear losing her children or being arrested for child neglect. Even though a number of States have adopted policies focused on the importance of treatment for pregnant women who are abusing drugs and of the accessibility of prenatal care, other States have approached this issue from a criminality standpoint (e.g., with child welfare and criminal laws) in the past few decades. Thus, the traumatic event's timing is a significant

component in understanding the context of trauma and trauma-related responses.

The social-ecological model depicted in Exhibit 1.1-2 provides a systemic framework for looking at individuals, families, and communities affected by trauma in general; it highlights the bidirectional influence that multiple contexts can have on the provision of behavioral health services to people who have experienced trauma (see thin arrow). Each ring represents a different system (refer to Exhibit 1.1-3 for examples of specific factors within each system). The innermost ring represents the individual and his or her biopsychosocial characteristics. The "Interpersonal" circle embodies all immediate relationships including family, friends, peers, and others. The "Community/Organizational" band represents social support networks, workplaces, neighborhoods, and institutions that directly influence the individual and his/her relationships. The "Societal" circle signifies the largest system—State and Federal policies and laws, such as economic and healthcare policies, social norms, governmental systems, and political ideologies. The outermost ring, "Period of Time in History," reflects the significance of the period of time during which the event occurred; it influences each other level represented in the circle. For example, making a comparison of society's attitudes and responses to veterans' homecomings across different wars and conflicts through time shows that homecoming environments can have either a protective or a negative effect on healing from the psychological and physical wounds of war, depending on the era in question. The thicker arrows in the figure represent the key influences of culture, developmental characteristics, and the type and characteristics of the trauma. All told, the context of traumatic events can significantly influence both initial and sustained responses to trauma; treatment needs; selection of prevention, intervention, and other treatment

Exhibit 1.1-3: Understanding the Levels Within the Social-Ecological Model of Trauma and Its Effects

Individual Factors	Interpersonal Factors	Community and Organizational Factors	Societal Factors	Cultural and Developmental Factors	Period of Time in History
Age, biophysical state, mental health status, temperament and other personality traits, education, gender, coping styles, socioeconomic status	Family, peer, and significant other interaction patterns, parent/family mental health, parents' history of trauma, social network	Neighborhood quality, school system and/or work environment, behavioral health system quality and accessibility, faith-based settings, transportation availability, community socioeconomic status, community employment rates	Laws, State and Federal economic and social policies, media, societal norms, judicial system	Collective or individualistic cultural norms, ethnicity, cultural subsystem norms, cognitive and maturational development	Societal attitudes related to military service members' homecomings, changes in diagnostic understanding between DSM-III-R* and DSM-5**

**Diagnostic and Statistical Manual of Mental Disorders,* Third Edition, Revised (American Psychiatric Association [APA], 1987)

***Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (APA, 2013a)

Case Illustration: Marisol

Marisol is a 28-year-old Latina woman working as a barista at a local coffee shop. One evening, she was driving home in the rain when a drunk driver crossed into her lane and hit her head on. Marisol remained conscious as she waited to be freed from the car and was then transported to the hospital. She sustained fractures to both legs. Her recovery involved two surgeries and nearly 6 months of rehabilitation, including initial hospitalization and outpatient physical therapy.

She described her friends and family as very supportive, saying that they often foresaw what she needed before she had to ask. She added that she had an incredible sense of gratitude for her employer and coworkers, who had taken turns visiting and driving her to appointments. Although she was able to return to work after 9 months, Marisol continued experiencing considerable distress about her inability to sleep well, which started just after the accident. Marisol describes repetitive dreams and memories of waiting to be transported to the hospital after the crash. The other driver was charged with driving under the influence (DUI), and it was reported that he had been convicted two other times for a DUI misdemeanor.

Answering the following questions will help you see how the different levels of influence affect the impact and outcome of the traumatic event Marisol experienced, as well as her responses to that event:

1. Based on the limited information provided in this illustration, how might Marisol's personality affect the responses of her family and friends, her coworkers, and the larger community?
2. In what ways could Marisol's ethnic and cultural background influence her recovery?
3. What societal factors could play a role in the car crash itself and the outcomes for Marisol and the other driver?

Explore the influence of the period of time in history during which the scenario occurs—compare the possible outcomes for both Marisol and the other driver if the crash occurred 40 years ago versus in the present day.

strategies; and ways of providing hope and promoting recovery.

Minimize the Risk of Retraumatization or Replicating Prior Trauma Dynamics

Trauma-informed treatment providers acknowledge that clients who have histories of trauma may be more likely to experience particular treatment procedures and practices as negative, reminiscent of specific characteristics of past trauma or abuse, or retraumatizing—feeling as if the past trauma is reoccurring or as if the treatment experience is as dangerous and unsafe as past traumas. For instance, clients may express feelings of powerlessness or being trapped if they are not actively involved in treatment decisions; if treatment processes or providers mirror specific behavior from the clients' past experiences with trauma, they may voice distress or respond in the same way as they did to the original trauma. Among the potentially retraumatizing elements of treatment are seclusion or "time-out" practices that isolate individuals, mislabeling client symptoms as personality or other mental disorders rather than as traumatic stress reactions, interactions that command authority, treatment assignments that could humiliate clients (such as asking a client to wear a sign in group that reflects one of their treatment issues, even if the assignment centers on positive attributes of the client), confronting clients as resistant, or presenting treatment as conditional upon conformity to the provider's beliefs and definitions of issues.

Clients' experiences are unique to the specific traumas they have faced and the surrounding

circumstances before, during, and after that trauma, so remember that even seemingly safe and standard treatment policies and procedures, including physical plant operations (e.g., maintenance, grounds, fire and safety procedures), may feel quite the contrary for a client if one or more of those elements is reminiscent of his or her experience of trauma in some way. Examples include having limited privacy or personal space, being interviewed in a room that feels too isolating or confining, undergoing physical examination by a medical professional of the same sex as the client's previous perpetrator of abuse, attending a group session in which another client expresses anger appropriately in a role play, or being directed not to talk about distressing experiences as a means of deescalating traumatic stress reactions.

Although some treatment policies or procedures are more obviously likely to solicit distress than others, *all* standard practices should be evaluated for their potential to retraumatize a client; this cannot be done without knowing the specific features of the individual's history of trauma. Consider, for instance, a treatment program that serves meals including entrees that combine more than one food group. Your client enters this program and refuses to eat most of the time; he expresses anger toward dietary staff and claims that food choices are limited. You may initially perceive your client's refusal to eat or to avoid certain foods as an eating disorder or a behavioral problem. However, a trauma-aware perspective might change your assumptions; consider that this client experienced neglect and abuse surrounding food throughout childhood (his mother forced him to eat meals prepared by combining anything in the refrigerator and cooking them together).

Advice to Counselors and Administrators: Sending the Right Message About Trauma

How often have you heard "We aren't equipped to handle trauma" or "We don't have time to deal with reactions that surface if traumatic experiences are discussed in treatment" from counselors and administrators in behavioral health services? For agencies, staff members, and clients, these statements present many difficulties and unwanted outcomes. For a client, such comments may replicate his or her earlier encounters with others (including family, friends, and previous behavioral health professionals) who had difficulty acknowledging or talking about traumatic experiences with him or her. A hands-off approach to trauma can also reinforce the client's own desire to avoid such discussions. Even when agencies and staff are motivated in these sentiments by a good intention—to contain clients' feelings of being overwhelmed—such a perspective sends strong messages to clients that their experiences are not important, that they are not capable of handling their trauma-associated feelings, and that dealing with traumatic experiences is simply too dangerous. Statements like these imply that recovery is not possible and provide no structured outlet to address memories of trauma or traumatic stress reactions.

Nevertheless, determining how and when to address traumatic stress in behavioral health services can be a real dilemma, especially if there are no trauma-specific philosophical, programmatic, or procedural processes in place. For example, it is difficult to provide an appropriate forum for a client to address past traumas if no forethought has been given to developing interagency and intra-agency collaborations for trauma-specific services. By anticipating the need for trauma-informed services and planning ahead to provide appropriate services to people who are affected by trauma, behavioral health service providers and program administrators can begin to develop informed intervention strategies that send a powerful, positive message:

- Both clients and providers can competently manage traumatic experiences and reactions.
- Providers are interested in hearing clients' stories and attending to their experiences.
- Recovery is possible.

As a treatment provider, you cannot consistently predict what may or may not be upsetting or retraumatizing to clients. Therefore, it is important to maintain vigilance and an attitude of curiosity with clients, inquiring about the concerns that they express and/or present in treatment. Remember that certain behaviors or emotional expressions can reflect what has happened to them in the past.

Foremost, a trauma-informed approach begins with taking practical steps to reexamine treatment strategies, program procedures, and organizational polices that could solicit distress or mirror common characteristics of traumatic experiences (loss of control, being trapped, or feeling disempowered). To better anticipate the interplay between various treatment elements and the more idiosyncratic aspects of a particular client's trauma history, you can:

- Work with the client to learn the cues he or she associates with past trauma.
- Obtain a good history.
- Maintain a supportive, empathetic, and collaborative relationship.
- Encourage ongoing dialog.
- Provide a clear message of availability and accessibility throughout treatment.

In sum, trauma-informed providers anticipate and respond to potential practices that may be perceived or experienced as retraumatizing to clients; they are able to forge new ways to respond to specific situations that trigger a trauma-related response, and they can provide clients with alternative ways of engaging in a particularly problematic element of treatment.

Create a Safe Environment

The need to create a safe environment is not new to providers; it involves an agency-wide effort supported by effective policies and procedures. However, creating safety within a trauma-informed framework far exceeds the standard expectations of physical plant safety (e.g., facility, environmental, and space-related concerns), security (of staff members, clients, and personal property), policies and procedures (including those specific to seclusion and restraint), emergency management and disaster planning, and adherence to client rights. Providers must be responsive and adapt the environment to establish and support clients' sense of physical and emotional safety.

Beyond anticipating that various environmental stimuli within a program may generate strong emotions and reactions in a trauma survivor (e.g., triggers such as lighting, access to exits, seating arrangements, emotionality within a group, or visual or auditory stimuli) and implementing strategies to help clients cope with triggers that evoke their experiences with trauma, other key elements in establishing a safe environment include consistency in client interactions and treatment processes, following through with what has been reviewed or agreed upon in sessions or meetings, and dependability. Mike's case illustration depicts ways in which the absence of these key elements could erode a client's sense of safety during the treatment process.

Neither providers nor service processes are always perfect. Sometimes, providers

Case Illustration: Mike

From the first time you provide outpatient counseling to Mike, you explain that he can call an agency number that will put him in direct contact with someone who can provide further assistance or support if he has emotional difficulty after the session or after agency hours. However, when he attempts to call one night, no one is available despite what you've described. Instead, Mike is directed by an operator to either use his local emergency room if he perceives his situation to be a crisis or to wait for someone on call to contact him. The inconsistency between what you told him in the session and what actually happens when he calls makes Mike feel unsafe and vulnerable.

unintentionally relay information inaccurately or inconsistently to clients or other staff members; other times, clients mishear something, or extenuating circumstances prevent providers from responding as promised. Creating safety is not about getting it right all the time; it's about how consistently and forthrightly you handle situations with a client when circumstances provoke feelings of being vulnerable or unsafe. Honest and compassionate communication that conveys a sense of handling the situation together generates safety. It is equally important that safety extends beyond the client. Counselors and other behavioral health staff members, including peer support specialists, need to be able to count on the agency to be responsive to and maintain their safety within the environment as well. By incorporating an organizational ethos that recognizes the importance of practices that promote physical safety and emotional well-being, behavioral health staff members may be more likely to seek support and supervision when needed and to comply with clinical and programmatic practices that minimize risks for themselves and their clients.

Beyond an attitudinal promotion of safety, organizational leaders need to consider and create avenues of professional development and assistance that will give their staff the means to seek support and process distressing circumstances or events that occur within the agency or among their clientele, such as case consultation and supervision, formal or informal processes to debrief service providers about difficult clinical issues, and referral processes for client psychological evaluations and employee assistance for staff. Organizational practices are only effective if supported by unswerving trauma awareness, training, and education among staff. Jane's case illustration shows the impact of a minor but necessary postponement in staff orientation for a new hire—not an unusual circumstance in behavioral health programs that have heavy caseloads and high staff turnover.

Identify Recovery From Trauma as a Primary Goal

Often, people who initiate or are receiving mental health or substance abuse services don't identify their experiences with trauma as a significant factor in their current challenges or problems. In part, this is because people who have been exposed to trauma, whether once or repeatedly, are generally reluctant to revisit it. They may already feel stuck in repetitive memories or experiences, which may add to their existing belief that any intervention will make matters worse or, at least, no better. For some clients, any introduction to their trauma-related memories or minor cues reminiscent of the trauma will cause them to experience strong, quick-to-surface emotions, supporting their belief that addressing trauma is dangerous and that they won't be able to handle the

Case Illustration: Jane

Jane, a newly hired female counselor, had a nephew who took his own life. The program that hired her was short of workers at the time; therefore, Jane did not have an opportunity to engage sufficiently in orientation outside of reviewing the policies and procedure manual. In an attempt to present well to her new employer and supervisor, she readily accepted client assignments without considering her recent loss. By not immersing herself in the program's perspective and policies on staff well-being, ethical and clinical considerations in client assignments, and how and when to seek supervision, Jane failed to engage in the practices, heavily supported by the agency, that promoted safety for herself and her clients. Subsequently, she felt emotionally overwhelmed at work and would often abruptly request psychiatric evaluation for clients who expressed any feelings of hopelessness out of sheer panic that they would attempt suicide.

emotions or thoughts that result from attempting to do so. Others readily view their experiences of trauma as being in the past; as a result, they engage in distraction, dissociation, and/or avoidance (as well as adaptation) due to a belief that trauma has little impact on their current lives and presenting problems. Even individuals who are quite aware of the impact that trauma has had on their lives may still struggle to translate or connect how these events continue to shape their choices, behaviors, and emotions. Many survivors draw no connection between trauma and their mental health or substance abuse problems, which makes it more difficult for them to see the value of trauma-informed or trauma-specific interventions, such as creating safety, engaging in psychoeducation, enhancing coping skills, and so forth.

As a trauma-informed provider, it is important that you help clients bridge the gap between their mental health and substance-related issues and the traumatic experiences they may have had. All too often, trauma occurs before substance use and mental disorders develop; then, such disorders and their associated symptoms and consequences create opportunities for additional traumatic events to occur. If individuals engage in mental health and substance abuse treatment without addressing the role that trauma has played in their lives, they are less likely to experience recovery in the long run. For example, a person with a history of trauma is more likely to have anxiety and depressive symptoms, use substances to self-medicate, and/or relapse after exposure to trauma-related cues. Thus, collaboration within and between behavioral health agencies is necessary to make integrated, timely, trauma-specific interventions available from the beginning to clients/consumers who engage in substance abuse and mental health services.

Support Control, Choice, and Autonomy

Not every client who has experienced trauma and is engaged in behavioral health services wants, or sees the need for, trauma-informed or trauma-specific treatment. Clients may think that they've already dealt with their trauma adequately, or they may believe that the effects of past trauma cause minimal distress for them. Other clients may voice the same sentiments, but without conviction—instead using avoidant behavior to deter distressing symptoms or reactions. Still others may struggle to see the role of trauma in their presenting challenges, not connecting their past traumatic experiences with other, more current difficulties (e.g., using substances to self-medicate strong emotions). Simply the idea of acknowledging trauma-related experiences and/or stress reactions may be too frightening or overwhelming for some clients, and others may fear that their reactions will be dismissed. On the other hand, some individuals want so much to dispense with their traumatic experiences and reactions that they hurriedly and repeatedly disclose their experiences before establishing a sufficiently safe environment or learning effective coping strategies to offset distress and other effects of retraumatization.

As these examples show, not everyone affected by trauma will approach trauma-informed services or recognize the impact of trauma in their lives in the same manner. This can be challenging to behavioral health service providers who are knowledgeable about the impact of trauma and who perceive the importance of addressing trauma and its effects with clients. As with knowing that different clients may be at different levels of awareness or stages of change in substance abuse treatment services, you should acknowledge that people affected by trauma

present an array of reactions, various levels of trauma awareness, and different degrees of urgency in their need to address trauma.

Appreciating clients' perception of their presenting problems and viewing their responses to the impact of trauma as adaptive—even when you believe their methods of dealing with trauma to be detrimental—are equally important elements of TIC. By taking the time to engage with clients and understand the ways they have perceived, adjusted to, and responded to traumatic experiences, providers are more likely to project the message that clients possess valuable personal expertise and knowledge about their own presenting problems. This shifts the viewpoint from "Providers know best" to the more collaborative "Together, we can find solutions."

How often have you heard from clients that they don't believe they can handle symptoms that emerge from reexperiencing traumatic cues or memories? Have you ever heard clients state that they can't trust themselves or their reactions, or that they never know when they are going to be triggered or how they are going to react? How confident would you feel about yourself if, at any time, a loud noise could initiate an immediate attempt to hide, duck, or dive behind something? Traumatic experiences have traditionally been described as exposure to events that cause intense fear, helplessness, horror, or feelings of loss of control. Participation in behavioral health services should not mirror these aspects of traumatic experience. Working collaboratively to facilitate clients' sense of control and to maximize clients' autonomy and choices throughout the treatment process, including treatment planning, is crucial in trauma-informed services.

For some individuals, gaining a sense of control and empowerment, along with understanding traumatic stress reactions, may be pivotal ingredients for recovery. By creating opportunities for empowerment, counselors and other behavioral health service providers help reinforce, clients' sense of competence, which is often eroded by trauma and prolonged traumatic stress reactions. Keep in mind that treatment strategies and procedures that prioritize client choice and control need not focus solely on major life decisions or treatment planning; you can apply such approaches to common tasks and everyday interactions between staff and consumers. Try asking your clients some of the following questions (which are only a sample of the types of questions that could be useful):

- What information would be helpful for us to know about what happened to you?
- Where/when would you like us to call you?
- How would you like to be addressed?
- Of the services I've described, which seem to match your present concerns and needs?
- From your experience, what responses from others appear to work best when you feel overwhelmed by your emotions?

Likewise, organizations need to reinforce the importance of staff autonomy, choice, and sense of control. What resources can staff members access, and what choices are available to them, in processing emotionally charged content or events in treatment? How often do administrators and supervisors seek out feedback on how to handle problematic situations (e.g., staff rotations for vacations, case consultations, changes in scheduling)? Think about the parallel between administration and staff members versus staff members and clients; often, the same philosophy, attitudes, and behaviors conveyed to staff members by administrative practices are mirrored in staff–client interactions. Simply stated, if staff members do not feel empowered, it will be a challenge for them to value the need for client empowerment. (For more information on administrative and workforce development issues, refer to Part 2, Chapters 1 and 2.)

Case Illustration: Mina

Mina initially sought counseling after her husband was admitted to an intensive outpatient drug and alcohol program. She was self-referred for low-grade depression, resentment toward her spouse, and codependency. When asked to define "codependency" and how the term applied to her, she responded that she always felt guilty and responsible for everyone in her family and for events that occurred even when she had little or no control over them.

After the intake and screening process, she expressed interest in attending group sessions that focused primarily on family issues and substance abuse, wherein her presenting concerns could be explored. In addition to describing dynamics and issues relating to substance abuse and its impact on her marriage, she referred to her low mood as frozen grief. During treatment, she reluctantly began to talk about an event that she described as life changing: the loss of her father. The story began to unfold in group; her father, who had been 62 years old, was driving her to visit a cousin. During the ride, he had a heart attack and drove off the road. As the car came to stop in a field, she remembered calling 911 and beginning cardiopulmonary resuscitation while waiting for the ambulance. She rode with the paramedics to the hospital, watching them work to save her father's life; however, he was pronounced dead soon after arrival.

She always felt that she never really said goodbye to her father. In group, she was asked what she would need to do or say to feel as if she had revisited that opportunity. She responded in quite a unique way, saying, "I can't really answer this question; the lighting isn't right for me to talk about my dad." The counselor encouraged her to adjust the lighting so that it felt "right" to her. Being invited to do so turned out to be pivotal in her ability to address her loss and to say goodbye to her father on her terms. She spent nearly 10 minutes moving the dimmer switch for the lighting as others in the group patiently waited for her to return to her chair. She then began to talk about what happened during the evening of her father's death, their relationship, the events leading up to that evening, what she had wanted to say to him at the hospital, and the things that she had been wanting to share with him since his death.

Weeks later, as the group was coming to a close, each member spoke about the most important experiences, tools, and insights that he or she had taken from participating. Mina disclosed that the group helped her establish boundaries and coping strategies within her marriage, but said that the event that made the most difference for her had been having the ability to adjust the lighting in the room. She explained that this had allowed her to control something over which she had been powerless during her father's death. To her, the lighting had seemed to stand out more than other details at the scene of the accident, during the ambulance ride, and at the hospital. She felt that the personal experience of losing her father and needing to be with him in the emergency room was marred by the obtrusiveness of staff, procedures, machines, and especially, the harsh lighting. She reflected that she now saw the lighting as a representation of this tragic event and the lack of privacy she had experienced when trying to say goodbye to her father. Mina stated that this moment in group had been the greatest gift: "…to be able to say my goodbyes the way I wanted… I was given an opportunity to have some control over a tragic event where I couldn't control the outcome no matter how hard I tried."

Create Collaborative Relationships and Participation Opportunities

This trauma-informed principle encompasses three main tenets. First, **ensure that the provider–client relationship is collaborative**, regardless of setting or service. Agency staff members cannot make decisions pertaining to interventions or involvement in community services autocratically; instead, they should develop trauma-informed, individualized care plans and/or treatment plans collaboratively with the client and, when appropriate, with family and caregivers. The nonauthoritarian approach that characterizes TIC views clients

as the experts in their own lives and current struggles, thereby emphasizing that clients and providers can learn from each other.

The second tenet is to **build collaboration beyond the provider–client relationship**. Building ongoing relationships across the service system, provider networks, and the local community enhances TIC continuity as clients move from one level of service to the next or when they are involved in multiple services at one time. It also allows you to learn about resources available to your clients in the service system or community and to connect with providers who have more advanced training in trauma-specific interventions and services.

The third tenet emphasizes the need to **ensure client/consumer representation and participation in behavioral health program development, planning, and evaluation as well as in the professional development of behavioral health workers**. To achieve trauma-informed competence in an organization or across systems, clients need to play an active role; this starts with providing program feedback. However, consumer involvement should not end there; rather, it should be encouraged throughout the implementation of trauma-informed services. So too, clients, potential clients, their families, and the community should be invited to participate in forming any behavioral health organization's plans to improve trauma-informed competence, provide TIC, and design relevant treatment services and organizational policies and procedures.

Trauma-informed principles and practices generated without the input of people affected by trauma are difficult to apply effectively. Likewise, staff trainings and presentations should include individuals who have felt the impact of trauma. Their participation reaches past the purely cognitive aspects of such education to offer a personal perspective on the strengths and resilience of people who have experienced trauma. The involvement of trauma survivors in behavioral health education lends a human face to subject matter that is all too easily made cerebral by some staff members in an attempt to avoid the emotionality of the topic.

Consumer participation also means giving clients/consumers the chance to obtain State training and certification, as well as employment in behavioral health settings as peer specialists. Programs that incorporate peer support services reinforce a powerful message—that provider–consumer partnership is important, and that consumers are valued. Peer support specialists are self-identified individuals who have progressed in their own recovery from alcohol dependence, drug addiction, and/or a mental disorder and work within behavioral health programs or at peer support centers to assist others with similar disorders and/or life experiences. Tasks and responsibilities may include leading a peer support group; modeling effective coping, help-seeking, and self-care strategies; helping clients practice new skills or monitor progress; promoting positive self-image to combat clients' potentially negative feelings about themselves and the discrimination they may perceive in the program or community; handling case management tasks; advocating for program changes; and representing a voice of hope that views recovery as possible.

Familiarize the Client With Trauma-Informed Services

Without thinking too much about it, you probably know the purpose of an intake process, the correct way to complete a screening device, the meaning of a lot of the jargon specific to behavioral health, and your program's expectations for client participation; in fact, maybe you're already involved in facilitating these processes in behavioral health services every day, and they've become almost

automatic for you. This can make it easy to forget that nearly everything clients and their families encounter in seeking behavioral health assistance is new to them. Thus, introducing clients to program services, activities, and interventions in a manner that *expects* them to be unfamiliar with these processes is essential, regardless of their clinical and treatment history. Beyond addressing the unfamiliarity of services, educating clients about each process—from first contact all the way through recovery services—gives them a chance to participate actively and make informed decisions across the continuum of care.

Familiarizing clients with trauma-informed services extends beyond explaining program services or treatment processes; it involves explaining the value and type of trauma-related questions that may be asked during an intake process, educating clients about trauma to help normalize traumatic stress reactions, and discussing trauma-specific interventions and other available services (including explanations of treatment methodologies and of the rationale behind specific interventions). Developmentally appropriate psychoeducation about trauma-informed services allows clients to be informed participants.

Incorporate Universal Routine Screenings for Trauma

Screening universally for client histories, experiences, and symptoms of trauma at intake can benefit clients and providers. Most providers know that clients can be affected by trauma, but universal screening provides a steady reminder to be watchful for past traumatic experiences and their potential influence upon a client's interactions and engagement with services across the continuum of care. Screening should guide treatment planning; it alerts the staff to potential issues and serves as a valuable tool to increase clients' awareness of the possible impact of trauma and the importance of addressing related issues during treatment.

Nonetheless, screenings are only as useful as the guidelines and processes established to address positive screens (which occur when clients respond to screening questions in a way that signifies possible trauma-related symptoms or histories). Staff should be trained to use screening tools consistently so that all clients are screened in the same way. Staff members also need to know how to score screenings and when specific variables (e.g., race/ethnicity, native language, gender, culture) may influence screening results. For example, a woman who has been sexually assaulted by a man may be wary of responding to questions if a male staff member or interpreter administers the screening or provides translation services. Likewise, a person in a current abusive or violent relationship may not acknowledge the interpersonal violence in fear of retaliation or as a result of disconnection or denial of his or her experience, and he or she may have difficulty in processing and then living between two worlds—what is acknowledged in treatment versus what is experienced at home.

In addition, staff training on using trauma-related screening tools needs to center on how and when to gather relevant information after the screening is complete. Organizational policies and procedures should guide staff members on how to respond to a positive screening, such as by making a referral for an indepth assessment of traumatic stress, providing the client with an introductory psychoeducational session on the typical biopsychosocial effects of trauma, and/or coordinating care so that the client gains access to trauma-specific services that meet his or her needs. Screening tool selection is an important ingredient in incorporating routine, universal screening practices into behavioral health services. Many screening tools are available, yet they differ in format

and in how they present questions. Select tools based not just on sound test properties, but also according to whether they encompass a broad range of experiences typically considered traumatic and are flexible enough to allow for an individual's own interpretation of traumatic events. For more information on screening and assessment of trauma and trauma-related symptoms and effects, see Chapter 4, "Screening and Assessment," in this TIP.

View Trauma Through a Sociocultural Lens

To understand how trauma affects an individual, family, or community, you must first understand life experiences and cultural background as key contextual elements for that trauma. As demonstrated in Exhibit 1.1-2, many factors shape traumatic experiences and individual and community responses to it; one of the most significant factors is culture. It influences the interpretation and meaning of traumatic events, individual beliefs regarding personal responsibility for the trauma and subsequent responses, and the meaning and acceptability of symptoms, support, and help-seeking behaviors. As this TIP proceeds to describe the differences among cultures pertaining to trauma, remember that there are numerous cross-cutting factors that can directly or indirectly influence the attitudes, beliefs, behaviors, resources, and opportunities within a given culture, subculture, or racial and/or ethnic group (Exhibit 1.1-4). For an indepth

Exhibit 1.1-4: Cross-Cutting Factors of Culture

Culture and Trauma

- Some populations and cultures are more likely than others to experience a traumatic event or a specific type of trauma.
- Rates of traumatic stress are high across all diverse populations and cultures that face military action and political violence.
- Culture influences not only whether certain events are perceived as traumatic, but also how an individual interprets and assigns meaning to the trauma.
- Some traumas may have greater impact on a given culture because those traumas represent something significant for that culture or disrupt cultural practices or ways of life.
- Culture determines acceptable responses to trauma and shapes the expression of distress. It significantly influences how people convey traumatic stress through behavior, emotions, and thinking immediately following a trauma and well after the traumatic experience has ceased.
- Traumatic stress symptoms vary according to the type of trauma within the culture.
- Culture affects what qualifies as a legitimate health concern and which symptoms warrant help.
- In addition to shaping beliefs about acceptable forms of help-seeking behavior and healing practices, culture can provide a source of strength, unique coping strategies, and specific resources.

exploration of these cross-cutting cultural factors, refer to the planned TIP, *Improving Cultural Competence* (SAMHSA, planned c).

When establishing TIC, it is vital that behavioral health systems, service providers, licensing agencies, and accrediting bodies build culturally responsive practices into their curricula, standards, policies and procedures, and credentialing processes. The implementation of culturally responsive practices will further guide the treatment planning process so that trauma-informed services are more appropriate and likely to succeed.

Use a Strengths-Focused Perspective: Promote Resilience

Fostering individual strengths is a key step in prevention when working with people who have been exposed to trauma. It is also an essential intervention strategy—one that builds on the individual's existing resources and views him or her as a resourceful, resilient survivor. Individuals who have experienced trauma develop many strategies and/or behaviors to adapt to its emotional, cognitive, spiritual, and physical consequences. Some behaviors may be effective across time, whereas others may eventually produce difficulties and disrupt the healing process. Traditionally, behavioral health services have tended to focus on presenting problems, risk factors, and symptoms in an attempt to prevent negative outcomes, provide relief, increase clients' level of functioning, and facilitate healing. However, focusing too much on these areas can undermine clients' sense of competence and hope. Targeting only presenting problems and symptoms does not provide individuals with an opportunity to see their own resourcefulness in managing very stressful and difficult experiences. It is important for providers to engage in interventions using a balanced approach that targets the strengths clients have

> "Trauma informed care recognizes symptoms as originating from adaptations to the traumatic event(s) or context. Validating resilience is important even when past coping behaviors are now causing problems. Understanding a symptom as an adaptation reduces a survivor's guilt and shame, increases their self esteem and provides a guideline for developing new skills and resources to allow new and better adaptation to the current situation."
>
> (Elliot et al., 2005, p. 467)

Advice to Counselors and Administrators: Using Strengths-Oriented Questions

Knowing a client's strengths can help you understand, redefine, and reframe the client's presenting problems and challenges. By focusing and building on an individual's strengths, counselors and other behavioral health professionals can shift the focus from "What is wrong with you?" to "What has worked for you?" It moves attention away from trauma-related problems and toward a perspective that honors and uses adaptive behaviors and strengths to move clients along in recovery.

Potential strengths-oriented questions include:

- The history that you provided suggests that you've accomplished a great deal since the trauma. What are some of the accomplishments that give you the most pride?
- What would you say are your strengths?
- How do you manage your stress today?
- What behaviors have helped you survive your traumatic experiences (during and afterward)?
- What are some of the creative ways that you deal with painful feelings?
- You have survived trauma. What characteristics have helped you manage these experiences and the challenges that they have created in your life?
- If we were to ask someone in your life, who knew your history and experience with trauma, to name two positive characteristics that help you survive, what would they be?
- What coping tools have you learned from your _____ (fill in: cultural history, spiritual practices, athletic pursuits, etc.)?
- Imagine for a moment that a group of people are standing behind you showing you support in some way. Who would be standing there? It doesn't matter how briefly or when they showed up in your life, or whether or not they are currently in your life or alive.
- How do you gain support today? (Possible answers include family, friends, activities, coaches, counselors, other supports, etc.)
- What does recovery look like for you?

developed to survive their experiences and to thrive in recovery. A strengths-based, resilience-minded approach lets trauma survivors begin to acknowledge and appreciate their fortitude and the behaviors that help them survive.

Foster Trauma-Resistant Skills

Trauma-informed services build a foundation on which individuals can begin to explore the role of trauma in their lives; such services can also help determine how best to address and tailor interventions to meet their needs. Prevention, mental health, and substance abuse treatment services should include teaching clients about how trauma can affect their lives; these services should also focus on developing self-care skills, coping strategies, supportive networks, and a sense of competence. Building trauma-resistant skills begins with normalizing the symptoms of traumatic stress and helping clients who have experienced trauma connect the dots between current problems and past trauma when appropriate.

Nevertheless, TIC and trauma-specific interventions that focus on skill-building should not do so at the expense of acknowledging individual strengths, creativity in adapting to trauma, and inherent attributes and tools clients possesses to combat the effects of trauma. Some theoretical models that use skill-building strategies base the value of this approach on a deficit perspective; they assume that some individuals lack the necessary tools to manage specific situations and, because of this deficiency, they encounter problems that others with effective skills would not experience. This type of perspective further assumes that, to recover, these individuals must learn new coping skills and behavior. TIC, on the other hand, makes the assumption that clients

Advice to Administrators: Self-Assessment for Trauma-Informed Systems

NCTIC has developed a self-assessment package for trauma-informed systems to help administrators structurally incorporate trauma into programs and services. The self-assessment can be used by systems of care to guide quality improvement with the goal of establishing fully trauma-informed treatment and recovery efforts (NCTIC, Center for Mental Health Services, 2007). Behavioral health treatment program administrators can use these materials and NCTIC as resources for improvement in delivering TIC.

are the experts in their own lives and have learned to adapt and acquire skills to survive. The TIC approach honors each individual's adaptations and acquired skills, and it helps clients explore how these may not be working as well as they had in the past and how their current repertoire of responses may not be as effective as other strategies.

Demonstrate Organizational and Administrative Commitment to TIC

Becoming a trauma-informed organization requires administrative guidance and support across all levels of an agency. Behavioral health staff will not likely sustain TIC practices without the organization's ongoing commitment to support professional development and to allocate resources that promote these practices. An agency that wishes to commit to TIC will benefit from an organizational assessment of how staff members identify and manage trauma and trauma-related reactions in their clients. Are they trauma aware—do they recognize that trauma can significantly affect a client's ability to function in one or more areas of his or her life? Do the staff members understand that traumatic experiences and trauma-related reactions can greatly influence clients' engagement, participation, and response to services?

Agencies need to embrace specific strategies across each level of the organization to create trauma-informed services; this begins with staff education on the impact of trauma among clients. Other agency strategies that reflect a trauma-informed infrastructure include, but are not limited to:

- Universal screening and assessment procedures for trauma.
- Interagency and intra-agency collaboration to secure trauma-specific services.
- Referral agreements and networks to match clients' needs.
- Mission and value statements endorsing the importance of trauma recognition.
- Consumer- and community-supported committees and trauma response teams.
- Workforce development strategies, including hiring practices.
- Professional development plans, including staff training/supervision focused on TIC.
- Program policies and procedures that ensure trauma recognition and secure trauma-informed practices, trauma-specific services, and prevention of retraumatization.

TIC requires organizational commitment, and often, cultural change. For more information on implementing TIC in organizations, see Part 2, Chapter 1 of this TIP.

Develop Strategies To Address Secondary Trauma and Promote Self-Care

Secondary trauma is a normal occupational hazard for mental health and substance abuse professionals, particularly those who serve populations that are likely to include survivors of trauma (Figley, 1995; Klinic Community Health Centre, 2008). Behavioral health staff members who experience secondary trauma present a range of traumatic stress reactions

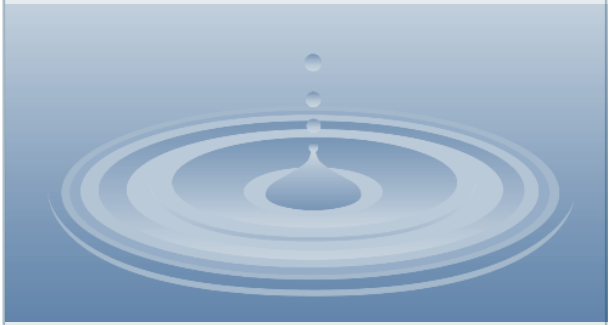
and effects from providing services focused on trauma or listening to clients recount traumatic experiences. So too, when a counselor has a history of personal trauma, working with trauma survivors may evoke memories of the counselor's own trauma history, which may increase the potential for secondary traumatization.

The range of reactions that manifest with secondary trauma can be, but are not necessarily, similar to the reactions presented by clients who have experienced primary trauma. Symptoms of secondary trauma can produce varying levels of difficulty, impairment, or distress in daily functioning; these may or may not meet diagnostic thresholds for acute stress, posttraumatic stress, or adjustment, anxiety, or mood disorders (Bober & Regehr, 2006). Symptoms may include physical or psychological reactions to traumatic memories clients have shared; avoidance behaviors during client interactions or when recalling emotional content in supervision; numbness, limited emotional expression, or diminished affect; somatic complaints; heightened arousal, including insomnia; negative thinking or depressed mood; and detachment from family, friends, and other supports (Maschi & Brown, 2010).

Working daily with individuals who have been traumatized can be a burden for counselors and other behavioral health service providers, but all too often, they blame the symptoms resulting from that burden on other stressors at work or at home. Only in the past 2 decades have literature and trainings begun paying attention to secondary trauma or compassion fatigue; even so, agencies often do not translate this knowledge into routine prevention practices. Counselors and other staff members may find it difficult to engage in activities that could ward off secondary trauma due to time constraints, workload, lack of agency resources, and/or an organizational culture that disapproves of help-seeking or provides inadequate staff support. The demands of providing care to trauma survivors cannot be ignored, lest the provider become increasingly impaired and less effective. Counselors with unacknowledged secondary trauma can cause harm to clients via poorly enforced boundaries, missed appointments, or even abandonment of clients and their needs (Pearlman & Saakvitne, 1995).

Essential components of TIC include organizational and personal strategies to address

The Impact of Trauma



Trauma is similar to a rock hitting the water's surface. The impact first creates the largest wave, which is followed by ever-expanding, but less intense, ripples. Likewise, the influence of a given trauma can be broad, but generally, its effects are less intense for individuals further removed from the trauma; eventually, its impact dissipates all around. For trauma survivors, the impact of trauma can be far-reaching and can affect life areas and relationships long after the trauma occurred. This analogy can also broadly describe the recovery process for individuals who have experienced trauma and for those who have the privilege of hearing their stories. As survivors reveal their trauma-related experiences and struggles to a counselor or another caregiver, the trauma becomes a shared experience, although it is not likely to be as intense for the caregiver as it was for the individual who experienced the trauma. The caregiver may hold onto the trauma's known and unknown effects or may consciously decide to engage in behaviors that provide support to further dissipate the impact of this trauma and the risk of secondary trauma.

Advice to Counselors: Decreasing the Risk of Secondary Trauma and Promoting Self-Care

- **Peer support.** Maintaining adequate social support will help prevent isolation and depression.
- **Supervision and consultation.** Seeking professional support will enable you to understand your own responses to clients and to work with them more effectively.
- **Training.** Ongoing professional training can improve your belief in your abilities to assist clients in their recoveries.
- **Personal therapy.** Obtaining treatment can help you manage specific problems and become better able to provide good treatment to your clients.
- **Maintaining balance.** A healthy, balanced lifestyle can make you more resilient in managing any difficult circumstances you may face.
  Setting clear limits and boundaries with clients. Clearly separating your personal and work life allows time to rejuvenate from stresses inherent in being a professional caregiver.

secondary trauma and its physical, cognitive, emotional, and spiritual consequences. In agencies and among individual providers, it is key for the culture to promote acceptability, accessibility, and accountability in seeking help, accessing support and supervision, and engaging in self-care behaviors in and outside of the agency or office. Agencies should involve staff members who work with trauma in developing informal and formal agency practices and procedures to prevent or address secondary trauma. Even though a number of community-based agencies face fiscal constraints, prevention strategies for secondary trauma can be intertwined with the current infrastructure (e.g., staff meetings, education, case consultations and group case discussions, group support, debriefing sessions as appropriate, supervision). For more information on strategies to address and prevent secondary trauma, see Part 2, Chapter 2 of this TIP.

Provide Hope—Recovery Is Possible

What defines recovery from trauma-related symptoms and traumatic stress disorders? Is it the total absence of symptoms or consequences? Does it mean that clients stop having nightmares or being reminded, by cues, of past trauma? When clients who have experienced trauma enter into a helping relationship to address trauma specifically, they are often looking for a cure, a remission of symptoms, or relief from the pain as quickly as possible. However, they often possess a history of unpredictable symptoms and symptom intensity that reinforces an underlying belief that recovery is not possible. On one hand, clients are looking for a message that they can be cured, while on the other hand, they have serious doubts about the likely success of any intervention.

Clients often express ambivalence about dealing with trauma even if they are fully aware of trauma's effects on their lives. The idea of living with more discomfort as they address the past or as they experiment with alternative ways of dealing with trauma-related symptoms or consequences is not an appealing prospect, and it typically elicits fear. Clients may interpret the uncomfortable feelings as dangerous or unsafe even in an environment and relationship that is safe and supportive.

How do you promote hope and relay a message that recovery is possible? First, maintain consistency in delivering services, promoting and providing safety for clients, and showing respect and compassion within the client–provider relationship. Along with clients' commitment to learning how to create safety for themselves, counselors and agencies need

to be aware of, and circumvent, practices that could retraumatize clients. Projecting hope and reinforcing the belief that recovery is possible extends well beyond the practice of establishing safety; it also encompasses discussing what recovery means and how it looks to clients, as well as identifying how they will know that they've entered into recovery in earnest.

Providing hope involves projecting an attitude that recovery is possible. This attitude also involves viewing clients as competent to make changes that will allow them to deal with trauma-related challenges, providing opportunities for them to practice dealing with difficult situations, and normalizing discomfort or difficult emotions and framing these as manageable rather than dangerous. If you convey this attitude consistently to your clients, they will begin to understand that discomfort is not a signal to avoid, but a sign to engage—and that behavioral, cognitive, and emotional responses to cues associated with previous traumas are a normal part of the recovery process. It's not the absence of responses to such triggers that mark recovery, but rather, how clients experience and manage those responses. Clients can also benefit from interacting with others who are further along in their recovery from trauma. Time spent with peer support staff or sharing stories with other trauma survivors who are well on their way to recovery is invaluable—it sends a powerful message that recovery is achievable, that there is no shame in being a trauma survivor, and that there is a future beyond the trauma.

As You Proceed

This chapter has established the foundation and rationale of this TIP, reviewed trauma-informed concepts and terminology, and provided an overview of TIC principles and a guiding framework for this text. As you proceed, be aware of the wide-ranging responses to trauma that occur not only across racially and ethnically diverse groups but also within specific communities, families, and individuals. Counselors, prevention specialists, other behavioral health workers, supervisors, and organizations all need to develop skills to create an environment that is responsive to the unique attributes and experiences of each client. As you read this TIP, remember that many cross-cutting factors influence the experiences, help-seeking behaviors, intervention responses, and outcomes of individuals, families, and populations who have survived trauma. Single, multiple, or chronic exposures to traumatic events, as well as the emotional, cognitive, behavioral, and spiritual responses to trauma, need to be understood within a social-ecological framework that recognizes the many ingredients prior to, during, and after traumatic experiences that set the stage for recovery.

2 Trauma Awareness

IN THIS CHAPTER

- Types of Trauma
- Characteristics of Trauma
- Individual and Sociocultural Features

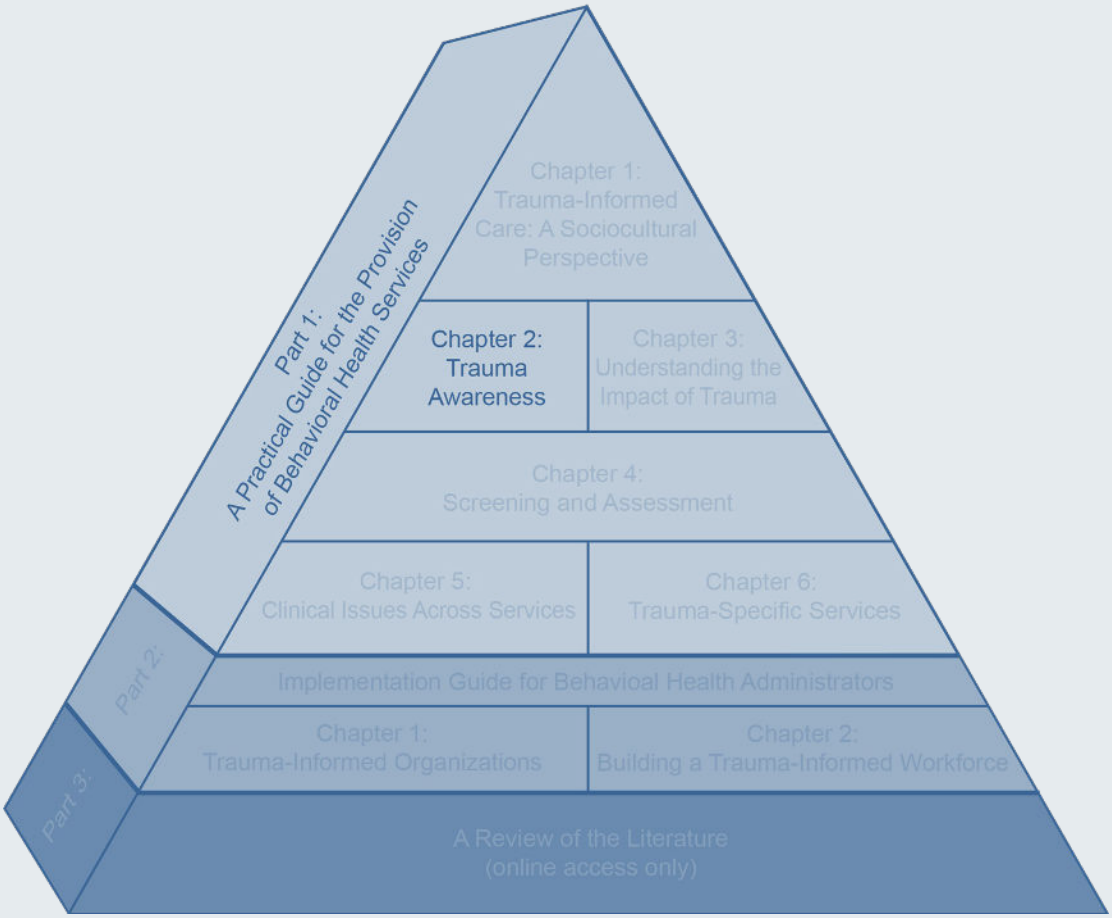
Traumatic experiences typically do not result in long-term impairment for most individuals. It is normal to experience such events across the lifespan; often, individuals, families, and communities respond to them with resilience. This chapter explores several main elements that influence why people respond differently to trauma. Using the social-ecological model outlined in Part 1, Chapter 1, this chapter explores some of the contextual and systemic dynamics that influence individual and community perceptions of trauma and its impact. The three main foci are: types of trauma, objective and subjective characteristics of trauma, and individual and sociocultural features that serve as risk or protective factors.

This chapter's main objective is to highlight the key characteristics of traumatic experiences. Trauma-informed behavioral health service providers understand that many influences shape the effects of trauma among individuals and communities—it is not just the event that determines the outcome, but also the event's context and the resultant interactions across systems.

Types of Trauma

The following section reviews various forms and types of trauma. It does not cover every conceivable trauma that an individual, group, or community may encounter. Specific traumas are reviewed only once, even when they could fit in multiple categories of trauma. Additionally, the order of appearance does not denote a specific trauma's importance or prevalence, and there is no lack of relevance implied if a given trauma is not specifically addressed in this Treatment Improvement Protocol (TIP). The intent is to give a broad perspective of the various categories and types of trauma to behavioral health workers who wish to be trauma informed.

TIC Framework in Behavioral Health Services—Trauma Awareness



Natural or Human-Caused Traumas

The classification of a trauma as natural or caused by humans can have a significant impact on the ways people react to it and on the types of assistance mobilized in its aftermath (see Exhibit 1.2-1 for trauma examples). Natural traumatic experiences can directly affect a small number of people, such as a tree falling on a car during a rainstorm, or many people and communities, as with a hurricane. Natural events, often referred to as "acts of God," are typically unavoidable. Human-caused traumas are caused by human failure (e.g., technological catastrophes, accidents, malevolence) or by human design (e.g., war). Although multiple factors contribute to the severity of a natural or human-caused trauma, traumas perceived as intentionally harmful often make the event more traumatic for people and communities.

For information on resources to prepare States, Territories, and local entities to deliver effective mental health and substance abuse responses during disasters, contact the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Disaster Technical Assistance Center:

4350 East West Hwy, Suite 1100
Bethesda, MD 20814 6233
Phone: 1 800 308 3515
Fax: 1 800 311 7691
Email: DTAC@samhsa.hhs.gov

Exhibit 1.2-1: Trauma Examples

Caused Naturally	Caused by People	
	Accidents, Technological Catastrophes	Intentional Acts
Tornado	Train derailment	Arson
Lightning strike	Roofing fall	Terrorism
Wildfire	Structural collapse	Sexual assault and abuse
Avalanche	Mountaineering accident	Homicides or suicides
Physical ailment or disease	Aircraft crash	Mob violence or rioting
Fallen tree	Car accident due to malfunction	Physical abuse and neglect
Earthquake	Mine collapse or fire	Stabbing or shooting
Dust storm	Radiation leak	Warfare
Volcanic eruption	Crane collapse	Domestic violence
Blizzard	Gas explosion	Poisoned water supply
Hurricane	Electrocution	Human trafficking
Cyclone	Machinery-related accident	School violence
Typhoon	Oil spill	Torture
Meteorite	Maritime accident	Home invasion
Flood	Accidental gun shooting	Bank robbery
Tsunami	Sports-related death	Genocide
Epidemic		Medical or food tampering
Famine		
Landslide or fallen boulder		

How survivors of natural trauma respond to the experience often depends on the degree of devastation, the extent of individual and community losses, and the amount of time it takes to reestablish daily routines, activities, and services (e.g., returning to school or work, being able to do laundry, having products to buy in a local store). The amount, accessibility, and duration of relief services can significantly influence the duration of traumatic stress reactions as well as the recovery process.

Alongside the disruption of daily routines, the presence of community members or outsiders in affected areas may add significant stress or create traumatic experiences in and of themselves. Examples include the threat of others stealing what remains of personal property, restrictions on travel or access to property or living quarters, disruption of privacy within shelters, media attention, and subsequent exposure to repetitive images reflecting the devastation. Therefore, it isn't just the natural disaster or event that can challenge an individual or community; often, the consequences of the event and behavioral responses from others within and outside the community play a role in pushing survivors away from effective coping or toward resilience and recovery.

Human-caused traumas are fundamentally different from natural disasters. They are either intentional, such as a convenience store robbery at gunpoint, or unintentional, such as the technological accident of a bridge collapse (as occurred in Minneapolis, Minnesota, in 2007; U.S. Fire Administration, 2007). The subsequent reactions to these traumas often depend on their intentionality. However, a person or group of people is typically the target of the survivors' anger and blame. Survivors of an unintentionally human-caused traumatic event may feel angry and frustrated because of the lack of protection or care offered by the responsible party or government, particularly if there has been a perceived act of omission. After intentional human-caused acts, survivors often struggle to understand the

Case Illustrations: Quecreek Mine Flood and Greensburg's Tornado

Quecreek Mine Flood

The year following the rescue of nine miners from the Quecreek mine in western Pennsylvania in 2002 was a difficult one for residents of Somerset County. The dazzle of publicity surrounding a handful of workers from a small town, tension between miners and rescuers, and animosity over money for movie and book deals, in addition to the trauma itself, resulted in a rescuer's suicide, a number of miners having trauma-related symptoms, and several rescuers needing to seek treatment for posttraumatic stress disorder (PTSD; Goodell, 2003).

Greensburg's Tornado

Greensburg, a small town in southern Kansas, was hit by a large tornado in 2007 that killed 11 residents and leveled 95 percent of the town while causing severe damage to the remaining 5 percent. Families and community members experienced significant grief and traumatic stress after the disaster. Yet today, Greensburg is rebuilding with a focus on being "green"—that is, environmentally responsible—from design to construction and all the way through demolition. This town has the highest number of Leadership in Energy and Environmental Design–certified buildings in the world. A reality television show about the town's reinvention ran for three seasons, demonstrating the town's residents and business owners working with local government and various corporations to make their home an even better place than it was before the tornado.

motives for performing the act, the calculated or random nature of the act, and the psychological makeup of the perpetrator(s).

Individual, Group, Community, and Mass Traumas

In recognizing the role of trauma and understanding responses to it, consider whether the trauma primarily affected an individual and perhaps his or her family (e.g., automobile accident, sexual or physical assault, severe illness); occurred within the context of a group (e.g., trauma experienced by first responders or those who have seen military combat) or community (e.g., gang-related shootings); transpired within a certain culture; or was a large-scale disaster (e.g., hurricane, terrorist attack). This context can have significant implications for whether (and how) people experience shame as a result of the trauma, the kinds of support and compassion they receive, whether their experiences are normalized or diminished by others, and even the kinds of services they are offered to help them recover and cope.

Individual trauma

An individual trauma refers to an event that only occurs to one person. It can be a single event (e.g., mugging, rape, physical attack, work-related physical injury) or multiple or prolonged events (e.g., a life-threatening illness, multiple sexual assaults). Although the trauma directly affects just one individual, others who know the person and/or are aware of the trauma will likely experience emotional repercussions from the event(s) as well, such as recounting what they said to the person before the event, reacting in disbelief, or thinking that it could just as easily have happened to them, too.

Survivors of individual trauma may not receive the environmental support and concern that members of collectively traumatized groups and communities receive. They are less likely to reveal their traumas or to receive validation of their experiences. Often, shame distorts their perception of responsibility for the trauma. Some survivors of individual traumas, especially those who have kept the trauma secret, may not receive needed comfort and

Advice to Counselors: Working With Clients Who Have Experienced Individual Traumas

In working with clients who have histories of individual trauma, counselors should consider that:

- Empathy, or putting oneself in the shoes of another, is more potent than sympathy (expressing a feeling of sorrow for another person).
- Some clients need to briefly describe the trauma(s) they have experienced, particularly in the early stages of recovery. Strategies that focus on reexperiencing the trauma, retrieving feelings related to the trauma, and bringing past experiences to the forefront should only be implemented if trauma-specific treatment planning and services are available.
- Understanding the trauma, especially in early recovery, should begin with educating the client about and normalizing trauma-related symptoms, creating a sense of safety within the treatment environment, and addressing how trauma symptoms may interfere with the client's life in the present.
- It is helpful to examine how the trauma affects opportunities to receive substance abuse and/or mental health treatment as well as treatment for and recovery from the trauma itself (e.g., by limiting one's willingness to share in or participate in group counseling).
- Identifying and exploring strengths in the client's history can help the client apply those strengths to his or her ability to function in the present.

acceptance from others; they are also are more likely to struggle with issues of causation (e.g., a young woman may feel unduly responsible for a sexual assault), to feel isolated by the trauma, and to experience repeated trauma that makes them feel victimized.

Physical injuries

Physical injuries are among the most prevalent individual traumas. Millions of emergency room (ER) visits each year relate directly to physical injuries. Most trauma patients are relatively young; about 70 percent of injury-related ER cases are people younger than 45 years old (McCaig & Burt, 2005). Dedicated ER hospital units, known as "trauma centers," specialize in physical traumas such as gunshot wounds, stabbings, and other immediate physical injuries. The term "trauma" in relation to ERs does not refer to psychological trauma, which is the focus of this TIP, yet physical injuries can be associated with psychological trauma. Sudden, unexpected, adverse health-related events can lead to extensive psychological trauma for patients and their families.

Excessive alcohol use is the leading risk factor for physical injuries; it's also the most promising target for injury prevention. Studies consistently connect injuries and substance use (Gentilello, Ebel, Wickizer, Salkever, & Rivara, 2005); nearly 50 percent of patients admitted to trauma centers have injuries attributable to alcohol abuse and dependence (Gentilello et al., 1999). One study found that two thirds of ambulatory assault victims presenting to an ER had positive substance use urinalysis results; more than half of all victims had PTSD 3 months later (Roy-Byrne et al.,

Acute stress disorder (ASD) prevalence among patients at medical trauma centers is very high, making trauma related disorders some of the most common complications seen in physically injured patients. Clients who have sustained serious injuries in car crashes, fires, stabbings, shootings, falls, and other events have an increased likelihood of developing trauma related mental disorders. Research suggests that PTSD and/or problem drinking is evident in nearly 50 percent of patients 1 year after discharge from trauma surgical units.

(Zatzick, Jurkovich, Gentilello, Wisner, & Rivara, 2002)

2004). Nearly 28 percent of patients whose drinking was identified as problematic during an ER visit for a physical injury will have a new injury within 1 year (Gentilello et al., 2005). For further information, see TIP 16, *Alcohol and Other Drug Screening of Hospitalized Trauma Patients* (Center for Substance Abuse Treatment [CSAT], 1995a).

Group trauma

The term "group trauma" refers to traumatic experiences that affect a particular group of people. This TIP intentionally distinguishes group trauma from mass trauma to highlight the unique experiences and characteristics of trauma-related reactions among small groups. These groups often share a common identity and history, as well as similar activities and concerns. They include vocational groups who specialize in managing traumas or who routinely place themselves in harm's way—for example, first responders, a group including police and emergency medical personnel. Some examples of group trauma include crews and their families who lose members from a commercial fishing accident, a gang whose members experience multiple deaths and injuries, teams of firefighters who lose members in a roof collapse, responders who attempt to save flood victims, and military service members in a specific theater of operation.

Survivors of group trauma can have different experiences and responses than survivors of individual or mass traumas. Survivors of group trauma, such as military service members and first responders, are likely to experience repeated trauma. They tend to keep the trauma experiences within the group, feeling that others outside the group will not understand; group outsiders are generally viewed as intruders. Members may encourage others in the group to shut down emotionally and repress their traumatic experiences—and there are some occupational roles that necessitate the repression of reactions to complete a mission or to be attentive to the needs at hand. Group members may not want to seek help and may discourage others from doing so out of fear that it may shame the entire group. In this environment, members may see it as a violation of group confidentiality when a member seeks assistance outside the group, such as by going to a counselor.

Group members who have had traumatic experiences in the past may not actively support traumatized colleagues for fear that acknowledging the trauma will increase the risk of repressed trauma-related emotions surfacing. However, groups with adequate resources for helping group members can develop a stronger and more supportive environment for handling subsequent traumas. These main group features influence the course of short- and long-term adjustments, including the development of traumatic stress symptoms associated with mental and substance use disorders.

Certain occupational groups are at greater risk of experiencing trauma—particularly multiple traumas. This TIP briefly reviews two main groups as examples in the following sections: first responders and military service members. For more detailed information on the impact of trauma and deployment, refer to the planned TIP, *Reintegration-Related Behavioral Health Issues in Veterans and Military Families* (SAMHSA, planned f).

First responders

First responders are usually emergency medical technicians, disaster management personnel, police officers, rescue workers, medical and behavioral health professionals, journalists, and volunteers from various backgrounds. They also include lifeguards, military personnel, and clergy. Stressors associated with the kinds of traumatic events and/or disasters first responders are likely to experience include

exposure to toxic agents, feeling responsible for the lives of others, witnessing catastrophic devastation, potential exposure to gruesome images, observing human and animal suffering and/or death, working beyond physical exhaustion, and the external and internal pressure of working against the clock.

Military service members

Military personnel are likely to experience numerous stressors associated with trauma. Service members who have repeatedly deployed to a war zone are at a greater risk for traumatic stress reactions (also known as combat stress reaction or traumatic stress injury), other military personnel who provide support services are also at risk for traumatic stress and secondary trauma (refer to the glossary portion of the "How This TIP Is Organized" section that precedes Part 1, Chapter 1, of this TIP). So too, service members who anticipate deployment or redeployment may exhibit psychological symptoms associated with traumatic stress. Some stressors that military service members may encounter include working while physically exhausted, exposure to gunfire, seeing or knowing someone who has been injured or killed, traveling in areas known for roadside bombs and rockets, extended hypervigilance, fear of being struck by an improvised explosive device, and so forth.

Trauma affecting communities and cultures

Trauma that affects communities and cultures covers a broad range of violence and atrocities that erode the sense of safety within a given community, including neighborhoods, schools, towns, and reservations. It may involve violence in the form of physical or sexual assaults, hate crimes, robberies, workplace or gang-related violence, threats, shootings, or stabbings—for example, the school shooting at Virginia Polytechnic Institute and State University in 2007. It also includes actions that attempt to dismantle systemic cultural practices, resources, and identities, such as making boarding school attendance mandatory for Native American children or placing them in non-Native foster homes. Cultural and/or community-based trauma can also occur via indifference or limited responsiveness to specific communities or cultures that are facing a potential catastrophe. Cultural traumas are events that, whether intentionally or not, erode the heritage of a culture—as with prejudice, disenfranchisement, and health inequities (e.g., late prenatal care, inability to afford medications, limited access to culturally appropriate health education, vicinity and quality of affordable medical services), among other examples.

"The excitement of the season had just begun, and then, we heard the news, oil in the water, lots of oil killing lots of water. It is too shocking to understand. Never in the millennium of our tradition have we thought it possible for the water to die, but it is true."

—Chief Walter Meganack, Port Graham, 1989

Of all the groups negatively affected by the Exxon Valdez oil spill, in many ways Alaska Natives were the most devastated. The oil spill destroyed more than economic resources; it shook the core cultural foundation of Native life. Alaska Native subsistence culture is based on an intimate relationship with the environment. Not only does the environment have sacred qualities for Alaska Natives; their survival also depends on the well-being of the ecosystem and the maintenance of cultural norms of subsistence. The spill directly threatened the well-being of the environment, disrupted subsistence behavior, and severely disturbed the sociocultural milieu of Alaska Natives.

Source: Gill & Picou, 1997, pp. 167–168.

Historical trauma

Historical trauma, known also as generational trauma, refers to events that are so widespread as to affect an entire culture; such events also have effects intense enough to influence generations of the culture beyond those who experienced them directly. The enslavement, torture, and lynching of African Americans; the forced assimilation and relocation of American Indians onto reservations; the extermination of millions of Jews and others in Europe during World War II; and the genocidal policies of the Hutus in Rwanda and the Khmer Rouge in Cambodia are examples of historical trauma.

In the past 50 years, research has explored the generational effects of the Holocaust upon survivors and their families. More recent literature has extended the concept of historical or generational trauma to the traumatic experiences of Native Americans. Reduced population, forced relocation, and acculturation are some examples of traumatic experiences that Native people have endured across centuries, beginning with the first European presence in the Americas. These tragic experiences have led to significant loss of cultural identity across generations and have had a significant impact on the well-being of Native communities (Whitbeck, Chen, Hoyt, & Adams, 2004). Data are limited on the association of mental and substance use disorders with historical trauma among Native people, but literature suggests that historical trauma has repercussions across generations, such as depression, grief, traumatic stress, domestic violence, and substance abuse, as well as significant loss of cultural knowledge, language, and identity (Gone, 2009). Historical trauma can increase the vulnerability of multiple generations to the effects of traumas that occur in their own lifetimes.

Mass trauma

Mass traumas or disasters affect large numbers of people either directly or indirectly. It is beyond the scope of this TIP to cover any specific disaster in detail; note, however, that mass traumas include large-scale natural and human-caused disasters (including intentional acts and accidents alike). Mass traumas may involve significant loss of property and lives as well as the widespread disruption of normal routines and services. Responding to such traumas often requires immediate and extensive resources that typically exceed the capacity of the affected communities, States, or countries in which they occur. Recent examples of such large-scale catastrophes include:

- In January 2010, a massive earthquake hit Haiti, killing hundreds of thousands of people and leaving over a million homeless.
- A nuclear reactor meltdown in the Ukraine in 1986 resulted in a technological and environmental disaster that affected tens of millions of people.
- The tsunami in the Indian Ocean in 2005 left hundreds of thousands dead in nine countries.

One factor that influences an individual's response to trauma is his or her ability to process one trauma before another trauma occurs. In mass traumas, the initial event causes considerable destruction, the consequences of which may spawn additional traumas and other stressful events that lead to more difficulties and greater need for adjustments among survivors, first responders, and disaster relief agencies. Often, a chain reaction occurs. Take, for example, Hurricane Katrina and its impact on the people of Louisiana and other coastal States. After the initial flooding, people struggled to obtain basic needs, including food, drinking water, safe shelter, clothing, medicines, personal hygiene items, and so forth, all as concern mounted about the safety of children and

other relatives, friends, and neighbors. In this and similar cases, the destruction from the initial flooding led to mass displacement of families and communities; many people had to relocate far from New Orleans and other badly affected areas, while also needing to gain financial assistance, reinitiate work to generate income, and obtain stable housing. People could not assimilate one stressor before another appeared.

Nevertheless, mass traumas can create an immediate sense of commonality—many people are "in the same boat," thus removing much of the isolation that can occur with other types of trauma. People can acknowledge their difficulties and receive support, even from strangers. It is easier to ask for help because blame is often externalized; large-scale disasters are often referred to as "acts of God" or, in cases of terrorism and other intentional events, as acts of "evil." Even so, survivors of mass trauma often encounter an initial rally of support followed by quickly diminishing services and dwindling care. When the disaster fades from the headlines, public attention and concern are likely to decrease, leaving survivors struggling to reestablish or reinvent their lives without much outside acknowledgment.

The experience of mass trauma can lead to the development of psychological symptoms and substance use at either a subclinical or a diagnostic level (refer to Part 3 of this TIP, available online, for more information highlighting the relationship between trauma and behavioral health problems). Likewise, one of the greatest risks for traumatic stress reactions after a mass tragedy is the presence of preexisting mental and co-occurring disorders, and individuals who are in early recovery from substance use disorders are at greater risk for such reactions as well. Nonetheless, people are amazingly resilient, and most will not develop long-term mental or substance use disorders after an event; in fact, most trauma-related symptoms will resolve in a matter of months (Keane & Piwowarczyk, 2006).

Interpersonal Traumas

Interpersonal traumas are events that occur (and typically continue to reoccur) between people who often know each other, such as spouses or parents and their children. Examples include physical and sexual abuse, sexual assault, domestic violence, and elder abuse.

Intimate partner violence

Intimate partner violence (IPV), often referred to as domestic violence, is a pattern of actual or threatened physical, sexual, and/or emotional abuse. It differs from simple assault in that multiple episodes often occur and the perpetrator is an intimate partner of the victim. Trauma associated with IPV is normally ongoing. Incidents of this form of violence are rarely isolated, and the client may still be in contact with and encountering abuse from the perpetrator while engaged in treatment.

Intimate partners include current and former spouses, boyfriends, and girlfriends. The majority of all nonfatal acts of violence and intimate partner homicides are committed against women; IPV accounts for over 20 percent of nonfatal violence against women but only 3.6 percent of that committed against men (Catalano, 2012). Children are the hidden casualties of IPV. They often witness the assaults or threats directly, within earshot, or by being exposed to the aftermath of the violence (e.g., seeing bruises and destruction of property, hearing the pleas for it to stop or the promises that it will never happen again).

Substance abuse, particularly involving alcohol, is frequently associated with IPV. It is the presence of alcohol-related problems in either partner, rather than the level of alcohol consumption itself, that is the important factor.

Drinking may or may not be the cause of the violence; that said, couples with alcohol-related disorders could have more tension and disagreement within the relationship in general, which leads to aggression and violence. The consumption of alcohol during a dispute is likely to decrease inhibitions and increase impulsivity, thus creating an opportunity for an argument to escalate into a physical altercation. More information on domestic violence and its effects on partners and families, as well as its connection with substance use and trauma-related disorders, is available in TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT, 1997b), and from the National Online Resource Center on Violence Against Women (http://www.vawnet.org/).

Developmental Traumas

Developmental traumas include specific events or experiences that occur within a given developmental stage and influence later development, adjustment, and physical and mental health. Often, these traumas are related to adverse childhood experiences (ACEs), but they can also result from tragedies that occur outside an expected developmental or life stage (e.g., a child dying before a parent, being diagnosed with a life-threatening illness as a young adult) or from events at any point in the life cycle that create significant loss and have life-altering consequences (e.g., the death of a significant other in the later years that leads to displacement of the surviving partner).

Adverse childhood experiences

Some people experience trauma at a young age through sexual, physical, or emotional abuse and neglect. The Adverse Childhood Experiences Study (Felitti et al., 1998) examined the effects of several categories of ACEs on adult health, including physical and emotional abuse; sexual abuse; a substance-dependent parent; an incarcerated, mentally ill, or suicidal household member; spousal abuse between parents; and divorce or separation that meant one parent was absent during childhood. The National Comorbidity Studies examined the prevalence of trauma and defined childhood adversities as parental death, parental divorce/separation, life-threatening illness, or extreme economic hardship in addition to the childhood experiences included in the Adverse Childhood Experiences Study (Green et al., 2010).

ACEs can negatively affect a person's well-being into adulthood. Whether or not these experiences occur simultaneously, are time-limited, or recur, they set the stage for increased vulnerability to physical, mental, and substance use disorders and enhance the risk

Child Neglect

Child neglect occurs when a parent or caregiver does not give a child the care he or she needs according to his or her age, even though that adult can afford to give that care or is offered help to give that care. Neglect can mean not providing adequate nutrition, clothing, and/or shelter. It can mean that a parent or caregiver is not providing a child with medical or mental health treatment or is not giving prescribed medicines the child needs. Neglect can also mean neglecting the child's education. Keeping a child from school or from special education can be neglect. Neglect also includes exposing a child to dangerous environments (e.g., exposure to domestic violence). It can mean poor supervision for a child, including putting the child in the care of someone incapable of caring for children. It can mean abandoning a child or expelling him or her from home. Lack of psychological care, including emotional support, attention, or love, is also considered neglect—and it is the most common form of abuse reported to child welfare authorities.

Source: dePanfilis, 2006.

for repeated trauma exposure across the life span. Childhood abuse is highly associated with major depression, suicidal thoughts, PTSD, and dissociative symptoms. So too, ACEs are associated with a greater risk of adult alcohol use. When a person experiences several adverse events in childhood, the risk of his or her heavy drinking, self-reported alcohol dependence, and marrying a person who is alcohol dependent is two to four times greater than that of a person with no ACEs (Dube, Anda, Felitti, Edwards, & Croft, 2002).

A detailed examination of the issues involved in providing substance abuse treatment to survivors of child abuse and neglect is the subject of TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT, 2000b).

Political Terror and War

Political terror and war are likely to have lasting consequences for survivors. In essence, anything that threatens the existence, beliefs, well-being, or livelihood of a community is likely to be experienced as traumatic by community members. Whether counselors are working with an immigrant or refugee enclave in the United States or in another country, they should be aware of local events, local history, and the possibility that clients have endured trauma. (For international information about the clinical, historical, and theoretical aspects of trauma and terrorism, see Danieli, Brom, & Sills, 2005.) Terrorism is a unique subtype of human-caused disasters. The overall goal of terrorist attacks is to maximize the uncertainty, anxiety, and fear of a large community, so the responses are often epidemic and affect large numbers of people who have had direct or indirect exposure to an event (Silver et al., 2004; Suvak, Maguen, Litz, Silver, & Holman, 2008). Terrorism has a variety of results not common to other disasters, such as reminders of the unpredictability of terrorist acts; increases in security measures for the general population; intensified suspicion about a particular population, ethnicity, or culture; and heightened awareness and/or arousal.

Refugees

According to the World Refugee Survey, there are an estimated 12 million refugees and asylum seekers, 21 million internally displaced people, and nearly 35 million uprooted people (U.S. Committee for Refugees and Immigrants, 2006). Many of these people have survived horrendous ordeals with profound and lasting effects for individuals and whole populations. In addition to witnessing deaths by execution, starvation, or beatings, many survivors have experienced horrific torture.

Refugees are people who flee their homes because they have experienced or have a reasonable fear of experiencing persecution. They

Torture and Captivity

Torture traumatizes by taking away an individual's personhood. To survive, victims have to give up their sense of self and will. They become the person the torturer designs or a nonperson, simply existing. Inevitably, the shame of the victim is enormous, because the focus of torture is to humiliate and degrade. As a result, victims often seek to hide their trauma and significant parts of their selfhood long after torture has ended and freedom has been obtained. According to Judith Herman, "the methods of establishing control over another person are based upon the systematic, repetitive infliction of psychological trauma. They are organized techniques of disempowerment and disconnection. Methods of psychological control are designed to instill terror and helplessness and to destroy the victim's sense of self in relation to others."

Source: Herman, 1997, p. 77.

differ from immigrants who willingly leave their homes or homeland to seek better opportunities. Although immigrants may experience trauma before migrating to or after reaching their new destination, refugees will often have greater exposure to trauma before migration. Refugees typically come from war-torn countries and may have been persecuted or tortured. Consequently, greater exposure to trauma, such as torture, before migrating often leads to more adjustment-related difficulties and psychological symptoms after relocation (Steel et al., 2009).

Refugees typically face substantial difficulties in assimilating into new countries and cultures. Moreover, the environment can create a new set of challenges that may include additional exposure to trauma and social isolation (Miller et al., 2002). These as well as additional factors influence adjustment, the development of mental illness (including PTSD), and the occurrence of substance use disorders. Additional factors that influence outcomes after relocation include receptivity of the local community, along with opportunities for social support and culturally responsive services.

Among refugee populations in the United States, little research is available on rates of mental illness and co-occurring substance use disorders and traumatic stress among refugee populations. Substance use patterns vary based on cultural factors as well as assimilation, yet research suggests that trauma increases the risk for substance use among refugees after war-related experiences (Kozarić-Kovačić, Ljubin, & Grappe, 2000). Therefore, providers should expect to see trauma-related disorders among refugees who are seeking treatment for a substance use disorder and greater prevalence of substance use disorders among refugees who seek behavioral health services.

Vietnamese Refugees

"Wars always have consequences, both immediate and remote, and the consequences are often tragic. One tragic circumstance often caused by war is the forceful, disorganized, and uncontrollable mass movement of both civilians and soldiers trying to escape the horrors of the wars or of an oppressive regime.…

"Vietnamese communists, by taking power in the North in 1954 and then in the South in 1975, caused two major upheavals in the Land of the Small Dragon, as Vietnam was once called. The first Vietnam War led to the 1954 exodus during which 1 million people fled from the North to the South. The second Vietnam War resulted in the dispersion, from 1975-1992, of approximately 2 million Vietnamese all over the world. These significant, unplanned, and uncoordinated mass movements around the world not only dislocated millions of people, but also caused thousands upon thousands of deaths at sea.…

"The second and third wave of refugees from 1976 onward went through a more difficult time. They had to buy their way out and to hide from soldiers and the police who hunted them down. After catching them, the police either asked for brides or threw the escapees into jails. Those who evaded police still had to face engine failures, sea storms, pirates…They then had to survive overcrowded boats for days or weeks, during which food and water could not be replenished and living conditions were terrible… Many people died from exhaustion, dehydration, and hunger. Others suffered at the hands of terrifying pirates… After the sea ordeal came the overcrowded camps where living conditions were most often substandard and where security was painfully lacking.…

"In the United States, within less than 3 decades, the Vietnamese population grew from a minority of perhaps 1,000 persons to the second largest refugee group behind Cubans."

Source: Vo, 2006, pp. 1–4.

System-Oriented Traumas: Retraumatization

Retraumatization occurs when clients experience something that makes them feel as though they are undergoing another trauma. Unfortunately, treatment settings and clinicians can create retraumatizing experiences, often without being aware of it, and sometimes clients themselves are not consciously aware that a clinical situation has actually triggered a traumatic stress reaction. Agencies that anticipate the risk for retraumatization and actively work on adjusting program policies and procedures to remain sensitive to the histories and needs of individuals who have undergone past trauma are likely to have more success in providing care, retaining clients, and achieving positive outcomes.

Staff and agency issues that can cause retraumatization include:

- Being unaware that the client's traumatic history significantly affects his or her life.
- Failing to screen for trauma history prior to treatment planning.
- Challenging or discounting reports of abuse or other traumatic events.
- Using isolation or physical restraints.
- Using experiential exercises that humiliate the individual.
- Endorsing a confrontational approach in counseling.
- Allowing the abusive behavior of one client toward another to continue without intervention.
- Labeling behavior/feelings as pathological.
- Failing to provide adequate security and safety within the program.
- Limiting participation of the client in treatment decisions and planning processes.
- Minimizing, discrediting, or ignoring client responses.
- Disrupting counselor–client relationships by changing counselors' schedules and assignments.
- Obtaining urine specimens in a nonprivate setting.

Advice to Counselors: Addressing Retraumatization

- Anticipate and be sensitive to the needs of clients who have experienced trauma regarding program policies and procedures in the treatment setting that might trigger memories of trauma, such as lack of privacy, feeling pushed to take psychotropic medications, perceiving that they have limited choices within the program or in the selection of the program, and so forth.
- Attend to clients' experiences. Ignoring clients' behavioral and emotional reactions to having their traumatic memories triggered is more likely to increase these responses than decrease them.
- Develop an individual coping plan in anticipation of triggers that the individual is likely to experience in treatment based on his or her history.
- Rehearse routinely the coping strategies highlighted in the coping plan. If the client does not practice strategies prior to being triggered, the likelihood of being able to use them effectively upon triggering is lessened. For example, it is far easier to practice grounding exercises in the absence of severe fear than to wait for that moment when the client is reexperiencing an aspect of a traumatic event. (For more information on grounding exercises, refer to *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*; Najavits, 2002a, pp. 125–131.)
- Recognize that clinical and programmatic efforts to control or contain behavior in treatment can cause traumatic stress reactions, particularly for trauma survivors for whom being trapped was part of the trauma experience.
- Listen for the specific trigger that seems to be driving the client's reaction. It will typically help both the counselor and client understand the behavior and normalize the traumatic stress reactions.
- Make sure that staff and other clients do not shame the trauma survivor for his or her behavior, such as through teasing or joking about the situation.
- Respond with consistency. The client should not get conflicting information or responses from different staff members; this includes information and responses given by administrators.

- Having clients undress in the presence of others.
- Inconsistently enforcing rules and allowing chaos in the treatment environment.
- Imposing agency policies or rules without exceptions or an opportunity for clients to question them.
- Enforcing new restrictions within the program without staff–client communication.
- Limiting access to services for ethnically diverse populations.
- Accepting agency dysfunction, including lack of consistent, competent leadership.

Characteristics of Trauma

The following section highlights several selected characteristics of traumatic experiences that influence the effects of traumatic stress. Objective characteristics are those elements of a traumatic event that are tangible or factual; subjective characteristics include internal processes, such as perceptions of traumatic experiences and meanings assigned to them.

Objective Characteristics

Was it a single, repeated, or sustained trauma?

Trauma can involve a single event, numerous or repeated events, or sustained/chronic experiences. A *single trauma* is limited to a single point in time. A rape, an automobile accident, the sudden death of a loved one—all are examples of a single trauma. Some people who experience a single trauma recover without any specific intervention. But for others—especially those with histories of previous trauma or mental or substance use disorders, or those for whom the trauma experience is particularly horrific or overwhelming—a single trauma can result in traumatic stress symptoms and trauma- and stress-related disorders. Single traumas do not necessarily have a lesser psychological impact than repeated traumas. After the terrorist attacks on September 11, 2001—a significant single trauma—many Manhattan residents experienced intrusive memories and sleep disruption whether they were at the site of the attacks or watched television coverage of it (Ford & Fournier, 2007; Galea et al., 2002).

A series of traumas happening to the same person over time is known as *repeated trauma*. This can include repeated sexual or physical assaults, exposure to frequent injuries of others, or seemingly unrelated traumas. Military personnel, journalists covering stories of mass tragedies or prolonged conflicts, and first responders who handle hundreds of cases each year typify repeated trauma survivors. Repetitive exposure to traumas can have a cumulative effect over one's lifetime. A person who was assaulted during adolescence, diagnosed with a life-threatening illness in his or her thirties, and involved in a serious car accident later in life has experienced repeated trauma.

Some repeated traumas are sustained or chronic. Sustained trauma experiences tend to wear down resilience and the ability to adapt. Some examples include children who endure ongoing sexual abuse, physical neglect, or emotional abuse; people who are in violent relationships; and people who live in chronic poverty. Individuals in chronically stressful, traumatizing environments are particularly susceptible to traumatic stress reactions, substance use, and mental disorders.

Bidirectional relationships exist between trauma and substance use as well as trauma and mental illness. For example, abuse of alcohol and drugs increases the risk of a traumatic experience and creates greater vulnerability to the effects of trauma; substance abuse reduces a person's ability to take corrective and remedial actions that might reduce the impact of the trauma. Likewise, traumatic stress leads to a greater likelihood of

Case Illustration: Yourself

Think of a time that was particularly stressful (but not traumatic) in your life. Revisit this period as an observer watching the events unfold and then ask yourself, "What made this time particularly stressful?" It is likely that a part of your answer will include the difficulty of managing one situation before another circumstance came along demanding your time. Stressful times denote being bombarded with many things at one time, perceived or actual, without sufficient time or ability to address them emotionally, cognitively, spiritually, and/or physically. The same goes for trauma—rapid exposure to numerous traumas one after another lessens one's ability to process the event before the next onslaught. This creates a cumulative effect, making it more difficult to heal from any one trauma.

substance abuse that, in turn, increases the risk for additional exposure to trauma. Paralleling this bidirectional relationship, mental illness increases vulnerability to the effects of trauma and raises the risk for substance use disorders and for encountering additional traumatic events. So too, early exposure to ACEs is associated with traumatic stress reactions and subsequent exposure to trauma in adult years.

People who have encountered multiple and longer doses of trauma are at the greatest risk for developing traumatic stress. For example, military reservists and other military service members who have had multiple long tours of duty are at greater risk for traumatic stress reactions (see the planned TIP, *Reintegration-Related Behavioral Health Issues in Veterans and Military Families;* SAMHSA, planned f). In addition, people are more likely to encounter greater impairment and distress from trauma if that trauma occurs with significant intensity and continues sporadically or unceasingly for extended periods.

Was there enough time to process the experience?

A particularly severe pattern of ongoing trauma, sometimes referred to as "cascading trauma," occurs when multiple traumas happen in a pattern that does not allow an individual to heal from one traumatic event before another occurs. Take, for example, California residents—they repeatedly face consecutive and/or simultaneous natural disasters including fires, landslides, floods, droughts, and earthquakes. In other cases, there is ample time to process an event, but processing is limited because people don't have supportive relationships or environments that model preventive practices. This can lead to greater vulnerability to traumas that occur later in life.

How many losses has the trauma caused?

Trauma itself can create significant distress, but often, the losses associated with a trauma have more far-reaching effects. For instance, a child may be forced to assume adult responsibilities, such as serving as a confidant for a parent who is sexually abusing him or her, and lose the opportunity of a childhood free from adult worries. In another scenario, a couple may initially feel grateful to have escaped a house fire, but they may nevertheless face significant community and financial losses months afterward. In evaluating the impact of trauma, it is helpful to access and discuss the losses associated with the initial trauma. The number of losses greatly influences an individual's ability to bounce back from the tragedy.

In the case illustration on the next page, Rasheed's losses cause him to disconnect from his wife, who loves and supports him. Successful confrontation of losses can be difficult if the losses compound each other, as with Rasheed's loss of his friend, his disability, his employment struggles, and the threats to his marriage and liberty. People can cite a specific

Case Illustration: Rasheed

Rasheed was referred to an employee assistance program by his employer. He considered quitting his job, but his wife insisted he talk to a counselor. He is a 41-year-old auto mechanic who, 4 years ago, caused a head-on collision while attempting to pass another vehicle. A close friend, riding in the passenger's seat, was killed, and two young people in the other vehicle were seriously injured and permanently disabled. Rasheed survived with a significant back injury and has only been able to work sporadically. He was convicted of negligent homicide and placed on probation because of his physical disability. He is on probation for another 4 years, and if he is convicted of another felony during that time, he will have to serve prison time for his prior offense.

While still in the hospital, Rasheed complained of feeling unreal, numb, and disinterested in the care he received. He did not remember the crash but remembers waking up in the hospital 2 days later. He had difficulty sleeping in the hospital and was aware of feelings of impending doom, although he was unaware of the legal charges he would later face. He was diagnosed with ASD.

He was discharged from the hospital with a variety of medications, including pain pills and a sleep aid. He rapidly became dependent on these medications, feeling he could not face the day without the pain medication and being unable to sleep without sleep medicine in larger doses than had been prescribed. Within 3 months of the accident, he was "doctor shopping" for pain pills and even had a friend obtain a prescription for the sleeping medication from that friend's doctor. In the 4 intervening years, Rasheed's drug use escalated, and his blunted emotions and detachment from friends became more profound. He became adept at obtaining pain pills from a variety of sources, most of them illegal. He fears that if he seeks treatment for the drug problem, he will have to admit to felony offenses and will probably be imprisoned. He also does not believe he can manage his life without the pain pills.

In the past 2 years, he has had recurring dreams of driving a car on the wrong side of the road and into the headlights of an oncoming vehicle. In the dream, he cannot control the car and wakes up just before the vehicles crash. At unusual times—for instance, when he is just awakening in the morning, taking a shower, or walking alone—he will feel profound guilt over the death of his friend in the accident. He becomes very anxious when driving in traffic or when he feels he is driving faster than he should. His marriage of 18 years has been marked by increasing emotional distance, and his wife has talked about separating if he does not do something about his problem. He has been unable to work consistently because of back pain and depression. He was laid off from one job because he could not concentrate and was making too many mistakes.

The counselor in the employee assistance program elicited information on Rasheed's drug use, although she suspected Rasheed was minimizing its extent and effects. Knowledgeable about psychological trauma, the counselor helped Rasheed feel safe enough to talk about the accident and how it had affected his life. She was struck by how little Rasheed connected his present difficulties to the accident and its aftermath. The counselor later commented that Rasheed talked about the accident as if it had happened to someone else. Rasheed agreed to continue seeing the counselor for five additional visits, during which time a plan would be made for Rasheed to begin treatment for drug dependence and PTSD.

event as precipitating their trauma, or, in other cases, the specific trauma can symbolize a series of disabling events in which the person felt his or her life was threatened or in which he or she felt emotionally overwhelmed, psychologically disorganized, or significantly disconnected from his or her surroundings. It will be important for Rasheed to understand how his losses played a part in his abuse of prescription medications to cope with symptoms associated with traumatic stress and loss, (e.g., guilt, depression, fear). If not addressed, his trauma could increase his risk for relapse.

Was the trauma expected or unexpected?

When talking about a trauma, people sometimes say they didn't see it coming. Being unprepared, unaware, and vulnerable often increases the risk of psychological injury, but these are common components of most traumas, given that most traumatic events do occur without warning (e.g., car crashes, terrorist attacks, sexual assaults). People with substance use disorders, mental illness, and/or cognitive disabilities may be especially vulnerable in that they may attend less or have competing concerns that diminish attention to what is going on around them, even in high-risk environments. However, most individuals attempt to gain some control over the tragedy by replaying the moments leading up to the event and processing how they could have anticipated it. Some people perseverate on these thoughts for months or years after the event.

Sometimes, a trauma is anticipated but has unexpected or unanticipated consequences, as in the case of Hurricane Katrina. Learning about what is likely to happen can reduce traumatization. For instance, training military personnel in advance of going to combat overseas prepares them to handle traumas and can reduce the impact of trauma.

Were the trauma's effects on the person's life isolated or pervasive?

When a trauma is isolated from the larger context of life, a person's response to it is more likely to be contained and limited. For instance, military personnel in combat situations can be significantly traumatized by what they experience. On return to civilian life or noncombat service, some are able to isolate the traumatic experience so that it does not invade ordinary, day-to-day living. This does not mean that the combat experience was not disturbing or that it will not resurface if the individual encounters an experience that triggers memories of the trauma; it just means that the person can more easily leave the trauma in the past and attend to the present.

Conversely, people who remain in the vicinity of the trauma may encounter greater challenges in recovery. The traumatic event intertwines with various aspects of the person's daily activities and interactions, thus increasing the possibility of being triggered by surrounding cues and experiencing subsequent psychological distress. However, another way to view this potential dilemma for the client is to reframe it as an opportunity—the repetitive exposure to trauma-related cues may provide vital guidance as to when and which treatment and coping techniques to use in the delivery of trauma-informed and trauma-specific behavioral health services.

Who was responsible for the trauma and was the act intentional?

If the severity of a trauma is judged solely by whether the act was intentional or not, events that reflect an intention to harm would be a primary indicator in predicting subsequent difficulties among individuals exposed to this form of trauma. For most survivors, there is an initial disbelief that someone would conceivably intend to harm others, followed by considerable emotional and, at times, behavioral investment in somehow making things right again or in making sense of a senseless, malicious act. For instance, in the wake of the World Trade Center attacks in New York City, people responded via renewed patriotism, impromptu candlelight vigils, attacks on people of Arab and Muslim descent, and unprecedented donations and willingness to wait in long lines to donate blood to the Red Cross. Each example is a response that in some way attempts to right the perceived wrong or attach new meaning to the event and subsequent consequences.

When terrible things happen, it is human nature to assign blame. Trauma survivors can become heavily invested in assigning blame or finding out who was at fault, regardless of the type of trauma. Often, this occurs as an attempt to make sense of, give meaning to, and reestablish a sense of predictability, control, and safety after an irrational or random act. It is far easier to accept that someone, including oneself, is at fault or could have done something different than it is to accept the fact that one was simply in the wrong place at the wrong time.

For some trauma survivors, needing to find out why a trauma occurred or who is at fault can become a significant block to growth when the individual would be better served by asking, "What do I need to do to heal?" Behavioral health professionals can help clients translate what they have learned about responsibility in recovery to other aspects of their lives. For instance, someone in treatment for co-occurring disorders who has internalized that becoming depressed or addicted was not his or her fault, but that recovery *is* a personal responsibility, can then apply the same principle to the experience of childhood abuse and thereby overcome negative judgments of self (e.g., thinking oneself to be a bad person who deserves abuse). The individual can then begin to reassign responsibility by attaching the blame to the perpetrator(s) while at the same time assuming responsibility for recovery.

Was the trauma experienced directly or indirectly?

Trauma that happens to someone directly seems to be more damaging than witnessing trauma that befalls others. For example, it is usually more traumatic to be robbed at gunpoint than to witness someone else being robbed or hearing someone tell a story about being robbed. Yet, sometimes, experiencing another's pain can be equally traumatic. For instance, parents often internalize the pain and suffering of their children when the children are undergoing traumatic circumstances (e.g., treatments for childhood cancer).

There are two ways to experience the trauma of others. An individual may witness the event, such as seeing someone killed or seriously injured in a car accident, or may learn of an event that happened to someone, such as a violent personal assault, suicide, serious accident, injury, or sudden or unexpected death. For many people, the impact of the trauma will depend on a host of variables, including their proximity to the event as eyewitnesses, the witnesses' response in the situation, their relationship to the victims, the degree of helplessness surrounding the experience, their exposure to subsequent consequences, and so on.

Case Illustration: Frank

Frank entered substance abuse treatment with diagnoses of co-occurring PTSD and substance use disorder. While on a whitewater kayak trip with his wife, her kayak became pinned on a rock, and Frank could only watch helplessly as she drowned. His drinking had increased markedly after the accident. He acknowledged a vicious cycle of sleep disturbance with intrusive nightmares followed by vivid memories and feelings of terror and helplessness after he awoke. He drank heavily at night to quiet the nightmares and memories, but heavy alcohol consumption perpetuated his trouble sleeping. He withdrew from contact with many of his old "couple friends" and his wife's family, with whom he had been close. At treatment entry, he described his life as "going to work and coming home." The trauma occurred 3 years before he sought treatment, but Frank continued to feel numb and disconnected from the world. His only emotion was anger, which he tried to keep in check. Integrated treatment for PTSD and substance abuse helped him sleep and taught him coping skills to use when the memories arose; it fostered his engagement and retention in long-term care for both disorders.

The effects of traumas such as genocide and internment in concentration camps can be felt across generations—stories, coping behaviors, and stress reactions can be passed across generational lines far removed from the actual events or firsthand accounts. Known as historical trauma, this type of trauma can affect the functioning of families, communities, and cultures for multiple generations.

What happened since the trauma?

In reviewing traumatic events, it is important to assess the degree of disruption after the initial trauma has passed, such as the loss of employment, assets, community events, behavioral health services, local stores, and recreational areas. There is typically an initial rally of services and support following a trauma, particularly if it is on a mass scale. However, the reality of the trauma's effects and their disruptiveness may have a more lasting impact. The deterioration of normalcy, including the disruption of day-to-day activities and the damage of structures that house these routines, will likely erode the common threads that provide a sense of safety in individual lives and communities. Hence, the degree of disruption in resuming normal daily activities is a significant risk factor for substance use disorders, subclinical psychological symptoms, and mental disorders. For example, adults displaced from their homes because of Hurricanes Katrina or Rita had significantly higher rates of past-month cigarette use, illicit drug use, and binge drinking than those who were not displaced (Office of Applied Studies, 2008).

Subjective Characteristics

Psychological meaning of trauma

An important clinical issue in understanding the impact of trauma is the meaning that the survivor has attached to the traumatic experience. Survivors' unique cognitive interpretations of an event—that is, their beliefs and assumptions—contribute to how they process, react to, cope with, and recover from the trauma. Does the event represent retribution for past deeds committed by the individual or his or her family? How does the individual attach meaning to his or her survival? Does he or she believe that it is a sign of a greater purpose not yet revealed? People who attempt to share their interpretation and meaning of the event can feel misunderstood and sometimes alienated (Paulson & Krippner, 2007; Schein, Spitz, Burlingame, & Muskin, 2006).

> It is important to remember that what happened is not nearly as important as what the trauma means to the individual.

People interpret traumatic events in vastly different ways, and many variables shape how an individual assigns meaning to the experience (framing the meaning through culture, family beliefs, prior life experiences and learning, personality and other psychological features, etc.). Even in an event that happens in a household, each family member may interpret the experience differently. Likewise, the same type of event can occur at two different times in a person's life, but his or her interpretation of the events may differ considerably because of developmental differences acquired between events, current cognitive and emotional processing skills, availability of and access to environmental resources, and so forth.

Disruption of core assumptions and beliefs

Trauma often engenders a crisis of faith (Frankl, 1992) that leads clients to question basic assumptions about life. Were the individual's core or life-organizing assumptions (e.g., about safety, perception of others, fairness, purpose of life, future dreams) challenged or disrupted during or after the traumatic event? (See the seminal work,

Resilience: Connection and Continuity

Research suggests that reestablishing ties to family, community, culture, and spiritual systems is not only vital to the individual, but it also influences the impact of the trauma upon future generations. For example, Baker and Gippenreiter (1998) studied the descendants of survivors of Joseph Stalin's purge. They found that families who were able to maintain a sense of connection and continuity with grandparents directly affected by the purge experienced fewer negative effects than those who were emotionally or physically severed from their grandparents. Whether the grandparents survived was less important than the connection the grandchildren felt to their pasts.

Shattered Assumptions, by Janoff-Bulman, 1992.) For example, some trauma survivors see themselves as irreparably wounded or beyond the possibility of healing. The following case illustration (Sonja) explores not only the importance of meaning, but also the role that trauma plays in altering an individual's core assumptions—the very assumptions that provide meaning and a means to organize our lives and our interactions with the world and others.

Cultural meaning of trauma

Counselors should strive to appreciate the cultural meaning of a trauma. How do cultural interpretations, cultural support, and cultural responses affect the experience of trauma? It is critical that counselors do not presume to understand the meaning of a traumatic experience without considering the client's cultural context. Culture strongly influences the perceptions of trauma. For instance, a trauma involving shame can be more profound for a person from an Asian culture than for someone from a European culture. Likewise, an Alaska Native individual or community, depending upon their Tribal ancestry, may believe that the traumatic experience serves as a form of retribution. Similarly, the sudden death of a family member or loved one can be less traumatic in a culture that has a strong belief in a positive afterlife. It is important for counselors to recognize that their perceptions of a specific trauma could be very different from their clients' perceptions. Be careful not to judge a client's beliefs in light of your own value system. For more information on culture and how to achieve cultural competence in providing behavioral health services, see SAMHSA's planned TIP, *Improving Cultural Competence* (SAMHSA, planned c).

Individual and Sociocultural Features

A wide variety of social, demographic, environmental, and psychological factors influence a person's experience of trauma, the severity of traumatic stress reactions following the event, and his or her resilience in dealing with the short- and long-term environmental, physical, sociocultural, and emotional consequences. This section addresses a few known factors that influence the risk of trauma along with the development of subclinical and diagnostic traumatic stress symptoms, such as mood and anxiety symptoms and disorders. It is not meant to be an exhaustive exploration of these factors, but rather, a brief presentation to make counselors and other behavioral health professionals aware that various factors influence risk for and protection against traumatic stress and subsequent reactions. (For a broader perspective on such factors, refer to Part 1, Chapter 1.)

Individual Factors

Several factors influence one's ability to deal with trauma effectively and increase one's risk for traumatic stress reactions. Individual factors pertain to the individual's genetic, biological, and psychological makeup and history as they influence the person's experience and

Case Illustration: Sonja

Sonja began to talk about how her life was different after being physically assaulted and robbed in a parking lot at a local strip mall a year ago. She recounts that even though there were people in the parking lot, no one came to her aid until the assailant ran off with her purse. She sustained a cheekbone fracture and developed visual difficulties due to the inflammation from the fracture. She recently sought treatment for depressive symptoms and reported that she had lost interest in activities that typically gave her joy. She reported isolating herself from others and said that her perception of others had changed dramatically since the attack.

Sonja had received a diagnosis of major depression with psychotic features 10 years earlier and received group therapy at a local community mental health center for 3 years until her depression went into remission. She recently became afraid that her depression was becoming more pronounced, and she wanted to prevent another severe depressive episode as well as the use of psychotropic medications, which she felt made her lethargic. Thus, she sought out behavioral health counseling.

As the sessions progressed, and after a psychological evaluation, it was clear that Sonja had some depressive symptoms, but they were subclinical. She denied suicidal thoughts or intent, and her thought process was organized with no evidence of hallucinations or delusions. She described her isolation as a reluctance to shop at area stores. On one hand, Sonja was self-compassionate about her reasons for avoidance, but on the other hand, she was concerned that the traumatic event had altered how she saw life and others. "I don't see people as very caring or kind, like I used to prior to the event. I don't trust them, and I feel people are too self-absorbed. I don't feel safe, and this bothers me. I worry that I'm becoming paranoid again. I guess I know better, but I just want to have the freedom to do what I want and go where I want."

Two months after Sonja initiated counseling, she came to the office exclaiming that things can indeed change. "You won't believe it. I had to go to the grocery store, so I forced myself to go the shopping center that had a grocery store attached to a strip mall. I was walking by a coffee shop, quickly browsing the items in the front window, when a man comes out of the shop talking at me. He says, 'You look like you need a cup of coffee.' What he said didn't register immediately. I looked at him blankly, and he said it again. 'You look like you need a cup of coffee. I'm the owner of the shop, and I noticed you looking in the window, and we have plenty of brewed coffee left before we close the shop. Come on in, it's on the house.' So I did! From that moment on, I began to see people differently. He set it right for me—I feel as if I have myself back again, as if the assault was a sign that I shouldn't trust people, and now I see that there is some goodness in the world. As small as this kindness was, it gave me the hope that I had lost."

For Sonja, the assault changed her assumptions about safety and her view of others. She also attached meaning to the event. She believed that the event was a sign that she shouldn't trust people and that people are uncaring. Yet these beliefs bothered her and contradicted how she saw herself in the world, and she was afraid that her depressive symptoms were returning.

For an inexperienced professional, her presentation may have ignited suspicions that she was beginning to present with psychotic features. However, it is common for trauma survivors to experience changes in core assumptions immediately after the event and to attach meaning to the trauma. Often, a key ingredient in the recovery process is first identifying the meaning of the event and the beliefs that changed following the traumatic experience. So when you hear a client say "I will never see life the same," this expression should trigger further exploration into how life is different, what meaning has been assigned to the trauma, and how the individual has changed his or her perception of self, others, and the future.

(Continued on the next page.)

Case Illustration: Sonja (continued)

Sometimes, reworking the altered beliefs and assumptions occurs with no formal intervention, as with Sonja. In her situation, a random stranger provided a moment that challenged an assumption generated from the trauma. For others, counseling may be helpful in identifying how beliefs and thoughts about self, others, and the world have changed since the event and how to rework them to move beyond the trauma. It is important to understand that the meaning that an individual attaches to the event(s) can either undermine the healing process (e.g., believing that you should not have survived, feeling shame about the trauma, continuing to engage in high-risk activities) or pave the road to recovery (e.g., volunteering to protect victim rights after being sexually assaulted). The following questions can help behavioral health staff members introduce topics surrounding assumptions, beliefs, interpretations, and meanings related to trauma:

- In what ways has your life been different since the trauma?
- How do you understand your survival? (This is an important question for clients who have been exposed to ACEs or cumulative trauma and those who survived a tragedy when others did not.)
- Do you believe that there are reasons that this event happened to you? What are they?
- What meaning does this experience have for you?
- Do you feel that you are the same person as before the trauma? In what ways are you the same? In what ways do you feel different?
- How did this experience change you as a person? Would you like to return to the person you once were? What would you need to do, or what would need to happen, for this to occur?
- Did the traumatic experience change you in a way that you don't like? In what ways?
- How do you view others and your future differently since the trauma?
- What would you like to believe now about the experience?

interpretation of, as well as his or her reactions to, trauma. However, many factors influence individual responses to trauma; it is not just individual characteristics. Failing to recognize that multiple factors aside from individual attributes and history influence experiences during and after trauma can lead to blaming the victim for having traumatic stress.

History of prior psychological trauma

People with histories of prior psychological trauma appear to be the most susceptible to severe traumatic responses (Nishith, Mechanic, & Resick, 2000; Vogt, Bruce, Street, & Stafford, 2007), particularly if they have avoided addressing past traumas. Because minimization, dissociation, and avoidance are common defenses for many trauma survivors, prior traumas are not always consciously available, and when they are, memories can be distorted to avoid painful affects. Some survivors who have repressed their experiences deny a history of trauma or are unable to explain their strong reactions to present situations.

Remember that the effects of trauma are cumulative; therefore, a later trauma that outwardly appears less severe may have more impact upon an individual than a trauma that occurred years earlier. Conversely, individuals who have experienced earlier traumas may have developed effective coping strategies or report positive outcomes as they have learned to adjust to the consequences of the trauma(s). This outcome is often referred to as posttraumatic growth or psychological growth.

Clients in behavioral health treatment who have histories of trauma can respond negatively to or seem disinterested in treatment efforts. They may become uncomfortable in groups that emphasize personal sharing; likewise, an individual who experiences brief bouts of dissociation (a reaction of some trauma survivors) may be misunderstood by others in treatment and seen as uninterested. Providers need to

attend to histories, adjust treatment to avoid retraumatization, and steer clear of labeling clients' behavior as pathological.

History of resilience

Resilience—the ability to thrive despite negative life experiences and heal from traumatic events—is related to the internal strengths and environmental supports of an individual. Most individuals are resilient despite experiencing traumatic stress. The ability to thrive beyond the trauma is associated with individual factors as well as situational and contextual factors. There are not only one or two primary factors that make an individual resilient; many factors contribute to the development of resilience. There is little research to indicate that there are specific traits predictive of resilience; instead, it appears that more general characteristics influence resilience, including neurobiology (Feder, Charney, & Collins, 2011), flexibility in adapting to change, beliefs prior to trauma, sense of self-efficacy, and ability to experience positive emotions (Bonanno & Mancini, 2011).

History of mental disorders

The correlations among traumatic stress, substance use disorders, and co-occurring mental disorders are well known. According to the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (American Psychiatric Association, 2013a), traumatic stress reactions are linked to higher rates of mood, substance-related, anxiety, trauma, stress-related, and other mental disorders, each of which can precede, follow, or emerge concurrently with trauma itself. A co-occurring mental disorder is a significant determinant of whether an individual can successfully address and resolve trauma as it emerges from the past or occurs in the present. Koenen, Stellman, Stellman, and Sommer (2003) found that the risk of developing PTSD following combat trauma was higher for individuals with preexisting conduct disorder, panic disorder, generalized anxiety disorder, and/or major depression than for those without preexisting mental disorders. For additional information on comorbidity of trauma and other mental disorders, see TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c).

Sociodemographic Factors

Demographic variables are not good predictors of who will experience trauma and subsequent traumatic stress reactions. Gender, age, race and ethnicity, sexual orientation, marital status, occupation, income, and education can all have some influence, but not enough to determine who should or should not receive screening for trauma and traumatic stress symptoms. The following sections cover a few selected variables. (For more information, please refer to Part 3 of this TIP, the online literature review.)

Gender

In the United States, men are at greater risk than women for being exposed to stressful events. Despite the higher prevalence among men, lifetime PTSD occurs at about twice the rate among women as it does in men. Less is known about gender differences with subclinical traumatic stress reactions. There are also other gender differences, such as the types of trauma experienced by men and women. Women are more likely to experience physical and sexual assault, whereas men are most likely to experience combat and crime victimization and to witness killings and serious injuries (Breslau, 2002; Kimerling, Ouimette, & Weitlauf, 2007; Tolin & Foa, 2006). Women in military service are subject to the same risks as men and are also at a greater risk for military sexual trauma. Men's traumas often occur in public; women's are more likely to take place in private settings. Perpetrators of traumas against men are often strangers, but women are more likely to know the perpetrator.

Age

In general, the older one becomes, the higher the risk of trauma—but the increase is not dramatic. Age is not particularly important in predicting exposure to trauma, yet at no age is one immune to the risk. However, trauma that occurs in the earlier and midlife years appears to have greater impact on people for different reasons. For younger individuals, the trauma can affect developmental processes, attachment, emotional regulation, life assumptions, cognitive interpretations of later experiences, and so forth (for additional resources, visit the National Child Traumatic Stress Network; http://www.nctsn.org/). For adults in midlife, trauma may have a greater impact due to the enhanced stress or burden of care that often characterizes this stage of life—caring for their children and their parents at the same time. Older adults are as likely as younger adults to recover quickly from trauma, yet they may have greater vulnerabilities, including their ability to survive without injury and their ability to address the current trauma without psychological interference from earlier stressful or traumatic events. Older people are naturally more likely to have had a history of trauma because they have lived longer, thus creating greater vulnerability to the effects of cumulative trauma.

Race, ethnicity, and culture

The potential for trauma exists in all major racial and ethnic groups in American society, yet few studies analyze the relationship of race and ethnicity to trauma exposure and/or traumatic stress reactions. Some studies show that certain racial and ethnic groups are at greater risk for specific traumas. For example, African Americans experienced higher rates of overall violence, aggravated assault, and robbery than Whites but were as likely to be victims of rape or sexual assault (Catalano, 2004). Literature reflects that diverse ethnic, racial, and cultural groups are more likely to experience adverse effects from various traumas and to meet criteria for posttraumatic stress (Bell, 2011).

Sexual orientation and gender identity

Lesbian, gay, bisexual, and transgender individuals are likely to experience various forms of trauma associated with their sexual orientation, including harsh consequences from families and faith traditions, higher risk of assault from casual sexual partners, hate crimes, lack of legal protection, and laws of exclusion (Brown, 2008). Gay and bisexual men as well as transgender people are more likely to experience victimization than lesbians and bisexual women. Dillon (2001) reported a trauma exposure rate of 94 percent among lesbian, gay,

Resilience: Cultural, Racial, and Ethnic Characteristics

The following list highlights characteristics that often nurture resilience among individuals from diverse cultural, racial, and ethnic groups:

- Strong kinship bonds
- Respect for elders and the importance of extended family
- Spirituality and religious practices (e.g., shrine visitations or the use of traditional healers)
- Value in friendships and warm personal relationships
- Expression of humor and creativity
- Instilling a sense of history, heritage, and historical traditions
- Community orientation, activities, and socialization
- Strong work ethic
- Philosophies and beliefs about life, suffering, and perseverance

"Fortune owes its existence to misfortune, and misfortune is hidden in fortune."

–Lao-Tzu teaching, Taoism (Wong & Wong, 2006)

and bisexual individuals; more than 40 percent of respondents experienced harassment due to their sexual orientation. Heterosexual orientation is also a risk for women, as women in relationships with men are at a greater risk of being physically and sexually abused.

People who are homeless

Homelessness is typically defined as the lack of an adequate or regular dwelling, or having a nighttime dwelling that is a publicly or privately supervised institution or a place not intended for use as a dwelling (e.g., a bus station). The U.S. Department of Housing and Urban Development (HUD) estimates that between 660,000 and 730,000 individuals were homeless on any given night in 2005 (HUD, 2007). Two thirds were unaccompanied persons; the other third were people in families. Adults who are homeless and unmarried are more likely to be male than female. About 40 percent of men who are homeless are veterans (National Coalition for the Homeless, 2002); this percentage has grown, including the number of veterans with dependent children (Kuhn & Nakashima, 2011).

Rates of trauma symptoms are high among people who are homeless (76 to 100 percent of women and 67 percent of men; Christensen et al., 2005; Jainchill, Hawke, & Yagelka, 2000), and the diagnosis of PTSD is among the most prevalent non-substance use Axis I disorders (Lester et al., 2007; McNamara, Schumacher, Milby, Wallace, & Usdan, 2001). People who are homeless report high levels of trauma (especially physical and sexual abuse in childhood or as adults) preceding their homeless status; assault, rape, and other traumas frequently happen while they are homeless. Research suggests that many women are homeless because they are fleeing domestic violence (National Coalition for the Homeless, 2002). Other studies suggest that women who are homeless are more likely to have histories of childhood physical and sexual abuse and to have experienced sexual assault as adults. A history of physical and/or sexual abuse is even more common among women who are homeless and have a serious mental illness.

Youth who are homeless, especially those who live without a parent, are likely to have experienced physical and/or sexual abuse. Between 21 and 42 percent of youth runaways report having been sexually abused before leaving their homes; for young women, rates range from 32 to 63 percent (Administration on Children, Youth and Families, 2002). Additionally, data reflect elevated rates of substance abuse for youth who are homeless and have histories of abuse.

More than half of people who are homeless have a lifetime prevalence of mental illness and substance use disorders. Those who are homeless have higher rates of substance abuse (84 percent of men and 58 percent of women), and substance use disorders, including alcohol and drug abuse/dependence, increase with longer lengths of homelessness (North, Eyrich, Pollio, & Spitznagel, 2004).

For more information on providing trauma-informed behavioral health services to clients who are homeless, and for further discussion of the incidence of trauma in this population, see TIP 55-R, *Behavioral Health Services for People Who Are Homeless* (SAMHSA, 2013b).

3 Understanding the Impact of Trauma

IN THIS CHAPTER

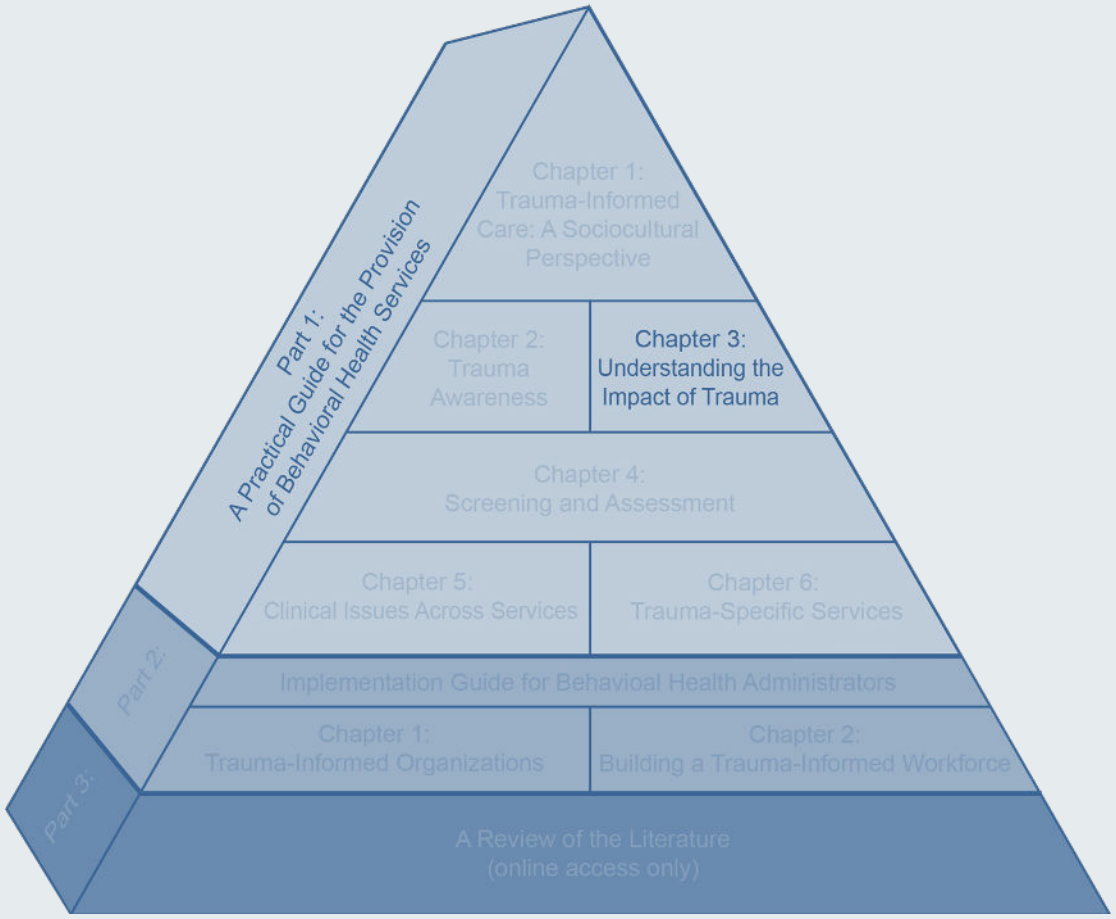
- Sequence of Trauma Reactions
- Common Experiences and Responses to Trauma
- Subthreshold Trauma Related Symptoms
- Specific Trauma Related Psychological Disorders
- Other Trauma Related and Co Occurring Disorders

Trauma-informed care (TIC) involves a broad understanding of traumatic stress reactions and common responses to trauma. Providers need to understand how trauma can affect treatment presentation, engagement, and the outcome of behavioral health services. This chapter examines common experiences survivors may encounter immediately following or long after a traumatic experience.

Trauma, including one-time, multiple, or long-lasting repetitive events, affects everyone differently. Some individuals may clearly display criteria associated with posttraumatic stress disorder (PTSD), but many more individuals will exhibit resilient responses or brief subclinical symptoms or consequences that fall outside of diagnostic criteria. The impact of trauma can be subtle, insidious, or outright destructive. How an event affects an individual depends on many factors, including characteristics of the individual, the type and characteristics of the event(s), developmental processes, the meaning of the trauma, and sociocultural factors.

This chapter begins with an overview of common responses, emphasizing that traumatic stress reactions are normal reactions to abnormal circumstances. It highlights common short- and long-term responses to traumatic experiences in the context of individuals who may seek behavioral health services. This chapter discusses psychological symptoms not represented in the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (DSM-5; American Psychiatric Association [APA], 2013a), and responses associated with trauma that either fall below the threshold of mental disorders or reflect resilience. It also addresses common disorders associated with traumatic stress. This chapter explores the role of culture in defining mental illness, particularly PTSD, and ends by addressing co-occurring mental and substance-related disorders.

TIC Framework in Behavioral Health Services—The Impact of Trauma



Sequence of Trauma Reactions

Survivors' immediate reactions in the aftermath of trauma are quite complicated and are affected by their own experiences, the accessibility of natural supports and healers, their coping and life skills and those of immediate family, and the responses of the larger community in which they live. Although reactions range in severity, even the most acute responses are natural responses to manage trauma—they are not a sign of psychopathology. Coping styles vary from action oriented to reflective and from emotionally expressive to reticent. Clinically, a response style is less important than the degree to which coping efforts successfully allow one to continue necessary activities, regulate emotions, sustain self-esteem, and maintain and enjoy interpersonal contacts. Indeed, a past error in traumatic stress psychology, particularly regarding group or mass traumas, was the assumption that all survivors need to express emotions associated with trauma and talk about the trauma; more recent research indicates that survivors who choose not to process their trauma are just as psychologically healthy as

Foreshortened future: Trauma can affect one's beliefs about the future via loss of hope, limited expectations about life, fear that life will end abruptly or early, or anticipation that normal life events won't occur (e.g., access to education, ability to have a significant and committed relationship, good opportunities for work).

those who do. The most recent psychological debriefing approaches emphasize respecting the individual's style of coping and not valuing one type over another.

Initial reactions to trauma can include exhaustion, confusion, sadness, anxiety, agitation, numbness, dissociation, confusion, physical arousal, and blunted affect. Most responses are normal in that they affect most survivors and are socially acceptable, psychologically effective, and self-limited. Indicators of more severe responses include continuous distress without periods of relative calm or rest, severe dissociation symptoms, and intense intrusive recollections that continue despite a return to safety. Delayed responses to trauma can include persistent fatigue, sleep disorders, nightmares, fear of recurrence, anxiety focused on flashbacks, depression, and avoidance of emotions, sensations, or activities that are associated with the trauma, even remotely. Exhibit 1.3-1 outlines some common reactions.

Common Experiences and Responses to Trauma

A variety of reactions are often reported and/or observed after trauma. Most survivors exhibit immediate reactions, yet these typically resolve without severe long-term consequences. This is because most trauma survivors are highly resilient and develop appropriate coping strategies, including the use of social supports, to deal with the aftermath and effects of trauma. Most recover with time, show minimal distress, and function effectively across major life areas and developmental stages. Even so, clients who show little impairment may still have subclinical symptoms or symptoms that do not fit diagnostic criteria for acute stress disorder (ASD) or PTSD. Only a small percentage of people with a history of trauma show impairment and symptoms that meet criteria for trauma-related stress disorders, including mood and anxiety disorders.

The following sections focus on some common reactions across domains (emotional, physical, cognitive, behavioral, social, and developmental) associated with singular, multiple, and enduring traumatic events. These reactions are often normal responses to trauma but can still be distressing to experience. Such responses are not signs of mental illness, nor do they indicate a mental disorder. Traumatic stress-related disorders comprise a specific constellation of symptoms and criteria.

Emotional

Emotional reactions to trauma can vary greatly and are significantly influenced by the individual's sociocultural history. Beyond the initial emotional reactions during the event, those most likely to surface include anger, fear, sadness, and shame. However, individuals may encounter difficulty in identifying any of these feelings for various reasons. They might lack experience with or prior exposure to emotional expression in their family or community. They may associate strong feelings with the past trauma, thus believing that emotional expression is too dangerous or will lead to feeling out of control (e.g., a sense of "losing it" or going crazy). Still others might deny that they have any feelings associated with their traumatic experiences and define their reactions as numbness or lack of emotions.

Emotional dysregulation

Some trauma survivors have difficulty regulating emotions such as anger, anxiety, sadness, and shame—this is more so when the trauma occurred at a young age (van der Kolk, Roth, Pelcovitz, & Mandel, 1993). In individuals who are older and functioning well

Exhibit 1.3-1: Immediate and Delayed Reactions to Trauma

Immediate Emotional Reactions	Delayed Emotional Reactions
Numbness and detachment Anxiety or severe fear Guilt (including survivor guilt) Exhilaration as a result of surviving Anger Sadness Helplessness Feeling unreal; depersonalization (e.g., feeling as if you are watching yourself) Disorientation Feeling out of control Denial Constriction of feelings Feeling overwhelmed	Irritability and/or hostility Depression Mood swings, instability Anxiety (e.g., phobia, generalized anxiety) Fear of trauma recurrence Grief reactions Shame Feelings of fragility and/or vulnerability Emotional detachment from anything that requires emotional reactions (e.g., significant and/or family relationships, conversations about self, discussion of traumatic events or reactions to them)
Immediate Physical Reactions	**Delayed Physical Reactions**
Nausea and/or gastrointestinal distress Sweating or shivering Faintness Muscle tremors or uncontrollable shaking Elevated heartbeat, respiration, and blood pressure Extreme fatigue or exhaustion Greater startle responses Depersonalization	Sleep disturbances, nightmares Somatization (e.g., increased focus on and worry about body aches and pains) Appetite and digestive changes Lowered resistance to colds and infection Persistent fatigue Elevated cortisol levels Hyperarousal Long-term health effects including heart, liver, autoimmune, and chronic obstructive pulmonary disease
Immediate Cognitive Reactions	**Delayed Cognitive Reactions**
Difficulty concentrating Rumination or racing thoughts (e.g., replaying the traumatic event over and over again) Distortion of time and space (e.g., traumatic event may be perceived as if it was happening in slow motion, or a few seconds can be perceived as minutes) Memory problems (e.g., not being able to recall important aspects of the trauma) Strong identification with victims	Intrusive memories or flashbacks Reactivation of previous traumatic events Self-blame Preoccupation with event Difficulty making decisions Magical thinking: belief that certain behaviors, including avoidant behavior, will protect against future trauma Belief that feelings or memories are dangerous Generalization of triggers (e.g., a person who experiences a home invasion during the daytime may avoid being alone during the day) Suicidal thinking
Immediate Behavioral Reactions	**Delayed Behavioral Reactions**
Startled reaction Restlessness Sleep and appetite disturbances Difficulty expressing oneself Argumentative behavior Increased use of alcohol, drugs, and tobacco Withdrawal and apathy Avoidant behaviors	Avoidance of event reminders Social relationship disturbances Decreased activity level Engagement in high-risk behaviors Increased use of alcohol and drugs Withdrawal

(Continued on the next page.)

Exhibit 1.3-1: Immediate and Delayed Reactions to Trauma (continued)

Immediate Existential Reactions	Delayed Existential Reactions
Intense use of prayer	Questioning (e.g., "Why me?")
Restoration of faith in the goodness of others (e.g., receiving help from others)	Increased cynicism, disillusionment
Loss of self-efficacy	Increased self-confidence (e.g., "If I can survive this, I can survive anything")
Despair about humanity, particularly if the event was intentional	Loss of purpose
Immediate disruption of life assumptions (e.g., fairness, safety, goodness, predictability of life)	Renewed faith
	Hopelessness
	Reestablishing priorities
	Redefining meaning and importance of life
	Reworking life's assumptions to accommodate the trauma (e.g., taking a self-defense class to reestablish a sense of safety)

Sources: Briere & Scott, 2006b; Foa, Stein, & McFarlane, 2006; Pietrzak, Goldstein, Southwick, & Grant, 2011.

prior to the trauma, such emotional dysregulation is usually short lived and represents an immediate reaction to the trauma, rather than an ongoing pattern. Self-medication—namely, substance abuse—is one of the methods that traumatized people use in an attempt to regain emotional control, although ultimately it causes even further emotional dysregulation (e.g., substance-induced changes in affect during and after use). Other efforts toward emotional regulation can include engagement in high-risk or self-injurious behaviors, disordered eating, compulsive behaviors such as gambling or overworking, and repression or denial of emotions; however, not all behaviors associated with self-regulation are considered negative. In fact, some individuals find creative, healthy, and industrious ways to manage strong affect generated by trauma, such as through renewed commitment to physical activity or by creating an organization to support survivors of a particular trauma.

Traumatic stress tends to evoke two emotional extremes: feeling either too much (overwhelmed) or too little (numb) emotion. Treatment can help the client find the optimal level of emotion and assist him or her with appropriately experiencing and regulating difficult emotions. In treatment, the goal is to help clients learn to regulate their emotions without the use of substances or other unsafe behavior. This will likely require learning new coping skills and how to tolerate distressing emotions; some clients may benefit from mindfulness practices, cognitive restructuring, and trauma-specific desensitization approaches, such as exposure therapy and eye movement desensitization and reprocessing (EMDR; refer to Part 1, Chapter 6, for more information on trauma-specific therapies).

Numbing

Numbing is a biological process whereby emotions are detached from thoughts, behaviors, and memories. In the following case illustration, Sadhanna's numbing is evidenced by her limited range of emotions associated with interpersonal interactions and her inability to associate any emotion with her history of abuse. She also possesses a belief in a foreshortened future. A prospective longitudinal study (Malta, Levitt, Martin, Davis, & Cloitre, 2009) that followed the development of PTSD in disaster workers highlighted the importance of understanding and appreciating numbing as a traumatic stress reaction. Because numbing

Case Illustration: Sadhanna

Sadhanna is a 22-year-old woman mandated to outpatient mental health and substance abuse treatment as the alternative to incarceration. She was arrested and charged with assault after arguing and fighting with another woman on the street. At intake, Sadhanna reported a 7-year history of alcohol abuse and one depressive episode at age 18. She was surprised that she got into a fight but admitted that she was drinking at the time of the incident. She also reported severe physical abuse at the hands of her mother's boyfriend between ages 4 and 15. Of particular note to the intake worker was Sadhanna's matter-of-fact way of presenting the abuse history. During the interview, she clearly indicated that she did not want to attend group therapy and hear other people talk about their feelings, saying, "I learned long ago not to wear emotions on my sleeve."

Sadhanna reported dropping out of 10th grade, saying she never liked school. She didn't expect much from life. In Sadhanna's first weeks in treatment, she reported feeling disconnected from other group members and questioned the purpose of the group. When asked about her own history, she denied that she had any difficulties and did not understand why she was mandated to treatment. She further denied having feelings about her abuse and did not believe that it affected her life now. Group members often commented that she did not show much empathy and maintained a flat affect, even when group discussions were emotionally charged.

symptoms hide what is going on inside emotionally, there can be a tendency for family members, counselors, and other behavioral health staff to assess levels of traumatic stress symptoms and the impact of trauma as less severe than they actually are.

Physical

Diagnostic criteria for PTSD place considerable emphasis on psychological symptoms, but some people who have experienced traumatic stress may present initially with physical symptoms. Thus, primary care may be the first and only door through which these individuals seek assistance for trauma-related symptoms. Moreover, there is a significant connection between trauma, including adverse childhood experiences (ACEs), and chronic health conditions. Common physical disorders and symptoms include somatic complaints; sleep disturbances; gastrointestinal, cardiovascular, neurological, musculoskeletal, respiratory, and dermatological disorders; urological problems; and substance use disorders.

Somatization

Somatization indicates a focus on bodily symptoms or dysfunctions to express emotional distress. Somatic symptoms are more likely to occur with individuals who have traumatic stress reactions, including PTSD. People from certain ethnic and cultural backgrounds may initially or solely present emotional distress via physical ailments or concerns. Many individuals who present with somatization are likely unaware of the connection between their emotions and the physical symptoms that they're experiencing. At times, clients may remain resistant to exploring emotional content and remain focused on bodily complaints as a means of avoidance. Some clients may insist that their primary problems are physical even when medical evaluations and tests fail to confirm ailments. In these situations, somatization may be a sign of a mental illness. However, various cultures approach emotional distress through the physical realm or view emotional and physical symptoms and well-being as one. It is important not to assume that clients with physical complaints are using somatization as a means to express emotional pain; they may have specific conditions or disorders that require medical attention. Foremost, counselors need to refer for medical evaluation.

Advice to Counselors: Using Information About Biology and Trauma

- Educate your clients:
  - Frame reexperiencing the event(s), hyperarousal, sleep disturbances, and other physical symptoms as physiological reactions to extreme stress.
  - Communicate that treatment and other wellness activities can improve both psychological and physiological symptoms (e.g., therapy, meditation, exercise, yoga). You may need to refer certain clients to a psychiatrist who can evaluate them and, if warranted, prescribe psychotropic medication to address severe symptoms.
  - Discuss traumatic stress symptoms and their physiological components.
  - Explain links between traumatic stress symptoms and substance use disorders, if appropriate.
  - Normalize trauma symptoms. For example, explain to clients that their symptoms are not a sign of weakness, a character flaw, being damaged, or going crazy.
- Support your clients and provide a message of hope—that they are not alone, they are not at fault, and recovery is possible and anticipated.

Biology of trauma

Trauma biology is an area of burgeoning research, with the promise of more complex and explanatory findings yet to come. Although a thorough presentation on the biological aspects of trauma is beyond the scope of this publication, what is currently known is that exposure to trauma leads to a cascade of biological changes and stress responses. These biological alterations are highly associated with PTSD, other mental illnesses, and substance use disorders. These include:

- Changes in limbic system functioning.
- Hypothalamic–pituitary–adrenal axis activity changes with variable cortisol levels.
- Neurotransmitter-related dysregulation of arousal and endogenous opioid systems.

As a clear example, early ACEs such as abuse, neglect, and other traumas affect brain development and increase a person's vulnerability to encountering interpersonal violence as an adult and to developing chronic diseases and other physical illnesses, mental illnesses, substance-related disorders, and impairment in other life areas (Centers for Disease Control and Prevention, 2012).

Hyperarousal and sleep disturbances

A common symptom that arises from traumatic experiences is hyperarousal (also called hypervigilance). Hyperarousal is the body's way of remaining prepared. It is characterized by sleep disturbances, muscle tension, and a lower threshold for startle responses and can persist years after trauma occurs. It is also one of the primary diagnostic criteria for PTSD.

Hyperarousal is a consequence of biological changes initiated by trauma. Although it

Case Illustration: Kimi

Kimi is a 35-year-old Native American woman who was group raped at the age of 16 on her walk home from a suburban high school. She recounts how her whole life changed on that day. "I never felt safe being alone after the rape. I used to enjoy walking everywhere. Afterward, I couldn't tolerate the fear that would arise when I walked in the neighborhood. It didn't matter whether I was alone or with friends—every sound that I heard would throw me into a state of fear. I felt like the same thing was going to happen again. It's gotten better with time, but I often feel as if I'm sitting on a tree limb waiting for it to break. I have a hard time relaxing. I can easily get startled if a leaf blows across my path or if my children scream while playing in the yard. The best way I can describe how I experience life is by comparing it to watching a scary, suspenseful movie—anxiously waiting for something to happen, palms sweating, heart pounding, on the edge of your chair."

serves as a means of self-protection after trauma, it can be detrimental. Hyperarousal can interfere with an individual's ability to take the necessary time to assess and appropriately respond to specific input, such as loud noises or sudden movements. Sometimes, hyperarousal can produce overreactions to situations perceived as dangerous when, in fact, the circumstances are safe.

Along with hyperarousal, sleep disturbances are very common in individuals who have experienced trauma. They can come in the form of early awakening, restless sleep, difficulty falling asleep, and nightmares. Sleep disturbances are most persistent among individuals who have trauma-related stress; the disturbances sometimes remain resistant to intervention long after other traumatic stress symptoms have been successfully treated. Numerous strategies are available beyond medication, including good sleep hygiene practices, cognitive rehearsals of nightmares, relaxation strategies, and nutrition.

Cognitive

Traumatic experiences can affect and alter cognitions. From the outset, trauma challenges the just-world or core life assumptions that

Cognitions and Trauma

The following examples reflect some of the types of cognitive or thought-process changes that can occur in response to traumatic stress.

Cognitive errors: Misinterpreting a current situation as dangerous because it resembles, even remotely, a previous trauma (e.g., a client overreacting to an overturned canoe in 8 inches of water, as if she and her paddle companion would drown, due to her previous experience of nearly drowning in a rip current 5 years earlier).

Excessive or inappropriate guilt: Attempting to make sense cognitively and gain control over a traumatic experience by assuming responsibility or possessing survivor's guilt, because others who experienced the same trauma did not survive.

Idealization: Demonstrating inaccurate rationalizations, idealizations, or justifications of the perpetrator's behavior, particularly if the perpetrator is or was a caregiver. Other similar reactions mirror idealization; traumatic bonding is an emotional attachment that develops (in part to secure survival) between perpetrators who engage in interpersonal trauma and their victims, and Stockholm syndrome involves compassion and loyalty toward hostage takers (de Fabrique, Van Hasselt, Vecchi, & Romano, 2007).

Trauma-induced hallucinations or delusions: Experiencing hallucinations and delusions that, although they are biological in origin, contain cognitions that are congruent with trauma content (e.g., a woman believes that a person stepping onto her bus is her father, who had sexually abused her repeatedly as child, because he wore shoes similar to those her father once wore).

Intrusive thoughts and memories: Experiencing, without warning or desire, thoughts and memories associated with the trauma. These intrusive thoughts and memories can easily trigger strong emotional and behavioral reactions, as if the trauma was recurring in the present. The intrusive thoughts and memories can come rapidly, referred to as flooding, and can be disruptive at the time of their occurrence. If an individual experiences a trigger, he or she may have an increase in intrusive thoughts and memories for a while. For instance, individuals who inadvertently are retraumatized due to program or clinical practices may have a surge of intrusive thoughts of past trauma, thus making it difficult for them to discern what is happening now versus what happened then. Whenever counseling focuses on trauma, it is likely that the client will experience some intrusive thoughts and memories. It is important to develop coping strategies before, as much as possible, and during the delivery of trauma-informed and trauma-specific treatment.

help individuals navigate daily life (Janoff-Bulman, 1992). For example, it would be difficult to leave the house in the morning if you believed that the world was not safe, that all people are dangerous, or that life holds no promise. Belief that one's efforts and intentions can protect oneself from bad things makes it less likely for an individual to perceive personal vulnerability. However, traumatic events—particularly if they are unexpected—can challenge such beliefs.

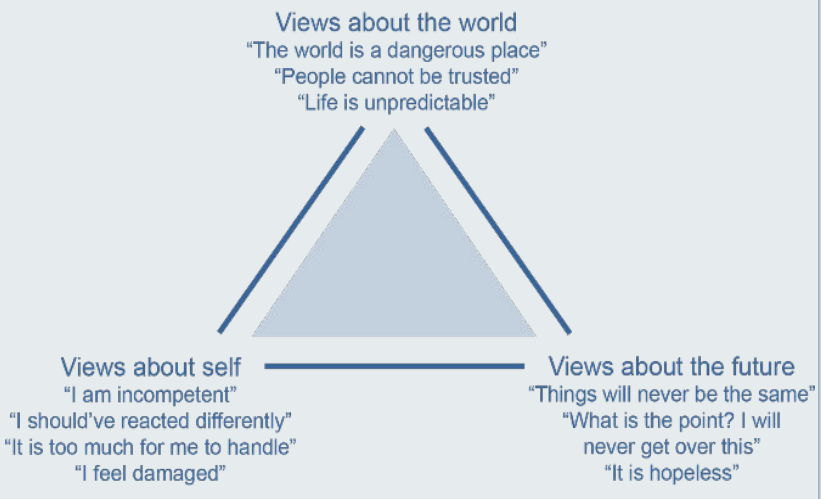
Let's say you always considered your driving time as "your time"—and your car as a safe place to spend that time. Then someone hits you from behind at a highway entrance. Almost immediately, the accident affects how you perceive the world, and from that moment onward, for months following the crash, you feel unsafe in any car. You become hypervigilant about other drivers and perceive that other cars are drifting into your lane or failing to stop at a safe distance behind you. For a time, your perception of safety is eroded, often leading to compensating behaviors (e.g., excessive glancing into the rearview mirror to see whether the vehicles behind you are stopping) until the belief is restored or reworked. Some individuals never return to their previous belief systems after a trauma, nor do they find a way to rework them—thus leading to a worldview that life is unsafe. Still, many other individuals are able to return to organizing core beliefs that support their perception of safety.

Many factors contribute to cognitive patterns prior to, during, and after a trauma. Adopting Beck and colleagues' cognitive triad model (1979), trauma can alter three main cognitive patterns: thoughts about self, the world (others/environment), and the future. To clarify, trauma can lead individuals to see themselves as incompetent or damaged, to see others and the world as unsafe and unpredictable, and to see the future as hopeless—believing that personal suffering will continue, or negative outcomes will preside for the foreseeable future (see Exhibit 1.3-2). Subsequently, this set of cognitions can greatly influence clients' belief in their ability to use internal resources and external support effectively. From a cognitive–behavioral perspective, these cognitions have a bidirectional relationship in sustaining or contributing to the development of depressive and anxiety symptoms after trauma. However, it is possible for cognitive patterns to help protect against debilitating psychological symptoms as well. Many factors contribute to cognitive patterns prior to, during, and after a trauma.

Feeling different

An integral part of experiencing trauma is feeling different from others, whether or not the trauma was an individual or group experience. Traumatic experiences typically feel surreal and challenge the necessity and value of mundane activities of daily life. Survivors

Exhibit 1.3-2: Cognitive Triad of Traumatic Stress



often believe that others will not fully understand their experiences, and they may think that sharing their feelings, thoughts, and reactions related to the trauma will fall short of expectations. However horrid the trauma may be, the *experience* of the trauma is typically profound.

The type of trauma can dictate how an individual feels different or believes that they are different from others. Traumas that generate shame will often lead survivors to feel more alienated from others—believing that they are "damaged goods." When individuals believe that their experiences are unique and incomprehensible, they are more likely to seek support, if they seek support at all, only with others who have experienced a similar trauma.

Triggers and flashbacks

Triggers

A trigger is a stimulus that sets off a memory of a trauma or a specific portion of a traumatic experience. Imagine you were trapped briefly in a car after an accident. Then, several years later, you were unable to unlatch a lock after using a restroom stall; you might have begun to feel a surge of panic reminiscent of the accident, even though there were other avenues of escape from the stall. Some triggers can be identified and anticipated easily, but many are subtle and inconspicuous, often surprising the individual or catching him or her off guard. In treatment, it is important to help clients identify potential triggers, draw a connection between strong emotional reactions and triggers, and develop coping strategies to manage those moments when a trigger occurs. A trigger is any sensory reminder of the traumatic event: a noise, smell, temperature, other physical sensation, or visual scene. Triggers can generalize to any characteristic, no matter how remote, that resembles or represents a previous trauma, such as revisiting the location where the trauma occurred, being alone, having your children reach the same age that you were when you experienced the trauma, seeing the same breed of dog that bit you, or hearing loud voices. Triggers are often associated with the time of day, season, holiday, or anniversary of the event.

Flashbacks

A flashback is reexperiencing a previous traumatic experience as if it were actually happening in that moment. It includes reactions that often resemble the client's reactions during the trauma. Flashback experiences are very brief and typically last only a few seconds, but the emotional aftereffects linger for hours or longer. Flashbacks are commonly initiated by a trigger, but not necessarily. Sometimes, they occur out of the blue. Other times, specific physical states increase a person's vulnerability to reexperiencing a trauma, (e.g., fatigue, high

Advice to Counselors: Helping Clients Manage Flashbacks and Triggers

If a client is triggered in a session or during some aspect of treatment, help the client focus on what is happening in the here and now; that is, use grounding techniques. Behavioral health service providers should be prepared to help the client get regrounded so that they can distinguish between what is happening now versus what had happened in the past (see Covington, 2008, and Najavits, 2002b, 2007b, for more grounding techniques). Offer education about the experience of triggers and flashbacks, and then normalize these events as common traumatic stress reactions. Afterward, some clients need to discuss the experience and understand why the flashback or trigger occurred. It often helps for the client to draw a connection between the trigger and the traumatic event(s). This can be a preventive strategy whereby the client can anticipate that a given situation places him or her at higher risk for retraumatization and requires use of coping strategies, including seeking support.

Source: Green Cross Academy of Traumatology, 2010.

stress levels). Flashbacks can feel like a brief movie scene that intrudes on the client. For example, hearing a car backfire on a hot, sunny day may be enough to cause a veteran to respond as if he or she were back on military patrol. Other ways people reexperience trauma, besides flashbacks, are via nightmares and intrusive thoughts of the trauma.

Dissociation, depersonalization, and derealization

Dissociation is a mental process that severs connections among a person's thoughts, memories, feelings, actions, and/or sense of identity. Most of us have experienced dissociation—losing the ability to recall or track a particular action (e.g., arriving at work but not remembering the last minutes of the drive). Dissociation happens because the person is engaged in an automatic activity and is not paying attention to his or her immediate environment. Dissociation can also occur during severe stress or trauma as a protective element whereby the individual incurs distortion of time, space, or identity. This is a common symptom in traumatic stress reactions.

Dissociation helps distance the experience from the individual. People who have experienced severe or developmental trauma may have learned to separate themselves from distress to survive. At times, dissociation can be very pervasive and symptomatic of a mental disorder, such as dissociative identity disorder (DID; formerly known as multiple personality disorder). According to the DSM-5, "dissociative disorders are characterized by a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior" (APA, 2013a, p. 291). Dissociative disorder diagnoses are closely associated with histories of severe childhood trauma or pervasive, human-caused, intentional trauma, such as that experienced by concentration camp survivors or victims of ongoing political imprisonment, torture, or long-term isolation. A mental health professional, preferably with significant training in working with dissociative disorders and with trauma, should be consulted when a dissociative disorder diagnosis is suspected.

Potential Signs of Dissociation

- Fixed or "glazed" eyes
- Sudden flattening of affect
- Long periods of silence
- Monotonous voice
- Stereotyped movements
- Responses not congruent with the present context or situation
- Excessive intellectualization

(Briere, 1996a)

The characteristics of DID can be commonly accepted experiences in other cultures, rather than being viewed as symptomatic of a traumatic experience. For example, in non-Western cultures, a sense of alternate beings within oneself may be interpreted as being inhabited by spirits or ancestors (Kirmayer, 1996). Other experiences associated with dissociation include depersonalization—psychologically "leaving one's body," as if watching oneself from a distance as an observer or through derealization, leading to a sense that what is taking place is unfamiliar or is not real.

If clients exhibit signs of dissociation, behavioral health service providers can use grounding techniques to help them reduce this defense strategy. One major long-term consequence of dissociation is the difficulty it causes in connecting strong emotional or physical reactions with an event. Often, individuals may believe that they are going crazy because they are not in touch with the nature of their reactions. By educating clients on the resilient qualities of dissociation while also emphasizing that it prevents them from addressing or

validating the trauma, individuals can begin to understand the role of dissociation. All in all, it is important when working with trauma survivors that the intensity level is not so great that it triggers a dissociative reaction and prevents the person from engaging in the process.

Behavioral

Traumatic stress reactions vary widely; often, people engage in behaviors to manage the aftereffects, the intensity of emotions, or the distressing aspects of the traumatic experience. Some people reduce tension or stress through avoidant, self-medicating (e.g., alcohol abuse), compulsive (e.g., overeating), impulsive (e.g., high-risk behaviors), and/or self-injurious behaviors. Others may try to gain control over their experiences by being aggressive or subconsciously reenacting aspects of the trauma.

Behavioral reactions are also the consequences of, or learned from, traumatic experiences. For example, some people act like they can't control their current environment, thus failing to take action or make decisions long after the trauma (learned helplessness). Other associate elements of the trauma with current activities, such as by reacting to an intimate moment in a significant relationship as dangerous or unsafe years after a date rape. The following sections discuss behavioral consequences of trauma and traumatic stress reactions.

Reenactments

A hallmark symptom of trauma is reexperiencing the trauma in various ways. Reexperiencing can occur through reenactments (literally, to "redo"), by which trauma survivors repetitively relive and recreate a past trauma in their present lives. This is very apparent in children, who play by mimicking what occurred during the trauma, such as by pretending to crash a toy airplane into a toy building after seeing televised images of the terrorist attacks on the World Trade Center on September 11, 2001. Attempts to understand reenactments are very complicated, as reenactments occur for a variety of reasons. Sometimes, individuals reenact past traumas to master them. Examples of reenactments include a variety of behaviors: self-injurious behaviors, hypersexuality, walking alone in unsafe areas or other high-risk behaviors, driving recklessly, or involvement in repetitive destructive relationships (e.g., repeatedly getting into romantic relationships with people who are abusive or violent), to name a few.

Self-harm and self-destructive behaviors

Self-harm is any type of intentionally self-inflicted harm, regardless of the severity of injury or whether suicide is intended. Often, self-harm is an attempt to cope with emotional or physical distress that seems overwhelming or to cope with a profound sense of dissociation or being trapped, helpless, and "damaged" (Herman, 1997; Santa Mina & Gallop, 1998). Self-harm is associated with past childhood sexual abuse and other forms of trauma as well as substance abuse. Thus,

Resilient Responses to Trauma

Many people find healthy ways to cope with, respond to, and heal from trauma. Often, people automatically reevaluate their values and redefine what is important after a trauma. Such resilient responses include:

- Increased bonding with family and community.
- Redefined or increased sense of purpose and meaning.
- Increased commitment to a personal mission.
- Revised priorities.
- Increased charitable giving and volunteerism.

Case Illustration: Marco

Marco, a 30-year-old man, sought treatment at a local mental health center after a 2-year bout of anxiety symptoms. He was an active member of his church for 12 years, but although he sought help from his pastor about a year ago, he reports that he has had no contact with his pastor or his church since that time. Approximately 3 years ago, his wife took her own life. He describes her as his soulmate and has had a difficult time understanding her actions or how he could have prevented them.

In the initial intake, he mentioned that he was the first person to find his wife after the suicide and reported feelings of betrayal, hurt, anger, and devastation since her death. He claimed that everyone leaves him or dies. He also talked about his difficulty sleeping, having repetitive dreams of his wife, and avoiding relationships. In his first session with the counselor, he initially rejected the counselor before the counselor had an opportunity to begin reviewing and talking about the events and discomfort that led him to treatment.

In this scenario, Marco is likely reenacting his feelings of abandonment by attempting to reject others before he experiences another rejection or abandonment. In this situation, the counselor will need to recognize the reenactment, explore the behavior, and examine how reenactments appear in other situations in Marco's life.

addressing self-harm requires attention to the client's reasons for self-harm. More than likely, the client needs help recognizing and coping with emotional or physical distress in manageable amounts and ways.

Among the self-harm behaviors reported in the literature are cutting, burning skin by heat (e.g., cigarettes) or caustic liquids, punching hard enough to self-bruise, head banging, hair pulling, self-poisoning, inserting foreign objects into bodily orifices, excessive nail biting, excessive scratching, bone breaking, gnawing at flesh, interfering with wound healing, tying off body parts to stop breathing or blood flow, swallowing sharp objects, and suicide. Cutting and burning are among the most common forms of self-harm.

Self-harm tends to occur most in people who have experienced repeated and/or early trauma (e.g., childhood sexual abuse) rather than in those who have undergone a single adult trauma (e.g., a community-wide disaster or a serious car accident). There are strong associations between eating disorders, self-harm, and substance abuse (Claes &Vandereycken, 2007; for discussion, see Harned, Najavits, & Weiss, 2006). Self-mutilation is also associated with (and part of the diagnostic criteria for) a number of personality disorders, including borderline and histrionic, as well as DID, depression, and some forms of schizophrenia; these disorders can co-occur with traumatic stress reactions and disorders.

It is important to distinguish self-harm that is suicidal from self-harm that is not suicidal and to assess and manage both of these very serious dangers carefully. Most people who engage in self-harm are not doing so with the intent to kill themselves (Noll, Horowitz, Bonanno, Trickett, & Putnam, 2003)—although self-harm can be life threatening and can escalate into suicidality if not managed therapeutically. Self-harm can be a way of getting attention or manipulating others, but most often it is not. Self-destructive behaviors such as substance abuse, restrictive or binge eating, reckless automobile driving, or high-risk impulsive behavior are different from self-harming behaviors but are also seen in clients with a history of trauma. Self-destructive behaviors differ from self-harming behaviors in that there may be no immediate negative impact of the behavior on the individual; they differ from suicidal behavior in that there is no intent to cause death in the short term.

Advice to Counselors: Working With Clients Who Are Self-Injurious

Counselors who are unqualified or uncomfortable working with clients who demonstrate self-harming, self-destructive, or suicidal or homicidal ideation, intent, or behavior should work with their agencies and supervisors to refer such clients to other counselors. They should consider seeking specialized supervision on how to manage such clients effectively and safely and how to manage their feelings about these issues. The following suggestions assume that the counselor has had sufficient training and experience to work with clients who are self-injurious. To respond appropriately to a client who engages in self-harm, counselors should:

- Screen the client for self-harm and suicide risk at the initial evaluation and throughout treatment.
- Learn the client's perspective on self-harm and how it "helps."
- Understand that self-harm is often a coping strategy to manage the intensity of emotional and/or physical distress.
- Teach the client coping skills that improve his or her management of emotions without self-harm.
- Help the client obtain the level of care needed to manage genuine risk of suicide or severe self-injury. This might include hospitalization, more intensive programming (e.g., intensive outpatient, partial hospitalization, residential treatment), or more frequent treatment sessions. The goal is to stabilize the client as quickly as possible, and then, if possible, begin to focus treatment on developing coping strategies to manage self-injurious and other harmful impulses.
- Consult with other team members, supervisors, and, if necessary, legal experts to determine whether one's efforts with and conceptualization of the self-harming client fit best practice guidelines. See, for example, Treatment Improvement Protocol (TIP) 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (Center for Substance Abuse Treatment [CSAT], 2005c). Document such consultations and the decisions made as a result of them thoroughly and frequently.
- Help the client identify how substance use affects self-harm. In some cases, it can increase the behavior (e.g., alcohol disinhibits the client, who is then more likely to self-harm). In other cases, it can decrease the behavior (e.g., heroin evokes relaxation and, thus, can lessen the urge to self-harm). In either case, continue to help the client understand how abstinence from substances is necessary so that he or she can learn more adaptive coping.
- Work collaboratively with the client to develop a plan to create a sense of safety. Individuals are affected by trauma in different ways; therefore, safety or a safe environment may mean something entirely different from one person to the next. Allow the client to define what safety means to him or her.

Counselors can also help the client prepare a safety card that the client can carry at all times. The card might include the counselor's contact information, a 24-hour crisis number to call in emergencies, contact information for supportive individuals who can be contacted when needed, and, if appropriate, telephone numbers for emergency medical services. The counselor can discuss with the client the types of signs or crises that might warrant using the numbers on the card. Additionally, the counselor might check with the client from time to time to confirm that the information on the card is current.

TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009a), has examples of safety agreements specifically for suicidal clients and discusses their uses in more detail. There is no credible evidence that a safety agreement is effective in preventing a suicide attempt or death. Safety agreements for clients with suicidal thoughts and behaviors should only be used as an adjunct support accompanying professional screening, assessment, and treatment for people with suicidal thoughts and behaviors. Keep in mind that safety plans or agreements may be perceived by the trauma survivor as a means of controlling behavior, subsequently replicating or triggering previous traumatic experiences.

All professionals—and in some States, anyone—could have ethical and legal responsibilities to those clients who pose an imminent danger to themselves or others. Clinicians should be aware of the pertinent State laws where they practice and the relevant Federal and professional regulations.

However, as with self-harming behavior, self-destructive behavior needs to be recognized and addressed and may persist—or worsen—without intervention.

Consumption of substances

Substance use often is initiated or increased after trauma. Clients in early recovery—especially those who develop PTSD or have it reactivated—have a higher relapse risk if they experience a trauma. In the first 2 months after September 11, 2001, more than a quarter of New Yorker residents who smoked cigarettes, drank alcohol, or used marijuana (about 265,000 people) increased their consumption. The increases continued 6 months after the attacks (Vlahov, Galea, Ahern, Resnick, & Kilpatrick, 2004). A study by the Substance Abuse and Mental Health Services Administration (SAMHSA, Office of Applied Studies, 2002) used National Survey on Drug Use and Health data to compare the first three quarters of 2001 with the last quarter and reported an increase in the prevalence rate for alcohol use among people 18 or older in the New York metropolitan area during the fourth quarter.

Interviews with New York City residents who were current or former cocaine or heroin users indicated that many who had been clean for 6 months or less relapsed after September 11, 2001. Others, who lost their income and could no longer support their habit, enrolled in methadone programs (Weiss et al., 2002). After the Oklahoma City bombing in 1995, Oklahomans reported double the normal rate of alcohol use, smoking more cigarettes, and a higher incidence of initiating smoking months and even years after the bombing (Smith, Christiansen, Vincent, & Hann, 1999).

Self-medication

Khantzian's self-medication theory (1985) suggests that drugs of abuse are selected for their specific effects. However, no definitive pattern has yet emerged of the use of particular substances in relation to PTSD or trauma symptoms. Use of substances can vary based on a variety of factors, including which trauma symptoms are most prominent for an individual and the individual's access to particular substances. Unresolved traumas sometimes lurk behind the emotions that clients cannot allow themselves to experience. Substance use and abuse in trauma survivors can be a way to self-medicate and thereby avoid or displace difficult emotions associated with traumatic experiences. When the substances are withdrawn, the survivor may use other behaviors to self-soothe, self-medicate, or avoid emotions. As likely, emotions can appear after abstinence in the form of anxiety and depression.

Avoidance

Avoidance often coincides with anxiety and the promotion of anxiety symptoms. Individuals begin to avoid people, places, or situations to alleviate unpleasant emotions, memories, or circumstances. Initially, the avoidance works, but over time, anxiety increases and the perception that the situation is unbearable or dangerous increases as well, leading to a greater need to avoid. Avoidance can be adaptive, but it is also a behavioral pattern that reinforces perceived danger without testing its validity, and it typically leads to greater problems across major life areas (e.g., avoiding emotionally oriented conversations in an intimate relationship). For many individuals who have traumatic stress reactions, avoidance is commonplace. A person may drive 5 miles longer to avoid the road where he or she had an accident. Another individual may avoid crowded places in fear of an assault or to circumvent strong emotional memories about an earlier assault that took place in a crowded area. Avoidance can come in many forms. When people can't tolerate strong affects associated with traumatic memories, they avoid, project,

deny, or distort their trauma-related emotional and cognitive experiences. A key ingredient in trauma recovery is learning to manage triggers, memories, and emotions without avoidance—in essence, becoming desensitized to traumatic memories and associated symptoms.

Social/Interpersonal

A key ingredient in the early stage of TIC is to establish, confirm, or reestablish a support system, including culturally appropriate activities, as soon as possible. Social supports and relationships can be protective factors against traumatic stress. However, trauma typically affects relationships significantly, regardless of whether the trauma is interpersonal or is of some other type. Relationships require emotional exchanges, which means that others who have close relationships or friendships with the individual who survived the trauma(s) are often affected as well—either through secondary traumatization or by directly experiencing the survivor's traumatic stress reactions. In natural disasters, social and community supports can be abruptly eroded and difficult to rebuild after the initial disaster relief efforts have waned.

Survivors may readily rely on family members, friends, or other social supports—or they may avoid support, either because they believe that no one will be understanding or trustworthy or because they perceive their own needs as a burden to others. Survivors who have strong emotional or physical reactions, including outbursts during nightmares, may pull away further in fear of being unable to predict their own reactions or to protect their own safety and that of others. Often, trauma survivors feel ashamed of their stress reactions, which further hampers their ability to use their support systems and resources adequately.

Many survivors of childhood abuse and interpersonal violence have experienced a significant sense of betrayal. They have often encountered trauma at the hands of trusted caregivers and family members or through significant relationships. This history of betrayal can disrupt forming or relying on supportive relationships in recovery, such as peer supports and counseling. Although this fear of trusting others is protective, it can lead to difficulty in connecting with others and greater vigilance in observing the behaviors of others, including behavioral health service providers. It is exceptionally difficult to override the feeling that someone is going to hurt you, take advantage of you, or, minimally, disappoint you. Early betrayal can affect one's ability to develop attachments, yet the formation of supportive relationships is an important antidote in the recovery from traumatic stress.

Developmental

Each age group is vulnerable in unique ways to the stresses of a disaster, with children and the elderly at greatest risk. Young children may display generalized fear, nightmares, heightened arousal and confusion, and physical symptoms, (e.g., stomachaches, headaches). School-age children may exhibit symptoms such as aggressive behavior and anger, regression to behavior seen at younger ages, repetitious traumatic play, loss of ability to concentrate, and worse school performance. Adolescents may display depression and social withdrawal, rebellion, increased risky activities such as sexual acting out, wish for revenge and action-oriented responses to trauma, and sleep and eating disturbances (Hamblen, 2001). Adults may display sleep problems, increased agitation, hypervigilance, isolation or withdrawal, and increased use of alcohol or drugs. Older adults may exhibit increased withdrawal and isolation, reluctance to leave home, worsening of chronic illnesses, confusion, depression, and fear (DeWolfe & Nordboe, 2000b).

Neurobiological Development: Consequences of Early Childhood Trauma

Findings in developmental psychobiology suggest that the consequences of early maltreatment produce enduring negative effects on brain development (DeBellis, 2002; Liu, Diorio, Day, Francis, & Meaney, 2000; Teicher, 2002). Research suggests that the first stage in a cascade of events produced by early trauma and/or maltreatment involves the disruption of chemicals that function as neurotransmitters (e.g., cortisol, norepinephrine, dopamine), causing escalation of the stress response (Heim, Mletzko, Purselle, Musselman, & Nemeroff, 2008; Heim, Newport, Mletzko, Miller, & Nemeroff, 2008; Teicher, 2002). These chemical responses can then negatively affect critical neural growth during specific sensitive periods of childhood development and can even lead to cell death.

Adverse brain development can also result from elevated levels of cortisol and catecholamines by contributing to maturational failures in other brain regions, such as the prefrontal cortex (Meaney, Brake, & Gratton, 2002). Heim, Mletzko et al. (2008) found that the neuropeptide oxytocin—important for social affiliation and support, attachment, trust, and management of stress and anxiety—was markedly decreased in the cerebrospinal fluid of women who had been exposed to childhood maltreatment, particularly those who had experienced emotional abuse. The more childhood traumas a person had experienced, and the longer their duration, the lower that person's current level of oxytocin was likely to be and the higher her rating of current anxiety was likely to be.

Using data from the Adverse Childhood Experiences Study, an analysis by Anda, Felitti, Brown et al. (2006) confirmed that the risk of negative outcomes in affective, somatic, substance abuse, memory, sexual, and aggression-related domains increased as scores on a measure of eight ACEs increased. The researchers concluded that the association of study scores with these outcomes can serve as a theoretical parallel for the effects of cumulative exposure to stress on the developing brain and for the resulting impairment seen in multiple brain structures and functions.

The National Child Traumatic Stress Network (http://www.nctsn.org) offers information about childhood abuse, stress, and physiological responses of children who are traumatized. Materials are available for counselors, educators, parents, and caregivers. There are special sections on the needs of children in military families and on the impact of natural disasters on children's mental health.

Subthreshold Trauma-Related Symptoms

Many trauma survivors experience symptoms that, although they do not meet the diagnostic criteria for ASD or PTSD, nonetheless limit their ability to function normally (e.g., regulate emotional states, maintain steady and rewarding social and family relationships, function competently at a job, maintain a steady pattern of abstinence in recovery). These symptoms can be transient, only arising in a specific context; intermittent, appearing for several weeks or months and then receding; or a part of the individual's regular pattern of functioning (but not to the level of DSM-5 diagnostic criteria). Often, these patterns are termed "subthreshold" trauma symptoms. Like PTSD, the symptoms can be misdiagnosed as depression, anxiety, or another mental illness. Likewise, clients who have experienced trauma may link some of their symptoms to their trauma and diagnose themselves as having PTSD, even though they do not meet all criteria for that disorder.

Combat Stress Reaction

A phenomenon unique to war, and one that counselors need to understand well, is combat stress reaction (CSR). CSR is an acute anxiety reaction occurring during or shortly after participating in military conflicts and wars as well as other operations within the war zone, known as the theater. CSR is not a formal diagnosis, nor is it included in the DSM-5 (APA, 2013a). It is similar to acute stress

Case Illustration: Frank

Frank is a 36-year-old man who was severely beaten in a fight outside a bar. He had multiple injuries, including broken bones, a concussion, and a stab wound in his lower abdomen. He was hospitalized for 3.5 weeks and was unable to return to work, thus losing his job as a warehouse forklift operator. For several years, when faced with situations in which he perceived himself as helpless and overwhelmed, Frank reacted with violent anger that, to others, appeared grossly out of proportion to the situation. He has not had a drink in almost 3 years, but the bouts of anger persist and occur three to five times a year. They leave Frank feeling even more isolated from others and alienated from those who love him. He reports that he cannot watch certain television shows that depict violent anger; he has to stop watching when such scenes occur. He sometimes daydreams about getting revenge on the people who assaulted him.

Psychiatric and neurological evaluations do not reveal a cause for Frank's anger attacks. Other than these symptoms, Frank has progressed well in his abstinence from alcohol. He attends a support group regularly, has acquired friends who are also abstinent, and has reconciled with his family of origin. His marriage is more stable, although the episodes of rage limit his wife's willingness to commit fully to the relationship. In recounting the traumatic event in counseling, Frank acknowledges that he thought he was going to die as a result of the fight, especially when he realized he had been stabbed. As he described his experience, he began to become very anxious, and the counselor observed the rage beginning to appear.

After his initial evaluation, Frank was referred to an outpatient program that provided trauma-specific interventions to address his subthreshold trauma symptoms. With a combination of cognitive–behavioral counseling, EMDR, and anger management techniques, he saw a gradual decrease in symptoms when he recalled the assault. He started having more control of his anger when memories of the trauma emerged. Today, when feeling trapped, helpless, or overwhelmed, Frank has resources for coping and does not allow his anger to interfere with his marriage or other relationships.

reaction, except that the precipitating event or events affect military personnel (and civilians exposed to the events) in an armed conflict situation. The terms "combat stress reaction" and "posttraumatic stress injury" are relatively new, and the intent of using these new terms is to call attention to the unique experiences of combat-related stress as well as to decrease the shame that can be associated with seeking behavioral health services for PTSD (for more information on veterans and combat stress reactions, see the planned TIP, *Reintegration-Related Behavioral Health Issues for Veterans and Military Families*; SAMHSA, planned f).

Although stress mobilizes an individual's physical and psychological resources to perform more effectively in combat, reactions to the stress may persist long after the actual danger has ended. As with other traumas, the nature of the event(s), the reactions of others, and the survivor's psychological history and resources affect the likelihood and severity of CSR. With combat veterans, this translates to the number, intensity, and duration of threat factors; the social support of peers in the veterans' unit; the emotional and cognitive resilience of the service members; and the quality of military leadership. CSR can vary from manageable and mild to debilitating and severe. Common, less severe symptoms of CSR include tension, hypervigilance, sleep problems, anger, and difficulty concentrating. If left untreated, CSR can lead to PTSD.

Common causes of CSR are events such as a direct attack from insurgent small arms fire or a military convoy being hit by an improvised explosive device, but combat stressors encompass a diverse array of traumatizing events, such as seeing grave injuries, watching others

Advice to Counselors: Understanding the Nature of Combat Stress

Several sources of information are available to help counselors deepen their understanding of combat stress and postdeployment adjustment. Friedman (2006) explains how a prolonged combat-ready stance, which is adaptive in a war zone, becomes hypervigilance and overprotectiveness at home. He makes the point that the "mutual interdependence, trust, and affection" (p. 587) that are so necessarily a part of a combat unit are different from relationships with family members and colleagues in a civilian workplace. This complicates the transition to civilian life. *Wheels Down: Adjusting to Life After Deployment* (Moore & Kennedy, 2011) provides practical advice for military service members, including inactive or active duty personnel and veterans, in transitioning from the theater to home.

The following are just a few of the many resources and reports focused on combat-related psychological and stress issues:

- *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (Tanielian & Jaycox, 2008)
- *On Killing* (Grossman, 1995), an indepth analysis of the psychological dynamics of combat
- *Haunted by Combat* (Paulson & Krippner, 2007), which contains specific chapters on Reserve and National Guard troops and female veterans
- *Treating Young Veterans: Promoting Resilience Through Practice and Advocacy* (Kelly, Howe-Barksdale, & Gitelson, 2011)

die, and making on-the-spot decisions in ambiguous conditions (e.g., having to determine whether a vehicle speeding toward a military checkpoint contains insurgents with explosives or a family traveling to another area). Such circumstances can lead to combat stress. Military personnel also serve in noncombat positions (e.g., healthcare and administrative roles), and personnel filling these supportive roles can be exposed to combat situations by proximity or by witnessing their results.

Specific Trauma-Related Psychological Disorders

Part of the definition of trauma is that the individual responds with intense fear, helplessness, or horror. Beyond that, in both the short term and the long term, trauma comprises a range of reactions from normal (e.g., being unable to concentrate, feeling sad, having trouble sleeping) to warranting a diagnosis of a trauma-related mental disorder. Most people who experience trauma have no long-lasting disabling effects; their coping skills and the support of those around them are sufficient to help them overcome their difficulties, and their ability to function on a daily basis over time is unimpaired. For others, though, the symptoms of trauma are more severe and last longer. The most common diagnoses associated with trauma are PTSD and ASD, but trauma is also associated with the onset of other mental disorders—particularly substance use disorders, mood disorders, various anxiety disorders, and personality disorders. Trauma also typically exacerbates symptoms of preexisting disorders, and, for people who are predisposed to a mental disorder, trauma can precipitate its onset. Mental disorders can occur almost simultaneously with trauma exposure or manifest sometime thereafter.

Acute Stress Disorder

ASD represents a normal response to stress. Symptoms develop within 4 weeks of the trauma and can cause significant levels of distress. Most individuals who have acute stress reactions never develop further impairment or PTSD. Acute stress disorder is highly associated with the experience of one specific trauma rather than the experience of long-term exposure to chronic traumatic stress. Diagnostic criteria are presented in Exhibit 1.3-3.

Exhibit 1.3-3: DSM-5 Diagnostic Criteria for ASD

A. Exposure to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways:
   1. Directly experiencing the traumatic event(s).
   2. Witnessing, in person, the event(s) as it occurred to others.
   3. Learning that the event(s) occurred to a close family member or close friend. **Note:** In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
   4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse). **Note:** This does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of nine (or more) of the following symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred:

Intrusion Symptoms:
   1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
   2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the event(s). **Note:** In children, there may be frightening dreams without recognizable content.
   3. Dissociative reactions (e.g., flashbacks), during which the individual feels or acts as if the traumatic event(s) were recurring. Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings. **Note:** In children, trauma-specific reenactment may occur in play.
   4. Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Negative Mood:
   5. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

Dissociative Symptoms:
   6. An altered sense of the reality of one's surroundings or oneself (e.g., seeing oneself from another's perspective, being in a daze, time slowing).
   7. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors, such as head injury, alcohol, or drugs).

Avoidance Symptoms:
   8. Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
   9. Efforts to avoid external reminders (e.g., people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Arousal Symptoms:
   10. Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep).
   11. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
   12. Hypervigilance.
   13. Problems with concentration.
   14. Exaggerated startle response.

(Continued on the next page.)

Exhibit 1.3-3: DSM-5 Diagnostic Criteria for ASD (continued)

C. Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure. **Note:** Symptoms typically begin immediately after the trauma, but persistence for at least 3 days and up to a month is needed to meet disorder criteria.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition (e.g., mild traumatic brain injury) and is not better explained by brief psychotic disorder.

Source: APA, 2013a, pp. 280–281.

The primary presentation of an individual with an acute stress reaction is often that of someone who appears overwhelmed by the traumatic experience. The need to talk about the experience can lead the client to seem self-centered and unconcerned about the needs of others. He or she may need to describe, in repetitive detail, what happened, or may seem obsessed with trying to understand what happened in an effort to make sense of the experience. The client is often hypervigilant and avoids circumstances that are reminders of the trauma. For instance, someone who was in a serious car crash in heavy traffic can become anxious and avoid riding in a car or driving in traffic for a finite time afterward. Partial amnesia for the trauma often accompanies ASD, and the individual may repetitively question others to fill in details. People with ASD symptoms sometimes seek assurance from others that the event happened in the way they remember, that they are not "going crazy" or "losing it," and that they could not have prevented the event. The next case illustration demonstrates the time-limited nature of ASD.

Differences between ASD and PTSD

It is important to consider the differences between ASD and PTSD when forming a diagnostic impression. The primary difference is the amount of time the symptoms have been present. ASD resolves 2 days to 4 weeks after an event, whereas PTSD continues beyond the 4-week period. The diagnosis of ASD can change to a diagnosis of PTSD if the condition is noted within the first 4 weeks after the event, but the symptoms persist past 4 weeks.

ASD also differs from PTSD in that the ASD diagnosis requires 9 out of 14 symptoms from five categories, including intrusion, negative mood, dissociation, avoidance, and arousal. These symptoms can occur at the time of the trauma or in the following month. Studies indicate that dissociation at the time of trauma is a good predictor of subsequent PTSD, so the inclusion of dissociative symptoms makes it more likely that those who develop ASD will later be diagnosed with PTSD (Bryant & Harvey, 2000). Additionally, ASD is a transient disorder, meaning that it is present in a person's life for a relatively short time and then passes. In contrast, PTSD typically becomes a primary feature of an individual's life. Over a lengthy period, PTSD can have profound effects on clients' perceptions of safety, their sense of hope for the future, their relationships with others, their physical health, the appearance of psychiatric symptoms, and their patterns of substance use and abuse.

There are common symptoms between PTSD and ASD, and untreated ASD is a possible predisposing factor to PTSD, but it is unknown whether most people with ASD are likely to develop PTSD. There is some suggestion that, as with PTSD, ASD is more

Case Illustration: Sheila

Two months ago, Sheila, a 55-year-old married woman, experienced a tornado in her home town. In the previous year, she had addressed a long-time marijuana use problem with the help of a treatment program and had been abstinent for about 6 months. Sheila was proud of her abstinence; it was something she wanted to continue. She regarded it as a mark of personal maturity; it improved her relationship with her husband, and their business had flourished as a result of her abstinence.

During the tornado, an employee reported that Sheila had become very agitated and had grabbed her assistant to drag him under a large table for cover. Sheila repeatedly yelled to her assistant that they were going to die. Following the storm, Sheila could not remember certain details of her behavior during the event. Furthermore, Sheila said that after the storm, she felt numb, as if she was floating out of her body and could watch herself from the outside. She stated that nothing felt real and it was all like a dream.

Following the tornado, Sheila experienced emotional numbness and detachment, even from people close to her, for about 2 weeks. The symptoms slowly decreased in intensity but still disrupted her life. Sheila reported experiencing disjointed or unconnected images and dreams of the storm that made no real sense to her. She was unwilling to return to the building where she had been during the storm, despite having maintained a business at this location for 15 years. In addition, she began smoking marijuana again because it helped her sleep. She had been very irritable and had uncharacteristic angry outbursts toward her husband, children, and other family members.

As a result of her earlier contact with a treatment program, Sheila returned to that program and engaged in psychoeducational, supportive counseling focused on her acute stress reaction. She regained abstinence from marijuana and returned shortly to a normal level of functioning. Her symptoms slowly diminished over a period of 3 weeks. With the help of her counselor, she came to understand the link between the trauma and her relapse, regained support from her spouse, and again felt in control of her life.

prevalent in women than in men (Bryant & Harvey, 2003). However, many people with PTSD do not have a diagnosis or recall a history of acute stress symptoms before seeking treatment for or receiving a diagnosis of PTSD.

Effective interventions for ASD can significantly reduce the possibility of the subsequent development of PTSD. Effective treatment of ASD can also reduce the incidence of other co-occurring problems, such as depression, anxiety, dissociative disorders, and compulsive behaviors (Bryant & Harvey, 2000). Intervention for ASD also helps the individual develop coping skills that can effectively prevent the recurrence of ASD after later traumas.

Although predictive science for ASD and PTSD will continue to evolve, both disorders are associated with increased substance use and mental disorders and increased risk of relapse; therefore, effective screening for ASD and PTSD is important for all clients with these disorders. Individuals in early recovery—lacking well-practiced coping skills, lacking environmental supports, and already operating at high levels of anxiety—are particularly susceptible to ASD. Events that would not normally be disabling can produce symptoms of intense helplessness and fear, numbing and depersonalization, disabling anxiety, and an inability to handle normal life events. Counselors should be able to recognize ASD and treat it rather than attributing the symptoms to a client's lack of motivation to change, being "dry drunk" (for those in substance abuse recovery), or being manipulative.

Posttraumatic Stress Disorder

The trauma-related disorder that receives the greatest attention is PTSD; it is the most

Case Illustration: Michael

Michael is a 62-year-old Vietnam veteran. He is a divorced father of two children and has four grandchildren. Both of his parents were dependent on alcohol. He describes his childhood as isolated. His father physically and psychologically abused him (e.g., he was beaten with a switch until he had welts on his legs, back, and buttocks). By age 10, his parents regarded him as incorrigible and sent him to a reformatory school for 6 months. By age 15, he was using marijuana, hallucinogens, and alcohol and was frequently truant from school.

At age 19, Michael was drafted and sent to Vietnam, where he witnessed the deaths of six American military personnel. In one incident, the soldier he was next to in a bunker was shot. Michael felt helpless as he talked to this soldier, who was still conscious. In Vietnam, Michael increased his use of both alcohol and marijuana. On his return to the United States, Michael continued to drink and use marijuana. He reenlisted in the military for another tour of duty.

His life stabilized in his early 30s, as he had a steady job, supportive friends, and a relatively stable family life. However, he divorced in his late 30s. Shortly thereafter, he married a second time, but that marriage ended in divorce as well. He was chronically anxious and depressed and had insomnia and frequent nightmares. He periodically binged on alcohol. He complained of feeling empty, had suicidal ideation, and frequently stated that he lacked purpose in his life.

In the 1980s, Michael received several years of mental health treatment for dysthymia. He was hospitalized twice and received 1 year of outpatient psychotherapy. In the mid-1990s, he returned to outpatient treatment for similar symptoms and was diagnosed with PTSD and dysthymia. He no longer used marijuana and rarely drank. He reported that he didn't like how alcohol or other substances made him feel anymore—he felt out of control with his emotions when he used them. Michael reported symptoms of hyperarousal, intrusion (intrusive memories, nightmares, and preoccupying thoughts about Vietnam), and avoidance (isolating himself from others and feeling "numb"). He reported that these symptoms seemed to relate to his childhood abuse and his experiences in Vietnam. In treatment, he expressed relief that he now understood the connection between his symptoms and his history.

commonly diagnosed trauma-related disorder, and its symptoms can be quite debilitating over time. Nonetheless, it is important to remember that PTSD symptoms are represented in a number of other mental illnesses, including major depressive disorder (MDD), anxiety disorders, and psychotic disorders (Foa et al., 2006). The DSM-5 (APA, 2013a) identifies four symptom clusters for PTSD: presence of intrusion symptoms, persistent avoidance of stimuli, negative alterations in cognitions and mood, and marked alterations in arousal and reactivity. Individuals must have been exposed to actual or threatened death, serious injury, or sexual violence, and the symptoms must produce significant distress and impairment for more than 4 weeks (Exhibit 1.3-4).

Certain characteristics make people more susceptible to PTSD, including one's unique personal vulnerabilities at the time of the traumatic exposure, the support (or lack of support) received from others at the time of the trauma and at the onset of trauma-related symptoms, and the way others in the person's environment gauge the nature of the traumatic event (Brewin, Andrews, & Valentine, 2000).

People with PTSD often present varying clinical profiles and histories. They can experience symptoms that are activated by environmental triggers and then recede for a period of time. Some people with PTSD who show mostly psychiatric symptoms (particularly depression and anxiety) are misdiagnosed and go untreated for their primary condition. For many people, the trauma experience and diagnosis

Exhibit 1.3-4: DSM-5 Diagnostic Criteria for PTSD

Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see the DSM-5 section titled "Posttraumatic Stress Disorder for Children 6 Years and Younger" (APA, 2013a).

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
   1. Directly experiencing the traumatic event(s).
   2. Witnessing, in person, the event(s) as it occurred to others.
   3. 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.
   4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
   1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
   2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). **Note:** In children, there may be frightening dreams without recognizable content.
   3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) **Note:** In children, trauma-specific reenactment may occur in play.
   4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
   5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

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:
   1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
   2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) 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 traumatic event(s) occurred, as evidenced by two (or more) of the following:
   1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia, and not to other factors such as head injury, alcohol, or drugs).
   2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
   3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
   4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
   5. Markedly diminished interest or participation in significant activities.
   6. Feelings of detachment or estrangement from others.
   7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

(Continued on the next page.)

Exhibit 1.3-4: DSM-5 Diagnostic Criteria for PTSD (continued)

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
   1. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
   2. Reckless or self-destructive behavior.
   3. Hypervigilance.
   4. Exaggerated startle response.
   5. Problems with concentration.
   6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted). **Note**: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify whether:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Source: APA, 2013a, pp. 271–272.

are obscured by co-occurring substance use disorder symptoms. The important feature of PTSD is that the disorder becomes an orienting feature of the individual's life. How well the person can work, with whom he or she associates, the nature of close and intimate relationships, the ability to have fun and rejuvenate, and the way in which an individual goes about confronting and solving problems in life are all affected by the client's trauma experiences and his or her struggle to recover.

Posttraumatic stress disorder: Timing of symptoms

Although symptoms of PTSD usually begin within 3 months of a trauma in adulthood, there can be a delay of months or even years before symptoms appear for some people. Some people may have minimal symptoms after a trauma but then experience a crisis later in life. Trauma symptoms can appear suddenly, even without conscious memory of the original trauma or without any overt provocation. Survivors of abuse in childhood can have a delayed response triggered by something that happens to them as adults. For example, seeing a movie about child abuse can trigger symptoms related

Advice to Counselors: Helping Clients With Delayed Trauma Responses

Clients who are experiencing a delayed trauma response can benefit if you help them to:

- Create an environment that allows acknowledgment of the traumatic event(s).
- Discuss their initial recall or first suspicion that they were having a traumatic response.
- Become educated on delayed trauma responses.
- Draw a connection between the trauma and presenting trauma-related symptoms.
- Create a safe environment.
- Explore their support systems and fortify them as needed.
- Understand that triggers can precede traumatic stress reactions, including delayed responses to trauma.
- Identify their triggers.
- Develop coping strategies to navigate and manage symptoms.

to the trauma. Other triggers include returning to the scene of the trauma, being reminded of it in some other way, or noting the anniversary of an event. Likewise, combat veterans and survivors of community-wide disasters may seem to be coping well shortly after a trauma, only to have symptoms emerge later when their life situations seem to have stabilized. Some clients in substance abuse recovery only begin to experience trauma symptoms when they maintain abstinence for some time. As individuals decrease tension-reducing or self-medicating behaviors, trauma memories and symptoms can emerge.

Culture and posttraumatic stress

Although research is limited across cultures, PTSD has been observed in Southeast Asian, South American, Middle Eastern, and Native American survivors (Osterman & de Jong, 2007; Wilson & Tang, 2007). As Stamm and Friedman (2000) point out, however, simply observing PTSD does not mean that it is the "best conceptual tool for characterizing posttraumatic distress among non-Western individuals" (p. 73). In fact, many trauma-related symptoms from other cultures do not fit the DSM-5 criteria. These include somatic and psychological symptoms and beliefs about the origins and nature of traumatic events. Moreover, religious and spiritual beliefs can affect how a survivor experiences a traumatic event and whether he or she reports the distress. For example, in societies where attitudes toward karma and the glorification of war veterans are predominant, it is harder for war veterans to come forward and disclose that they are emotionally overwhelmed or struggling. It would be perceived as inappropriate and possibly demoralizing to focus on the emotional distress that he or she still bears. (For a review of cultural competence in treating trauma, refer to Brown, 2008.)

Methods for measuring PTSD are also culturally specific. As part of a project begun in 1972, the World Health Organization (WHO) and the National Institutes of Health (NIH) embarked on a joint study to test the cross-cultural applicability of classification systems for various diagnoses. WHO and NIH identified apparently universal factors of psychological disorders and developed specific instruments to measure them. These instruments, the Composite International Diagnostic Interview and the Schedules for Clinical Assessment in Neuropsychiatry, include certain criteria from the DSM (Fourth Edition, Text Revision; APA, 2000a) as well as criteria from the International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10; Exhibit 1.3-5).

Exhibit 1.3-5: ICD-10 Diagnostic Criteria for PTSD

A. The patient must have been exposed to a stressful event or situation (either brief or long-lasting) of exceptionally threatening or catastrophic nature, which would be likely to cause pervasive distress in almost anyone.

B. There must be persistent remembering or "reliving" of the stressor in intrusive "flashbacks," vivid memories, or recurring dreams, or in experiencing distress when exposed to circumstances resembling or associated with the stressor.

C. The patient must exhibit an actual or preferred avoidance of circumstances resembling or associated with the stressor, which was not present before exposure to the stressor.

D. Either of the following must be present:
   1. Inability to recall, either partially or completely, some important aspects of the period of exposure to the stressor.
   2. Persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor), shown by any two of the following:
      a. Difficulty in falling or staying asleep.
      b. Irritability or outbursts of anger.
      c. Difficulty in concentrating.
      d. Exaggerated startle response.

E. Criteria B, C, and D must all be met within 6 months of the stressful event or at the end of a period of stress. (For some purposes, onset delayed more than 6 months can be included, but this should be clearly specified.)

Source: WHO, 1992.

Complex trauma and complex traumatic stress

When individuals experience multiple traumas, prolonged and repeated trauma during childhood, or repetitive trauma in the context of significant interpersonal relationships, their reactions to trauma have unique characteristics (Herman, 1992). This unique constellation of reactions, called complex traumatic stress, is not recognized diagnostically in the DSM-5, but theoretical discussions and research have begun to highlight the similarities and differences in symptoms of posttraumatic stress versus complex traumatic stress (Courtois & Ford, 2009). Often, the symptoms generated from complex trauma do not fully match PTSD criteria and exceed the severity of PTSD. Overall, literature reflects that PTSD criteria or subthreshold symptoms do not fully account for the persistent and more impairing clinical presentation of complex trauma. Even though current research in the study of traumatology is prolific, it is still in the early stages of development. The idea that there may be more diagnostic variations or subtypes is forthcoming, and this will likely pave the way for more client-matching interventions to better serve those individuals who have been repeatedly exposed to multiple, early childhood, and/or interpersonal traumas.

Other Trauma-Related and Co-Occurring Disorders

The symptoms of PTSD and other mental disorders overlap considerably; these disorders often coexist and include mood, anxiety,

The term "**co occurring disorders**" refers to cases when a person has one or more mental disorders as well as one or more substance use disorders (including sub stance abuse). Co occurring disorders are common among individuals who have a history of trauma and are seeking help.

Advice to Counselors: Universal Screening and Assessment

Only people specifically trained and licensed in mental health assessment should make diagnoses; trauma can result in complicated cases, and many symptoms can be present, whether or not they meet full diagnostic criteria for a specific disorder. Only a trained assessor can distinguish accurately among various symptoms and in the presence of co-occurring disorders. However, behavioral health professionals without specific assessment training can still serve an important role in screening for possible mental disorders using established screening tools (CSAT, 2005c; see also Chapter 4 of this TIP). In agencies and clinics, it is critical to provide such screenings systematically—for each client—as PTSD and other co-occurring disorders are typically underdiagnosed or misdiagnosed.

substance use, and personality disorders. Thus, it's common for trauma survivors to be underdiagnosed or misdiagnosed. If they have not been identified as trauma survivors, their psychological distress is often not associated with previous trauma, and/or they are diagnosed with a disorder that marginally matches their presenting symptoms and psychological sequelae of trauma. The following sections present a brief overview of some mental disorders that can result from (or be worsened by) traumatic stress. PTSD is not the only diagnosis related to trauma nor its only psychological consequence; trauma can broadly influence mental and physical health in clients who already have behavioral health disorders.

People With Mental Disorders

MDD is the most common co-occurring disorder in people who have experienced trauma and are diagnosed with PTSD. A well-established causal relationship exists between stressful events and depression, and a prior history of MDD is predictive of PTSD after exposure to major trauma (Foa et al., 2006).

Many survivors with severe mental disorders function fairly well following trauma, including disasters, as long as essential services aren't interrupted. For others, additional mental health supports may be necessary. For more information, see *Responding to the Needs of People With Serious and Persistent Mental Illness in Times of Major Disaster* (Center for Mental Health Services, 1996).

Co-occurrence is also linked with greater impairment and more severe symptoms of both disorders, and the person is less likely to experience remission of symptoms within 6 months.

Generalized anxiety, obsessive–compulsive, and other anxiety disorders are also associated with PTSD. PTSD may exacerbate anxiety disorder symptoms, but it is also likely that preexisting anxiety symptoms and anxiety disorders increase vulnerability to PTSD. Preexisting anxiety primes survivors for greater hyperarousal and distress. Other disorders, such as personality and somatization disorders, are also associated with trauma, but the history of trauma is often overlooked as a significant factor or necessary target in treatment.

The relationship between PTSD and other disorders is complex. More research is now examining the multiple potential pathways among PTSD and other disorders and how various sequences affect clinical presentation. TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c), is valuable in understanding the relationship of substance use to other mental disorders.

People With Substance Use Disorders

There is clearly a correlation between trauma (including individual, group, or mass trauma) and substance use as well as the presence of posttraumatic stress (and other trauma-related disorders) and substance use disorders. Alcohol and drug use can be, for some, an effort to

Co-Occurring PTSD and Other Mental Disorders

- Individuals with PTSD often have at least one additional diagnosis of a mental disorder.
- The presence of other disorders typically worsens and prolongs the course of PTSD and complicates clinical assessment, diagnosis, and treatment.
- The most common co-occurring disorders, in addition to substance use disorders, include mood disorders, various anxiety disorders, eating disorders, and personality disorders.
- Exposure to early, severe, and chronic trauma is linked to more complex symptoms, including impulse control deficits, greater difficulty in emotional regulation and establishing stable relationships, and disruptions in consciousness, memory, identity, and/or perception of the environment (Dom, De, Hulstijn, & Sabbe, 2007; Waldrop, Back, Verduin, & Brady, 2007).
- Certain diagnostic groups and at-risk populations (e.g., people with developmental disabilities, people who are homeless or incarcerated) are more susceptible to trauma exposure and to developing PTSD if exposed but less likely to receive appropriate diagnosis and treatment.
- Given the prevalence of traumatic events in clients who present for substance abuse treatment, counselors should assess all clients for possible trauma-related disorders.

manage traumatic stress and specific PTSD symptoms. Likewise, people with substance use disorders are at higher risk of developing PTSD than people who do not abuse substances. Counselors working with trauma survivors or clients who have substance use disorders have to be particularly aware of the possibility of the other disorder arising.

Timeframe: PTSD and the onset of substance use disorders

Knowing whether substance abuse or PTSD came first informs whether a causal relationship exists, but learning this requires thorough assessment of clients and access to complete data on PTSD; substance use, abuse, and dependence; and the onset of each. Much current research focuses solely on the age of onset of substance use (not abuse), so determining causal relationships can be difficult.

The relationship between PTSD and substance use disorders is thought to be bidirectional and cyclical: substance use increases trauma risk, and exposure to trauma escalates substance use to manage trauma-related symptoms. Three other causal pathways described by Chilcoat and Breslau's seminal work (1998) further explain the relationship between PTSD and substance use disorders:

1. The "self-medication" hypothesis suggests that clients with PTSD use substances to manage PTSD symptoms (e.g., intrusive memories, physical arousal). Substances such as alcohol, cocaine, barbiturates, opioids, and amphetamines are frequently abused in attempts to relieve or numb emotional pain or to forget the event.
2. The "high-risk" hypothesis states that drug and alcohol use places people who use substances in high-risk situations that increase their chances of being exposed to events that lead to PTSD.
3. The "susceptibility" hypothesis suggests that people who use substances are more susceptible to developing PTSD after exposure to trauma than people who do not. Increased vulnerability may result from failure to develop effective stress management strategies, changes in brain chemistry, or damage to neurophysiological systems due to extensive substance use.

PTSD and substance abuse treatment

PTSD can limit progress in substance abuse recovery, increase the potential for relapse, and complicate a client's ability to achieve success in various life areas. Each disorder can mask or hide the symptoms of the other, and both need

Case Illustration: Maria

Maria is a 31-year-old woman diagnosed with PTSD and alcohol dependence. From ages 8 to 12, she was sexually abused by an uncle. Maria never told anyone about the abuse for fear that she would not be believed. Her uncle remains close to the family, and Maria still sees him on certain holidays. When she came in for treatment, she described her emotions and thoughts as out of control. Maria often experiences intrusive memories of the abuse, which at times can be vivid and unrelenting. She cannot predict when the thoughts will come; efforts to distract herself from them do not always work. She often drinks in response to these thoughts or his presence, as she has found that alcohol can dull her level of distress. Maria also has difficulty falling asleep and is often awakened by nightmares. She does not usually remember the dreams, but she wakes up feeling frightened and alert and cannot go back to sleep.

Maria tries to avoid family gatherings but often feels pressured to go. Whenever she sees her uncle, she feels intense panic and anger but says she can usually "hold it together" if she avoids him. Afterward, however, she describes being overtaken by these feelings and unable to calm down. She also describes feeling physically ill and shaky. At these times, she often isolates herself, stays in her apartment, and drinks steadily for several days. Maria also reports distress pertaining to her relationship with her boyfriend. In the beginning of their relationship, she found him comforting and enjoyed his affection, but more recently, she has begun to feel anxious and unsettled around him. Maria tries to avoid sex with him, but she sometimes gives in for fear of losing the relationship. She finds it easier to have sex with him when she is drunk, but she often experiences strong feelings of dread and disgust reminiscent of her abuse. Maria feels guilty and confused about these feelings.

to be assessed and treated if the individual is to have a full recovery. There is a risk of misinterpreting trauma-related symptoms in substance abuse treatment settings. For example, avoidance symptoms in an individual with PTSD can be misinterpreted as lack of motivation or unwillingness to engage in substance abuse treatment; a counselor's efforts to address substance abuse–related behaviors in early recovery can likewise provoke an exaggerated response from a trauma survivor who has profound traumatic experiences of being trapped and controlled. Exhibit 1.3-6 lists important facts about PTSD and substance use disorders for counselors.

Sleep, PTSD, and substance use

Many people have trouble getting to sleep and/or staying asleep after a traumatic event; consequently, some have a drink or two to help them fall asleep. Unfortunately, any initially helpful effects are likely not only to wane quickly, but also to incur a negative rebound effect. When someone uses a substance before going to bed, "sleep becomes lighter and more easily disrupted," and rapid eye movement sleep (REM) "increases, with an associated increase in dreams and nightmares," as the effects wear off (Auerbach, 2003, p. 1185).

People with alcohol dependence report multiple types of sleep disturbances over time, and it is not unusual for clients to report that they cannot fall asleep without first having a drink. Both REM and slow wave sleep are reduced in clients with alcohol dependence, which is also associated with an increase in the amount of time it takes before sleep occurs, decreased overall sleep time, more nightmares, and reduced sleep efficiency. Sleep during withdrawal is "frequently marked by severe insomnia and sleep fragmentation…a loss of restful sleep and feelings of daytime fatigue. Nightmares and vivid dreams are not uncommon" (Auerbach, 2003, pp. 1185–1186).

Confounding changes in the biology of sleep that occur in clients with PTSD and substance use disorders often add to the problems of

Exhibit 1.3-6: PTSD and Substance Use Disorders: Important Treatment Facts

Profile Severity

- PTSD is one of the most common co-occurring mental disorders found in clients in substance abuse treatment (CSAT, 2005c).
- People in treatment for PTSD tend to abuse a wide range of substances, including opioids, cocaine, marijuana, alcohol, and prescription medications.
- People in treatment for PTSD and substance abuse have a more severe clinical profile than those with just one of these disorders.
- PTSD, with or without major depression, significantly increases risk for suicidality (CSAT, 2009a).

Gender Differences

- Rates of trauma-related disorders are high in men and women in substance abuse treatment.
- Women with PTSD and a substance use disorder most frequently experienced rape or witnessed a killing or injury; men with both disorders typically witnessed a killing or injury or were the victim of sudden injury or accident (Cottler, Nishith, & Compton, 2001).

Risk of Continued Cycle of Violence

- While under the influence of substances, a person is more vulnerable to traumatic events (e.g., automobile crashes, assaults).
- Perpetrators of violent assault often are under the influence of substances or test positive for substances at the time of arrest.

Treatment Complications

- It is important to recognize and help clients understand that becoming abstinent from substances does not resolve PTSD; in fact, some PTSD symptoms become worse with abstinence for some people. Both disorders must be addressed in treatment.
- Treatment outcomes for clients with PTSD and a substance use disorder are worse than for clients with other co-occurring disorders or who only abuse substances (Brown, Read, & Kahler, 2003).

recovery. Sleep can fail to return to normal for months or even years after abstinence, and the persistence of sleep disruptions appears related to the likelihood of relapse. Of particular clinical importance is the vicious cycle that can also begin during "slips"; relapse initially improves sleep, but continued drinking leads to sleep disruption. This cycle of initial reduction of an unpleasant symptom, which only ends up exacerbating the process as a whole, can take place for clients with PTSD as well as for clients with substance use disorders. There are effective cognitive–behavioral therapies and nonaddictive pharmacological interventions for sleep difficulties.

4 Screening and Assessment

IN THIS CHAPTER

- Screening and Assessment
- Barriers and Challenges to Trauma Informed Screening and Assessment
- Cross Cultural Screening and Assessment
- Choosing Instruments
- Trauma Informed Screening and Assessment
- Concluding Note

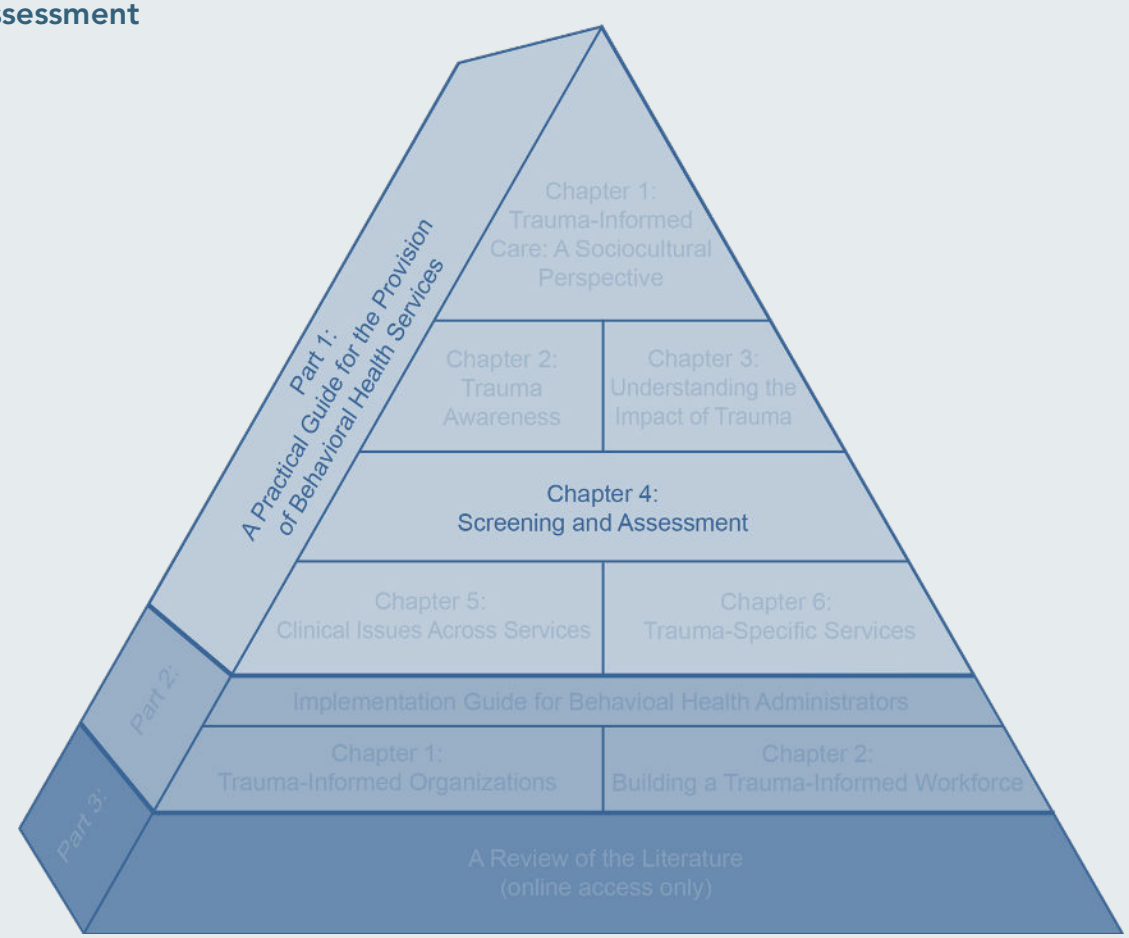
Why screen universally for trauma in behavioral health services? Exposure to trauma is common; in many surveys, more than half of respondents report a history of trauma, and the rates are even higher among clients with mental or substance use disorders. Furthermore, behavioral health problems, including substance use and mental disorders, are more difficult to treat if trauma-related symptoms and disorders aren't detected early and treated effectively (Part 3, Section 1, of this Treatment Improvement Protocol [TIP], available online, summarizes research on the prevalence of trauma and its relationship with other behavioral health problems).

Not addressing traumatic stress symptoms, trauma-specific disorders, and other symptoms/disorders related to trauma can impede successful mental health and substance abuse treatment. Unrecognized, unaddressed trauma symptoms can lead to poor engagement in treatment, premature termination, greater risk for relapse of psychological symptoms or substance use, and worse outcomes. Screening can also prevent misdiagnosis and inappropriate treatment planning. People with histories of trauma often display symptoms that meet criteria for other disorders.

Without screening, clients' trauma histories and related symptoms often go undetected, leading providers to direct services toward symptoms and disorders that may only partially explain client presentations and distress. Universal screening for trauma history and trauma-related symptoms can help behavioral health practitioners identify individuals at risk of developing more pervasive and severe symptoms of traumatic stress. Screening, early identification, and intervention serves as a prevention strategy.

Screening to identify clients who have histories of trauma and experience trauma related symptoms is a prevention strategy.

Trauma-Informed Care Framework in Behavioral Health Services—Screening and Assessment



The chapter begins with a discussion of screening and assessment concepts, with a particular focus on trauma-informed screening. It then highlights specific factors that influence screening and assessment, including timing and environment. Barriers and challenges in providing trauma-informed screening are discussed, along with culturally specific screening and assessment considerations and guidelines. Instrument selection, trauma-informed screening and assessment tools, and trauma-informed screening and assessment processes are reviewed as well. For a more research-oriented perspective on screening and assessment for traumatic stress disorders, please refer to the literature review provided in Part 3 of this TIP, which is available online.

Screening and Assessment

Screening

The first two steps in screening are to determine whether the person has a history of trauma and whether he or she has trauma-related symptoms. Screening mainly obtains answers to "yes" or "no" questions: "Has this client experienced a trauma in the past?" and "Does this client at this time warrant further assessment regarding trauma-related symptoms?" If someone acknowledges a trauma history, then further screening is necessary to determine whether trauma-related symptoms are present. However, the presence of such symptoms does not necessarily say anything about their severity, nor does a positive screen indicate that a disorder actually exists. Positive

Screening is often the first contact between the client and the treatment provider, and the client forms his or her first impression of treatment during this intake process. Thus, how screening is conducted can be as important as the actual information gathered, as it sets the tone of treatment and begins the relationship with the client.

screens only indicate that assessment or further evaluation is warranted, and negative screens do not necessarily mean that an individual doesn't have symptoms that warrant intervention.

Screening procedures should always define the steps to take after a positive or negative screening. That is, the screening process establishes precisely how to score responses to screening tools or questions and clearly defines what constitutes a positive score (called a "cut-off score") for a particular potential problem. The screening procedures detail the actions to take after a client scores in the positive range. Clinical supervision is helpful—and sometimes necessary—in judging how to proceed.

Trauma-informed screening is an essential part of the intake evaluation and the treatment planning process, but it is not an end in itself. Screening processes can be developed that allow staff without advanced degrees or graduate-level training to conduct them, whereas assessments for trauma-related disorders require a mental health professional trained in assessment and evaluation processes. The most important domains to screen among individuals with trauma histories include:

- Trauma-related symptoms.
- Depressive or dissociative symptoms, sleep disturbances, and intrusive experiences.
- Past and present mental disorders, including typically trauma-related disorders (e.g., mood disorders).
- Severity or characteristics of a specific trauma type (e.g., forms of interpersonal violence, adverse childhood events, combat experiences).
- Substance abuse.
- Social support and coping styles.
- Availability of resources.
- Risks for self-harm, suicide, and violence.
- Health screenings.

Assessment

When a client screens positive for substance abuse, trauma-related symptoms, or mental disorders, the agency or counselor should follow up with an assessment. A positive screening calls for more action—an assessment that determines and defines presenting struggles to develop an appropriate treatment plan and to make an informed and collaborative decision about treatment placement. Assessment determines the nature and extent of the client's problems; it might require the client to respond to written questions, or it could involve a clinical interview by a mental health or substance abuse professional qualified to assess the client and arrive at a diagnosis. A clinical assessment delves into a client's past and current experiences, psychosocial and cultural history, and assets and resources.

Assessment protocols can require more than a single session to complete and should also use multiple avenues to obtain the necessary clinical information, including self-assessment tools, past and present clinical and medical records, structured clinical interviews, assessment measures, and collateral information from significant others, other behavioral health professionals, and agencies. Qualifications for conducting assessments and clinical interviews are more rigorous than for screening. Advanced degrees, licensing or certification, and special training in administration, scoring, and interpretation of specific assessment instruments and interviews are often

Advice to Counselors: Screening and Assessing Clients

- Ask all clients about any possible history of trauma; use a checklist to increase proper identification of such a history (see the online Adverse Childhood Experiences Study Score Calculator [http://acestudy.org/ace_score] for specific questions about adverse childhood experiences).
- Use only validated instruments for screening and assessment.
- Early in treatment, screen all clients who have histories of exposure to traumatic events for psychological symptoms and mental disorders related to trauma.
- When clients screen positive, also screen for suicidal thoughts and behaviors (see TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment*; Center for Substance Abuse Treatment [CSAT], 2009a).
- Do not delay screening; do not wait for a period of abstinence or stabilization of symptoms.
- Be aware that some clients will not make the connection between trauma in their histories and their current patterns of behavior (e.g., alcohol and drug use and/or avoidant behavior).
- Do not require clients to describe emotionally overwhelming traumatic events in detail.
- Focus assessment on how trauma symptoms affect clients' current functioning.
- Consider using paper-and-pencil instruments for screening and assessment as well as self-report measures when appropriate; they are less threatening for some clients than a clinical interview.
- Talk about how you will use the findings to plan the client's treatment, and discuss any immediate action necessary, such as arranging for interpersonal support, referrals to community agencies, or moving directly into the active phase of treatment. It is helpful to explore the strategies clients have used in the past that have worked to relieve strong emotions (Fallot & Harris, 2001).
- At the end of the session, make sure the client is grounded and safe before leaving the interview room (Litz, Miller, Ruef, & McTeague, 2002). Readiness to leave can be assessed by checking on the degree to which the client is conscious of the current environment, what the client's plan is for maintaining personal safety, and what the client's plans are for the rest of the day.

required. Counselors must be familiar with (and obtain) the level of training required for any instruments they consider using.

For people with histories of traumatic life events who screen positive for possible trauma-related symptoms and disorders, thorough assessment gathers all relevant information necessary to understand the role of the trauma in their lives; appropriate treatment objectives, goals, planning, and placement; and any ongoing diagnostic and treatment considerations, including reevaluation or follow-up.

Overall, assessment may indicate symptoms that meet diagnostic criteria for a substance use or mental disorder or a milder form of symptomatology that doesn't reach a diagnostic level—or it may reveal that the positive screen was false and that there is no significant cause for concern. Information from an assessment is used to plan the client's treatment. The plan can include such domains as level of care, acute safety needs, diagnosis, disability, strengths and skills, support network, and cultural context. Assessments should reoccur throughout treatment. Ongoing assessment during treatment can provide valuable information by revealing further details of trauma history as clients' trust in staff members grows and by gauging clients' progress.

Timing of Screening and Assessment

As a trauma-informed counselor, you need to offer psychoeducation and support from the outset of service provision; this begins with explaining screening and assessment and with proper pacing of the initial intake and evaluation process. The client should understand the screening process, why the specific questions are important, and that he or she may choose to delay a response or to not answer a question

at all. Discussing the occurrence or consequences of traumatic events can feel as unsafe and dangerous to the client as if the event were reoccurring. It is important not to encourage avoidance of the topic or reinforce the belief that discussing trauma-related material is dangerous, but be sensitive when gathering information in the initial screening. Initial questions about trauma should be general and gradual. Taking the time to prepare and explain the screening and assessment process to the client gives him or her a greater sense of control and safety over the assessment process.

Clients with substance use disorders

No screening or assessment of trauma should occur when the client is under the influence of alcohol or drugs. Clients under the influence are more likely to give inaccurate information. Although it's likely that clients in an active phase of use (albeit not at the assessment itself) or undergoing substance withdrawal can provide consistent information to obtain a valid screening and assessment, there is insufficient data to know for sure. Some theorists state that no final assessment of trauma or posttraumatic stress disorder (PTSD) should occur during these early phases (Read, Bollinger, & Sharkansky, 2003), asserting that symptoms of withdrawal can mimic PTSD and thus result in overdiagnosis of PTSD and other trauma-related disorders. Alcohol or drugs can also cause memory impairment that clouds the client's history of trauma symptoms. However, Najavits (2004) and others note that underdiagnosis, not overdiagnosis, of trauma and PTSD has been a significant issue in the substance abuse field and thus claim that it is essential to obtain an initial assessment early, which can later be modified if needed (e.g., if the client's symptom pattern changes). Indeed, clinical observations suggest that assessments for both trauma and PTSD—even during active use or withdrawal—appear robust (Coffey, Schumacher, Brady, & Dansky, 2003). Although some PTSD symptoms and trauma memories can be dampened or increased to a degree, their overall presence or absence, as assessed early in treatment, appears accurate (Najavits, 2004).

Conduct Assessments Throughout Treatment

Ongoing assessments let counselors:

- Track changes in the presence, frequency, and intensity of symptoms.
- Learn the relationships among the client's trauma, presenting psychological symptoms, and substance abuse.
- Adjust diagnoses and treatment plans as needed.
- Select prevention strategies to avoid more pervasive traumatic stress symptoms.

The Setting for Trauma Screening and Assessment

Advances in the development of simple, brief, and public-domain screening tools mean that at least a basic screening for trauma can be done in almost any setting. Not only can clients be screened and assessed in behavioral health treatment settings; they can also be evaluated in the criminal justice system, educational settings, occupational settings, physicians' offices, hospital medical and trauma units, and emergency rooms. Wherever they occur, trauma-related screenings and subsequent assessments can reduce or eliminate wasted resources, relapses, and, ultimately, treatment failures among clients who have histories of trauma, mental illness, and/or substance use disorders.

Creating an effective screening and assessment environment

You can greatly enhance the success of treatment by paying careful attention to how you approach the screening and assessment process. Take into account the following points:

- ***Clarify for the client what to expect in the screening and assessment process.*** For example, tell the client that the screening and assessment phase focuses on identifying issues that might benefit from treatment. Inform him or her that during the trauma screening and assessment process, uncomfortable thoughts and feelings can arise. Provide reassurance that, if they do, you'll assist in dealing with this distress—but also let them know that, even with your assistance, some psychological and physical reactions to the interview may last for a few hours or perhaps as long as a few days after the interview, and be sure to highlight the fact that such reactions are normal (Read et al., 2003).
- ***Approach the client in a matter-of-fact, yet supportive, manner.*** Such an approach helps create an atmosphere of trust, respect, acceptance, and thoughtfulness (Melnick & Bassuk, 2000). Doing so helps to normalize symptoms and experiences generated by the trauma; consider informing clients that such events are common but can cause continued emotional distress if they are not treated. Clients may also find it helpful for you to explain the purpose of certain difficult questions. For example, you could say, "Many people have experienced troubling events as children, so some of my questions are about whether you experienced any such events while growing up." Demonstrate kindness and directness in equal measure when screening/assessing clients (Najavits, 2004).
- ***Respect the client's personal space.*** Cultural and ethnic factors vary greatly regarding the appropriate physical distance to maintain during the interview. You should respect the client's personal space, sitting neither too far from nor too close to the client; let your observations of the client's comfort level during the screening and assessment process guide the amount of distance. Clients with trauma may have particular sensitivity about their bodies, personal space, and boundaries.
- ***Adjust tone and volume of speech to suit the client's level of engagement and degree of comfort in the interview process.*** Strive to maintain a soothing, quiet demeanor. Be sensitive to how the client might hear what you have to say in response to personal disclosures. Clients who have been traumatized may be more reactive even to benign or well-intended questions.
- ***Provide culturally appropriate symbols of safety in the physical environment.*** These include paintings, posters, pottery, and other room decorations that symbolize the safety of the surroundings to the client population. Avoid culturally inappropriate or insensitive items in the physical environment.
- ***Be aware of one's own emotional responses to hearing clients' trauma histories.*** Hearing about clients' traumas may be very painful and can elicit strong emotions. The client may interpret your reaction to his or her revelations as disinterest, disgust for the client's behavior, or some other inaccurate interpretation. It is important for you to monitor your interactions and to check in with the client as necessary. You may also feel emotionally drained to the point that it interferes with your ability to accurately listen to or assess clients. This effect of exposure to traumatic stories, known as secondary traumatization, can result in symptoms similar to those experienced by the client (e.g., nightmares, emotional numbing); if necessary, refer to a colleague for assessment (Valent, 2002). Secondary traumatization is addressed in greater detail in Part 2, Chapter 2, of this TIP.
- ***Overcome linguistic barriers via an interpreter.*** Deciding when to add an interpreter requires careful judgment. The interpreter should be knowledgeable of behavioral

health terminology, be familiar with the concepts and purposes of the interview and treatment programming, be unknown to the client, and be part of the treatment team. Avoid asking family members or friends of the client to serve as interpreters.

- ***Elicit only the information necessary for determining a history of trauma and the possible existence and extent of traumatic stress symptoms and related disorders.*** There is no need to probe deeply into the details of a client's traumatic experiences at this stage in the treatment process. Given the lack of a therapeutic relationship in which to process the information safely, pursuing details of trauma can cause retraumatization or produce a level of response that neither you nor your client is prepared to handle. Even if a client wants to tell his or her trauma story, it's your job to serve as "gatekeeper" and preserve the client's safety. Your tone of voice when suggesting postponement of a discussion of trauma is very important. Avoid conveying the message, "I really don't want to hear about it." Examples of appropriate statements are:
  - "Your life experiences are very important, but at this early point in our work together, we should start with what's going on in your life currently rather than discussing past experiences in detail. If you feel that certain past experiences are having a big effect on your life now, it would be helpful for us to discuss them as long as we focus on your safety and recovery right now."
  - "Talking about your past at this point could arouse intense feelings—even more than you might be aware of right now. Later, if you choose to, you can talk with your counselor about how to work on exploring your past."
  - "Often, people who have a history of trauma want to move quickly into the details of the trauma to gain relief. I understand this desire, but my concern for you at this moment is to help you establish a sense of safety and support before moving into the traumatic experiences. We want to avoid retraumatization—meaning, we want to establish resources that weren't available to you at the time of the trauma before delving into more content."
- ***Give the client as much personal control as possible during the assessment by:***
  - Presenting a rationale for the interview and its stress-inducing potential, making clear that the client has the right to refuse to answer any and all questions.
  - Giving the client (where staffing permits) the option of being interviewed by someone of the gender with which he or she is most comfortable.
  - Postponing the interview if necessary (Fallot & Harris, 2001).
- ***Use self-administered, written checklists rather than interviews when possible to assess trauma.*** Traumas can evoke shame, guilt, anger, or other intense feelings that can make it difficult for the client to report them aloud to an interviewer. Clients are more likely to report trauma when they use self-administered screening tools; however, these types of screening instruments only guide the next step. Interviews should coincide with self-administered tools to create a sense of safety for the client (someone is present as he or she completes the screening) and to follow up with more indepth data gathering after a self-administered screening is complete. The Trauma History Questionnaire (THQ) is a self-administered tool (Green, 1996). It has been used successfully with clinical and nonclinical populations, including medical patients, women who have experienced domestic violence, and people with serious mental illness (Hooper, Stockton,

Krupnick, & Green, 2011). Screening instruments (including the THQ) are included in Appendix D of this TIP.

- ***Interview the client if he or she has trouble reading or writing or is otherwise unable to complete a checklist.*** Clients who are likely to minimize their trauma when using a checklist (e.g., those who exhibit significant symptoms of dissociation or repression) benefit from a clinical interview. A trained interviewer can elicit information that a self-administered checklist does not capture. Overall, using both a self-administered questionnaire and an interview can help achieve greater clarity and context.
- ***Allow time for the client to become calm and oriented to the present if he or she has very intense emotional responses when recalling or acknowledging a trauma.*** At such times, avoid responding with such exclamations as "I don't know how you survived that!" (Bernstein, 2000). If the client has difficulty self-soothing, guide him or her through grounding techniques (Exhibit 1.4-1), which are particularly useful—perhaps even critical—to achieving a successful

Exhibit 1.4-1: Grounding Techniques

Grounding techniques are important skills for assessors and all other behavioral health service providers who interact with traumatized clients (e.g., nurses, security, administrators, clinicians). Even if you do not directly conduct therapy, knowledge of grounding can help you defuse an escalating situation or calm a client who is triggered by the assessment process. Grounding strategies help a person who is overwhelmed by memories or strong emotions or is dissociating; they help the person become aware of the here and now. A useful metaphor is the experience of walking out of a movie theater. When the person dissociates or has a flashback, it's like watching a mental movie; grounding techniques help him or her step out of the movie theater into the daylight and the present environment. The client's task is not only to hold on to moments from the past, but also to acknowledge that what he or she was experiencing is from the past. Try the following techniques:

1. **Ask the client to state what he or she observes.**
   Guide the client through this exercise by using statements like, "You seem to feel very scared/angry right now. You're probably feeling things related to what happened in the past. Now, you're in a safe situation. Let's try to stay in the present. Take a slow deep breath, relax your shoulders, put your feet on the floor; let's talk about what day and time it is, notice what's on the wall, etc. What else can you do to feel okay in your body right now?"
2. **Help the client decrease the intensity of affect.**
   - "Emotion dial": A client imagines turning down the volume on his or her emotions.
   - Clenching fists can move the energy of an emotion into fists, which the client can then release.
   - Guided imagery can be used to visualize a safe place.
   - Distraction (see #3 below).
   - Use strengths-based questions (e.g., "How did you survive?" or "What strengths did you possess to survive the trauma?").
3. **Distract the client from unbearable emotional states.**
   - Have the client focus on the external environment (e.g., name red objects in the room).
   - Ask the client to focus on recent and future events (e.g., "to do" list for the day).
   - Help the client use self-talk to remind himself or herself of current safety.
   - Use distractions, such as counting, to return the focus to current reality.
   - Somatosensory techniques (toe-wiggling, touching a chair) can remind clients of current reality.
4. **Ask the client to use breathing techniques.**
   - Ask the client to inhale through the nose and exhale through the mouth.
   - Have the client place his or her hands on his or her abdomen and then watch the hands go up and down while the belly expands and contracts.

Source: Melnick & Bassuk, 2000.

interview when a client has dissociated or is experiencing intense feelings in response to screening and/or interview questions.

- ***Avoid phrases that imply judgment about the trauma.*** For example, don't say to a client who survived Hurricane Katrina and lost family members, "It was God's will," or "It was her time to pass," or "It was meant to be." Do not make assumptions about what a person has experienced. Rather, listen supportively without imposing personal views on the client's experience.
- ***Provide feedback about the results of the screening.*** Keep in mind the client's vulnerability, ability to access resources, strengths, and coping strategies. Present results in a synthesized manner, avoiding complicated, overly scientific jargon or explanations. Allow time to process client reactions during the feedback session. Answer client questions and concerns in a direct, honest, and compassionate manner. Failure to deliver feedback in this way can negatively affect clients' psychological status and severely weaken the potential for developing a therapeutic alliance with the client.
- ***Be aware of the possible legal implications of assessment.*** Information you gather during the screening and assessment process can necessitate mandatory reporting to authorities, even when the client does not want such information disclosed (Najavits, 2004). For example, you can be required to report a client's experience of child abuse even if it happened many years ago or the client doesn't want the information reported. Other legal issues can be quite complex, such as confidentiality of records, pursuing a case against a trauma perpetrator and divulging information to third parties while still protecting the legal status of information used in prosecution, and child custody issues (Najavits, 2004). It's essential that you know the laws in your State, have an expert legal consultant available, and access clinical supervision.

Barriers and Challenges to Trauma-Informed Screening and Assessment

Barriers

It is not necessarily easy or obvious to identify an individual who has survived trauma without screening. Moreover, some clients may deny that they have encountered trauma and its effects even after being screened or asked direct questions aimed at identifying the occurrence of traumatic events. The two main barriers to the evaluation of trauma and its related disorders in behavioral health settings are clients not reporting trauma and providers overlooking trauma and its effects.

Concerning the first main barrier, some events will be experienced as traumatic by one person but considered nontraumatic by another. A history of trauma encompasses not only the experience of a potentially traumatic event, but also the person's responses to it and the meanings he or she attaches to the event. Certain situations make it more likely that the client will not be forthcoming about traumatic events or his or her responses to those events. Some clients might not have ever thought of a particular event or their response to it as traumatic and thus might not report or even recall the event. Some clients might feel a reluctance to discuss something that they sense might bring up uncomfortable feelings (especially with a counselor whom they've only recently met). Clients may avoid openly discussing traumatic events or have difficulty recognizing or articulating their experience of trauma for other reasons, such as feelings of shame, guilt, or fear of retribution by others associated with the event (e.g., in cases of interpersonal or

Common Reasons Why Some Providers Avoid Screening Clients for Trauma

Treatment providers may avoid screening for traumatic events and trauma-related symptoms due to:

- A reluctance to inquire about traumatic events and symptoms because these questions are not a part of the counselor's or program's standard intake procedures.
- Underestimation of the impact of trauma on clients' physical and mental health.
- A belief that treatment of substance abuse issues needs to occur first and exclusively, before treating other behavioral health disorders.
- A belief that treatment should focus solely on presenting symptoms rather than exploring the potential origins or aggravators of symptoms.
- A lack of training and/or feelings of incompetence in effectively treating trauma-related problems (Salyers, Evans, Bond, & Meyer, 2004).
- Not knowing how to respond therapeutically to a client's report of trauma.
- Fear that a probing trauma inquiry will be too disturbing to clients.
- Not using common language with clients that will elicit a report of trauma (e.g., asking clients if they were abused as a child without describing what is meant by abuse).
- Concern that if disorders are identified, clients will require treatment that the counselor or program does not feel capable of providing (Fallot & Harris, 2001).
- Insufficient time for assessment to explore trauma histories or symptoms.
- Untreated trauma-related symptoms of the counselor, other staff members, and administrators.

domestic violence). Still others may deny their history because they are tired of being interviewed or asked to fill out forms and may believe it doesn't matter anyway.

A client may not report past trauma for many reasons, including:

- Concern for safety (e.g., fearing more abuse by a perpetrator for revealing the trauma).
- Fear of being judged by service providers.
- Shame about victimization.
- Reticence about talking with others in response to trauma.
- Not recalling past trauma through dissociation, denial, or repression (although genuine blockage of all trauma memory is rare among trauma survivors; McNally, 2003).
- Lack of trust in others, including behavioral health service providers.
- Not seeing a significant event as traumatic.

Regarding the second major barrier, counselors and other behavioral health service providers may lack awareness that trauma can significantly affect clients' presentations in treatment and functioning across major life areas, such as relationships and work. In addition, some counselors may believe that their role is to treat only the presenting psychological and/or substance abuse symptoms, and thus they may not be as sensitive to histories and effects of trauma. Other providers may believe that a client should abstain from alcohol and drugs for an extended period before exploring trauma symptoms. Perhaps you fear that addressing a clients' trauma history will only exacerbate symptoms and complicate treatment. Behavioral health service providers who hold biases may assume that a client doesn't have a history of trauma and thus fail to ask the "right" questions, or they may be uncomfortable with emotions that arise from listening to client experiences and, as a result, redirect the screening or counseling focus.

Challenges

Awareness of acculturation and language

Acculturation levels can affect screening and assessment results. Therefore, indepth discussions may be a more appropriate way to gain an understanding of trauma from the client's point of view. During the intake, prior to trauma screening, determine the client's history of

Common Assessment Myths

Several common myths contribute to underassessment of trauma-related disorders (Najavits, 2004):

- ***Myth #1: Substance abuse itself is a trauma.*** However devastating substance abuse is, it does not meet the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5; American Psychiatric Association [APA], 2013a), criteria for trauma per se. Nevertheless, high-risk behaviors that are more likely to occur during addiction, such as interpersonal violence and self-harm, significantly increase the potential for traumatic injury.
- ***Myth #2: Assessment of trauma is enough.*** Thorough assessment is the best way to identify the existence and extent of trauma-related problems. However, simply identifying trauma-related symptoms and disorders is just the first step. Also needed are individualized treatment protocols and action to implement these protocols.
- ***Myth #3: It is best to wait until the client has ended substance use and withdrawal to assess for PTSD.*** Research does not provide a clear answer to the controversial question of when to assess for PTSD; however, Najavits (2004) and others note that underdiagnosis of trauma and PTSD has been more significant in the substance abuse field than overdiagnosis. Clinical experience shows that the PTSD diagnosis is rather stable during substance use or withdrawal, but symptoms can become more or less intense; memory impairment from alcohol or drugs can also cloud the symptom picture. Thus, it is advisable to establish a tentative diagnosis and then reassess after a period of abstinence, if possible.

migration, if applicable, and primary language. Questions about the client's country of birth, length of time in this country, events or reasons for migration, and ethnic self-identification are also appropriate at intake. Also be aware that even individuals who speak English well might have trouble understanding the subtleties of questions on standard screening and assessment tools. It is not adequate to translate items simply from English into another language; words, idioms, and examples often don't translate directly into other languages and therefore need to be adapted. Screening and assessment should be conducted in the client's preferred language by trained staff members who speak the language or by professional translators familiar with treatment jargon.

Awareness of co-occurring diagnoses

A trauma-informed assessor looks for psychological symptoms that are associated with trauma or simply occur alongside it. Symptom screening involves questions about past or present mental disorder symptoms that may indicate the need for a full mental health assessment. A variety of screening tools are available, including symptom checklists. However, you should only use symptom checklists when you need information about how your client is currently feeling; don't use them to screen for specific disorders. Responses will likely change from one administration of the checklist to the next.

Basic mental health screening tools are available. For example, the Mental Health Screening Form-III screens for present or past symptoms of most mental disorders (Carroll & McGinley, 2001); it is available at no charge from Project Return Foundation, Inc. and is also reproduced in TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c). Other screening tools, such as the Beck Depression Inventory II and the Beck Anxiety Inventory (Beck, Wright, Newman, & Liese, 1993), also screen broadly for mental and substance use disorders, as well as for specific disorders often associated with trauma. For further screening information and resources on depression and suicide, see TIP 48, *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery* (CSAT, 2008), and TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009a).

For screening substance use disorders, see TIP 11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* (CSAT, 1994); TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* (CSAT, 1997a); TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT, 1999c); TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c); and TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT, 2009d).

A common dilemma in the assessment of trauma-related disorders is that certain trauma symptoms are also symptoms of other disorders. Clients with histories of trauma typically present a variety of symptoms; thus, it is important to determine the full scope of symptoms and/or disorders present to help improve treatment planning. Clients with trauma-related and substance use symptoms and disorders are at increased risk for additional Axis I and/or Axis II mental disorders (Brady, Killeen, Saladin, Dansky, & Becker, 1994; Cottler, Nishith, & Compton, 2001). These symptoms need to be distinguished so that other presenting subclinical features or disorders do not go unidentified and untreated. To accomplish this, a comprehensive assessment of the client's mental health is recommended.

Misdiagnosis and underdiagnosis

Many trauma survivors are either misdiagnosed (i.e., given diagnoses that are not accurate) or underdiagnosed (i.e., have one or more diagnoses that have not been identified at all). Such diagnostic errors could result, in part, from the fact that many general instruments to evaluate mental disorders are not sufficiently sensitive to identify posttraumatic symptoms and can misclassify them as other disorders, including personality disorders or psychoses. Intrusive posttraumatic symptoms, for example, can show up on general measures as indicative of hallucinations or obsessions. Dissociative symptoms can be interpreted as indicative of schizophrenia. Trauma-based cognitive symptoms can be scored as evidence for paranoia or other delusional processes (Briere, 1997). Some of the most common misdiagnoses in clients with PTSD and substance abuse are:

- ***Mood and anxiety disorders.*** Overlapping symptoms with such disorders as major depression, generalized anxiety disorder, and bipolar disorder can lead to misdiagnosis.
- ***Borderline personality disorder.*** Historically, this has been more frequently diagnosed than PTSD. Many of the symptoms, including a pattern of intense interpersonal relationships, impulsivity, rapid and unpredictable mood swings, power struggles in the treatment environment, underlying anxiety and depressive symptoms, and transient, stress-related paranoid ideation or severe dissociative symptoms overlap. The effect of this misdiagnosis on treatment can be particularly negative; counselors often view clients with a borderline personality diagnosis as difficult to treat and unresponsive to treatment.
- ***Antisocial personality disorder.*** For men and women who have been traumatized in childhood, "acting out" behaviors, a lack of empathy and conscience, impulsivity, and self-centeredness can be functions of trauma and survival skills rather than true antisocial characteristics.
- ***Attention deficit hyperactivity disorder (ADHD).*** For children and adolescents, impulsive behaviors and concentration problems can be diagnosed as ADHD rather than PTSD.

It is possible, however, for clients to legitimately have any of these disorders in addition to trauma-related disorders. Given the overlap of posttraumatic symptoms with those of other disorders, a wide variety of diagnoses often needs to be considered to avoid misidentifying

other disorders as PTSD and vice versa. A trained and experienced mental health professional will be required to weigh differential diagnoses. TIP 42 (CSAT, 2005c) explores issues related to differential diagnosis.

Cross-Cultural Screening and Assessment

Many trauma-related symptoms and disorders are culture specific, and a client's cultural background must be considered in screening and assessment (for review of assessment and cultural considerations when working with trauma, see Wilson & Tang, 2007). Behavioral health service providers must approach screening and assessment processes with the influences of culture, ethnicity, and race firmly in mind. Cultural factors, such as norms for expressing psychological distress, defining trauma, and seeking help in dealing with trauma, can affect:

- How traumas are experienced.
- The meaning assigned to the event(s).
- How trauma-related symptoms are expressed (e.g., as somatic expressions of distress, level of emotionality, types of avoidant behavior).
- Willingness to express distress or identify trauma with a behavioral health service provider and sense of safety in doing so.
- Whether a specific pattern of behavior, emotional expression, or cognitive process is considered abnormal.
- Willingness to seek treatment inside and outside of one's own culture.
- Response to treatment.
- Treatment outcome.

When selecting assessment instruments, counselors and administrators need to choose,

Culture-Specific Stress Responses

Culture-bound concepts of distress exist that don't necessarily match diagnostic criteria. Culture-specific symptoms and syndromes can involve physical complaints, broad emotional reactions, or specific cognitive features. Many such syndromes are unique to a specific culture but can broaden to cultures that have similar beliefs or characteristics. Culture-bound syndromes are typically treated by traditional medicine and are known throughout the culture. Cultural concepts of distress include:

- ***Ataques de nervios.*** Recognized in Latin America and among individuals of Latino descent, the primary features of this syndrome include intense emotional upset (e.g., shouting, crying, trembling, dissociative or seizure-like episodes). It frequently occurs in response to a traumatic or stressful event in the family.
- ***Nervios.*** This is considered a common idiom of distress among Latinos; it includes a wide range of emotional distress symptoms including headaches, nervousness, tearfulness, stomach discomfort, difficulty sleeping, and dizziness. Symptoms can vary widely in intensity, as can impairment from them. This often occurs in response to stressful or difficult life events.
- ***Susto.*** This term, meaning "fright," refers to a concept found in Latin American cultures, but it is not recognized among Latinos from the Caribbean. *Susto* is attributed to a traumatic or frightening event that causes the soul to leave the body, thus resulting in illness and unhappiness; extreme cases may result in death. Symptoms include appetite or sleep disturbances, sadness, lack of motivation, low self-esteem, and somatic symptoms.
- ***Taijin kyofusho.*** Recognized in Japan and among some American Japanese, this "interpersonal fear" syndrome is characterized by anxiety about and avoidance of interpersonal circumstances. The individual presents worry or a conviction that his or her appearance or social interactions are inadequate or offensive. Other cultures have similar cultural descriptions or syndromes associated with social anxiety.

Sources: APA, 2013, pp. 833–837; Briere & Scott, 2006b.

whenever possible, instruments that are culturally appropriate for the client. Instruments that have been normed for, adapted to, and tested on specific cultural and linguistic groups should be used. Instruments that are not normed for the population are likely to contain cultural biases and produce misleading results. Subsequently, this can lead to misdiagnosis, overdiagnosis, inappropriate treatment plans, and ineffective interventions. Thus, it is important to interpret all test results cautiously and to discuss the limitations of instruments with clients from diverse ethnic populations and cultures. For a review of cross-cultural screening and assessment considerations, refer to the planned TIP, *Improving Cultural Competence* (Substance Abuse and Mental Health Services Administration, planned c).

Choosing Instruments

Numerous instruments screen for trauma history, indicate symptoms, assess trauma-related and other mental disorders, and identify related clinical phenomena, such as dissociation. One instrument is unlikely to meet all screening or assessment needs or to determine the existence and full extent of trauma symptoms and traumatic experiences. The following sections present general considerations in selecting standardized instruments.

Purpose

Define your assessment needs. Do you need a standardized screening or assessment instrument for clinical purposes? Do you need information on a specific aspect of trauma, such as history, PTSD, or dissociation? Do you wish to make a formal diagnosis, such as PTSD? Do you need to determine quickly whether a client has experienced a trauma? Do you want an assessment that requires a clinician to administer it, or can the client complete the instrument himself or herself? Does the instrument match the current and specific diagnostic criteria established in the DSM-5?

Population

Consider the population to be assessed (e.g., women, children, adolescents, refugees, disaster survivors, survivors of physical or sexual violence, survivors of combat-related trauma, people whose native language is not English); some tools are appropriate only for certain populations. Is the assessment process developmentally and culturally appropriate for your client? Exhibit 1.4-2 lists considerations in choosing a screening or assessment instrument for trauma and/or PTSD.

Instrument Quality

An instrument should be psychometrically adequate in terms of sensitivity and specificity or reliability and validity as measured in several ways under varying conditions. Published research offers information on an instrument's psychometric properties as well as its utility in both research and clinical settings. For further information on a number of widely used trauma evaluation tools, see Appendix D and Antony, Orsillo, and Roemer's paper (2001).

The DSM-5 and Updates to Screening and Assessment Instruments

The recent publication of the DSM-5 (APA, 2013a) reflects changes to certain diagnostic criteria, which will affect screening tools and criteria for trauma-related disorders. Criterion A2 (specific to traumatic stress disorders, acute stress, and posttraumatic stress disorders), included in the fourth edition (text revision) of the DSM (DSM-IV-TR; APA, 2000a), has been eliminated; this criterion stated that the individual's response to the trauma needs to involve intense fear, helplessness, or horror. There are now four cluster symptoms, not three: reexperiencing, avoidance, arousal, and persistent negative alterations in cognitions and mood. Changes to the DSM-5 were made to symptoms within each cluster. Thus, screening will need modification to adjust to this change (APA, 2012b).

Exhibit 1.4-2: Key Areas of Trauma Screening and Assessment

Trauma
Key question: Did the client experience a trauma?

Examples of measures: Life Stressor Checklist-Revised (Wolfe & Kimerling, 1997); Trauma History Questionnaire (Green, 1996); Traumatic Life Events Questionnaire (Kubany et al., 2000).

Note: A good trauma measure identifies events a person experienced (e.g., rape, assault, accident) and also evaluates other trauma-related symptoms (e.g., presence of fear, helplessness, or horror).

Acute Stress Disorder (ASD) and PTSD
Key question: Does the client meet criteria for ASD or PTSD?

Examples of measures: Clinician-Administered PTSD Scale (CAPS; Blake et al., 1990); Modified PTSD Symptom Scale (Falsetti, Resnick, Resnick, & Kilpatrick, 1993); PTSD Checklist (Weathers, Litz, Herman, Huska, & Keane, 1993); Stanford Acute Stress Reaction Questionnaire (Cardena, Koopman, Classen, Waelde, & Spiegel, 2000).

Note: A PTSD diagnosis requires the person to meet criteria for having experienced a trauma; some measures include this, but others do not and require use of a separate trauma measure. The CAPS is an interview; the others listed are self-report questionnaires and take less time.

Other Trauma-Related Symptoms
Key question: Does the client have other symptoms related to trauma? These include depressive symptoms, self-harm, dissociation, sexuality problems, and relationship issues, such as distrust.

Examples of measures: Beck Depression Inventory II (Beck, 1993; Beck et al., 1993); Dissociative Experiences Scale (Bernstein & Putnam, 1986; Carlson & Putnam, 1993); Impact of Event Scale (measures intrusion and avoidance due to exposure to traumatic events; Horowitz, Wilner, & Alvarez, 1979; Weiss & Marmar, 1997); Trauma Symptom Inventory (Briere, 1995); Trauma Symptom Checklist for Children (Briere, 1996b); Modified PTSD Symptom Scale (Falsetti et al., 1993).

Note: These measures can be helpful for clinical purposes and for outcome assessment because they gauge *levels* of symptoms. Trauma-related symptoms are broader than diagnostic criteria and thus useful to measure, even if the patient doesn't meet criteria for any specific diagnoses.

Other Trauma-Related Diagnoses
Key question: Does the client have other disorders related to trauma? These include mood disorders, anxiety disorders besides traumatic stress disorders, and dissociative disorders.

Examples of measures: Mental Health Screening Form III (Carroll & McGinley, 2001); The Mini-International Neuropsychiatric Interview (M.I.N.I.) Structured Clinical Interview for DSM-IV-TR, Patient Edition (First, Spitzer, Gibbon, & Williams, revised 2011); Structured Clinical Interview for DSM-IV-TR, Non-Patient Edition (First, Spitzer, Gibbon, & Williams, revised 2011a).

Note: For complex symptoms and diagnoses such as dissociation and dissociative disorders, interviews are recommended. Look for measures that incorporate DSM-5 criteria.

Sources: Antony et al., 2001; Najavits, 2004.

Practical Issues

Is the instrument freely and readily available, or is there a fee? Is costly and extensive training required to administer it? Is the instrument too lengthy to be used in the clinical setting? Is it easily administered and scored with accompanying manuals and/or other training materials? How will results be presented to or used with the client? Is technical support available for difficulties in administration, scoring, or interpretation of results? Is special equipment required such as a microphone, a video camera, or a touch-screen computer with audio?

Trauma-Informed Screening and Assessment

The following sections focus on initial screening. For more information on screening and assessment tools, including structured interviews, see Exhibit 1.4-2. Screening is only as good as the actions taken afterward to address a positive screen (when clients acknowledge that they experience symptoms or have encountered events highlighted within the screening). Once a screening is complete and a positive screen is acquired, the client then needs referral for a more indepth assessment to ensure development of an appropriate treatment plan that matches his or her presenting problems.

Establish a History of Trauma

A person cannot have ASD, PTSD, or any trauma-related symptoms without experiencing trauma; therefore, it is necessary to inquire about painful, difficult, or overwhelming past experiences. Initial information should be gathered in a way that is minimally intrusive yet clear. Brief questionnaires can be less threatening to a client than face-to-face interviews, but interviews should be an integral part of any screening and assessment process. If the client initially denies a history of trauma (or minimizes it), administer the questionnaire later or delay additional trauma-related questions until the client has perhaps developed more trust in the treatment setting and feels safer with the thoughts and emotions that might arise in discussing his or her trauma experiences.

The Stressful Life Experiences (SLE) screen (Exhibit 1.4-3) is a checklist of traumas that also considers the client's view of the impact of those events on life functioning. Using the SLE can foster the client–counselor relationship. By going over the answers with the client, you can gain a deep understanding of your client, and the client receives a demonstration of your sensitivity and concern for what the client has experienced. The National Center for PTSD Web site offers similar instruments (http://www.ptsd.va.gov/professional/pages/assessments/assessment.asp).

In addition to broad screening tools that capture various traumatic experiences and symptoms, other screening tools, such as the Combat Exposure Scale (Keane et al., 1989) and the Intimate Partner Violence Screening Tool (Exhibit 1.4-4), focus on acknowledging a specific type of traumatic event.

Screen for Trauma-Related Symptoms and Disorders in Clients With Histories of Trauma

This step evaluates whether the client's trauma resulted in subclinical or diagnosable disorders. The counselor can ask such questions as, "Have you received any counseling or therapy? Have you ever been diagnosed or treated for a psychological disorder in the past? Have you ever been prescribed medications for your emotions in the past?" Screening is typically conducted by a wide variety of behavioral health service providers with different levels of training and education; however, all

Exhibit 1.4-3: SLE Screening

Please fill in the number that best represents how much the following statements describe your experiences. You will need to use two scales, one for how well the statement describes your experiences and one for how stressful you found this experience. The two scales are below.

Describes your Experience:

0	1	2	3	4	5	6	7	8	9	10
Did not experience this	a little like my experiences				somewhat like my experiences					exactly like my experiences

Stressfulness of Experience:

0	1	2	3	4	5	6	7	8	9	10
Not at all stressful	not very stressful				somewhat stressful					extremely stressful

Describes your Experience	Life Experience	Stressfulness Then		Stressfulness Now
	I have witnessed or experienced a natural disaster; like a hurricane or earthquake.			
	I have witnessed or experienced a human made disaster like a plane crash or industrial disaster.			
	I have witnessed or experienced a serious accident or injury.			
	I have witnessed or experienced chemical or radiation exposure happening to me, a close friend or a family member.			
	I have witnessed or experienced a life threatening illness happening to me, a close friend or a family member.			
	I have witnessed or experienced the death of my spouse or child.			
	I have witnessed or experienced the death of a close friend or family member (other than my spouse or child).			
	I or a close friend or family member has been kidnapped or taken hostage.			
	I or a close friend or family member has been the victim of a terrorist attack or torture.			
	I have been involved in combat or a war or lived in a war affected area.			
	I have seen or handled dead bodies other than at a funeral.			
	I have felt responsible for the serious injury or death of another person.			
	I have witnessed or been attacked with a weapon other than in combat or family setting			
	As a child/teen I was hit, spanked, choked or pushed hard enough to cause injury			
	As an adult, I was hit, choked or pushed hard enough to cause injury.			
	As an adult or child, I have witnessed someone else being choked, hit, spanked, or pushed hard enough to cause injury.			
	As a child/teen I was forced to have unwanted sexual contact.			
	As an adult I was forced to have unwanted sexual contact.			
	As a child or adult I have witnessed someone else being forced to have unwanted sexual contact			
	I have witnessed or experienced an extremely stressful event not already mentioned. Please Explain:_____ _____			

Sources: Hudnall Stamm, 1996, 1997. Used with permission.

Exhibit 1.4-4: STaT Intimate Partner Violence Screening Tool

1. Have you ever been in a relationship where your partner has pushed or **Slapped** you?
2. Have you ever been in a relationship where your partner **Threatened** you with violence?
3. Have you ever been in a relationship where your partner has thrown, broken, or punched **Things**?

Source: Paranjape & Liebschutz, 2003. Used with permission

individuals who administer screenings, regardless of education level and experience, should be aware of trauma-related symptoms, grounding techniques, ways of creating safety for the client, proper methods for introducing screening tools, and the protocol to follow when a positive screen is obtained. (See Appendix D for information on specific instruments.) Exhibit 1.4-5 is an example of a screening instrument for trauma symptoms, the Primary Care PTSD (PC-PTSD) Screen. Current research (Prins et al., 2004) suggests that the optimal cutoff score for the PC-PTSD is 3. If sensitivity is of greater concern than efficiency, a cutoff score of 2 is recommended.

Exhibit 1.4-5: PC-PTSD Screen

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, *in the past month*, you…

1. Have had nightmares about it or thought about it when you did not want to?
   YES NO
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
   YES NO
3. Were constantly on guard, watchful, or easily startled?
   YES NO
4. Felt numb or detached from others, activities, or your surroundings?
   YES NO

Source: Prins et al., 2004. Material used is in the public domain.

Another instrument that can screen for traumatic stress symptoms is the four-item self-report SPAN, summarized in Exhibit 1.4-6, which is derived from the 17-item Davidson Trauma Scale (DTS). SPAN is an acronym for the four items the screening addresses: startle, physiological arousal, anger, and numbness. It was developed using a small, diverse sample of adult patients (N=243; 72 percent women; 17.4 percent African American; average age = 37 years) participating in several clinical studies, including a family study of rape trauma, combat veterans, and Hurricane Andrew survivors, among others.

The SPAN has a high diagnostic accuracy of 0.80 to 0.88, with sensitivity (percentage of true positive instances) of 0.84 and specificity (percentage of true negative instances) of 0.91 (Meltzer-Brody, Churchill, & Davidson, 1999). SPAN scores correlated highly with the full DTS (r = 0.96) and other measures, such as the Impact of Events Scale (r = 0.85) and the Sheehan Disability Scale (r = 0.87).

The PTSD Checklist (Exhibit 1.4-7), developed by the National Center for PTSD, is in the public domain. Originally developed for combat veterans of the Vietnam and Persian

Exhibit 1.4-6: The SPAN

The SPAN instrument is a brief screening tool that asks clients to identify the trauma in their past that is most disturbing to them currently. It then poses four questions that ask clients to rate the frequency and severity with which they have experienced, in the past week, different types of trauma-related symptoms (startle, physiological arousal, anger, and numbness).

To order this screening instrument, use the following contact information:
Multi-Health Systems, Inc.
P.O. Box 950
North Tonawanda, NY
14120-0950
Phone: 800-456-3003

Source: Meltzer-Brody et al., 1999.

Exhibit 1.4-7: The PTSD Checklist

Instructions to Client: Below is a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully and circle the number that indicates how much you have been bothered by that problem *in the past month*.

1. Repeated, disturbing memories, thoughts, or images of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
2. Repeated, disturbing dreams of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
4. Feeling very upset when something reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
5. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
6. Avoiding thinking about or talking about a stressful experience or avoiding having feelings related to it?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
7. Avoiding activities or situations because they reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
8. Trouble remembering important parts of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
9. Loss of interest in activities that you used to enjoy?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
10. Feeling distant or cut off from other people?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
12. Feeling as if your future will somehow be cut short?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
13. Trouble falling or staying asleep?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
14. Feeling irritable or having angry outbursts?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
15. Having difficulty concentrating?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
16. Being "super-alert" or watchful or on guard?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
17. Feeling jumpy or easily startled?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

Source: Weathers et al., 1993. Material used is in the public domain.

Gulf Wars, it has since been validated on a variety of noncombat traumas (Keane, Brief, Pratt, & Miller, 2007). When using the checklist, identify a specific trauma first and then have the client answer questions in relation to that one specific trauma.

Other Screening and Resilience Measures

Along with identifying the presence of trauma-related symptoms that warrant assessment to determine the severity of symptoms as well as whether or not the individual possesses subclinical symptoms or has met criteria for a trauma-related disorder, clients should receive other screenings for symptoms associated with trauma (e.g., depression, suicidality). It is important that screenings address both external and internal resources (e.g., support systems, strengths, coping styles). Knowing the client's strengths can significantly shape the treatment planning process by allowing you to use strategies that have already worked for the client and incorporating strategies to build resilience (Exhibit 1.4-8).

Exhibit 1.4-8: Resilience Scales

A number of scales with good psychometric properties measure resilience:

- Resilience Scale (Wagnild & Young, 1993)
- Resilience Scale for Adults (Friborg, Hjemdal, Rosenvinge, & Martinussen, 2003)
- Connor Davidson Resilience Scale, 25-,10-, and 2-Item (Connor & Davidson, 2003; Campbell-Sills & Stein, 2007; Vaishnavi, Connor, & Davidson, 2007, respectively)
- Dispositional Resilience Scale, 45-,30-, 15-item forms (Bartone, Roland, Picano, &Williams, 2008)

Preliminary research shows improvement of individual resilience through treatment interventions in other populations (Lavretsky, Siddarth, & Irwin, 2010).

Screen for suicidality

All clients—particularly those who have experienced trauma—should be screened for suicidality by asking, "In the past, have you ever had suicidal thoughts, had intention to commit suicide, or made a suicide attempt? Do you have any of those feelings now? Have you had any such feelings recently?" Behavioral health service providers should receive training to screen for suicide. Additionally, clients with substance use disorders and a history of psychological trauma are at heightened risk for suicidal thoughts and behaviors; thus, screening for suicidality is indicated. See TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009a). For additional descriptions of screening processes for suicidality, see TIP 42 (CSAT, 2005c).

Concluding Note

Screenings are only beneficial if there are follow-up procedures and resources for handling positive screens, such as the ability to review results with and provide feedback to the individual after the screening, sufficient resources to complete a thorough assessment or to make an appropriate referral for an assessment, treatment planning processes that can easily incorporate additional trauma-informed care objectives and goals, and availability and access to trauma-specific services that match the client's needs. Screening is only the first step!

5 Clinical Issues Across Services

IN THIS CHAPTER

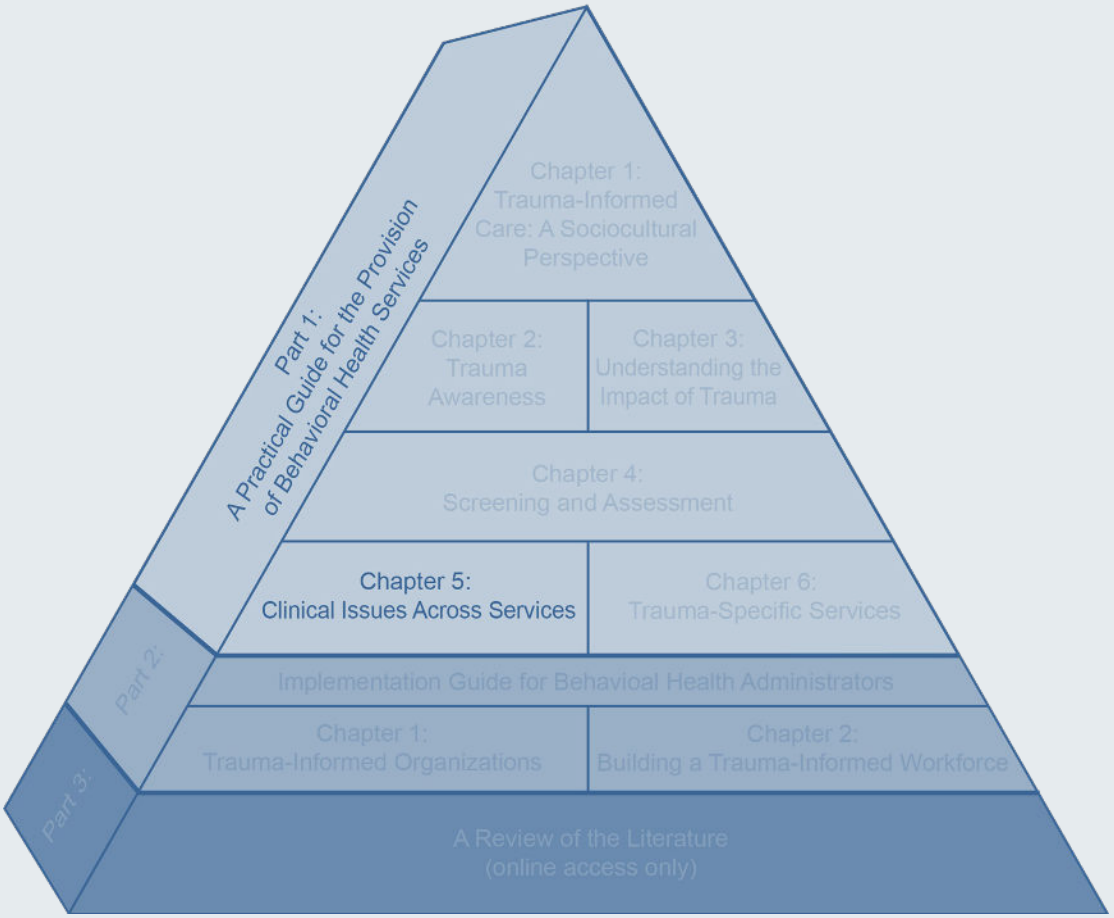
- Trauma Informed Prevention and Treatment Objectives
- Treatment Issues
- Making Referrals to Trauma Specific Services

Many clients in behavioral health treatment may have histories of trauma, so counselors should be prepared to help them address issues that arise from those histories. This chapter begins with a thorough discussion of trauma-informed prevention and treatment objectives along with practical counselor strategies. Specific treatment issues related to working with trauma survivors in a clinical setting are discussed as well, including client engagement, pacing and timing, traumatic memories, and culturally appropriate and gender-responsive services. The chapter ends with guidelines for making referrals to trauma-specific services.

Trauma-Informed Prevention and Treatment Objectives

Trauma-informed care (TIC) not only focuses on identifying individuals who have histories of trauma and traumatic stress symptoms; it also places considerable effort in creating an environment that helps them recognize the impact of trauma and determine the next course of action in a safe place. For some individuals, psychoeducation and development or reinforcement of coping strategies will be the most suitable and effective strategy, whereas others may request or warrant a referral for more trauma-specific interventions (see Part 1, Chapter 6, of this Treatment Improvement Protocol [TIP]). Although research is limited in the area of building resilience to prevent exacerbation of trauma symptoms and traumatic stress disorders, TIC also focuses on prevention strategies to avoid retraumatization in treatment, to promote resilience, and to prevent the development of trauma-related disorders. The following sections highlight key trauma-informed prevention and treatment objectives.

TIC Framework in Behavioral Health Services—Clinical Issues Across Services



Establish Safety

Beyond identifying trauma and trauma-related symptoms, the initial objective of TIC is establishing safety. Borrowing from Herman's (1992) conceptualization of trauma recovery, safety is the first goal of treatment. Establishing safety is especially crucial at the outset of trauma-informed treatment and often becomes a recurrent need when events or therapeutic changes raise safety issues, such as a change in treatment staffing due to vacations.

In the context of TIC, safety has a variety of meanings. Perhaps most importantly, the client has to have some degree of ***safety from trauma symptoms***. Recurring intrusive nightmares; painful memories that burst forth seemingly without provocation; feelings of sadness, anger, shame, or being overwhelmed; or not having control over sudden disconnections from others make moment-to-moment living feel unsafe. Clients might express feeling unsafe through statements such as, "I can't control my feelings," or, "I just space out and disconnect from the world for no reason," or, "I'm afraid to go to sleep because of the nightmares." The intense feelings that accompany trauma can also make clients feel unsafe. They may wake up in the morning feeling fine but become immobilized by depression as the day progresses. Clients with histories of trauma may experience panicky feelings of being trapped or abandoned. An early effort in trauma treatment is thus helping the client

Advice to Counselors: Strategies To Promote Safety

Strategy #1: Teach clients how and when to use grounding exercises when they feel unsafe or overwhelmed.

Strategy #2: Establish some specific routines in individual, group, or family therapy (e.g., have an opening ritual or routine when starting and ending a group session). A structured setting can provide a sense of safety and familiarity for clients with histories of trauma.

Strategy #3: Facilitate a discussion on safe and unsafe behaviors. Have clients identify, on paper, behaviors that promote safety and behaviors that feel unsafe for them today.

Strategy #4: Refer to *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* (Najavits, 2002a). This menu-based manual covers an array of treatment topics, including the core concept of safety. Each topic consists of several segments, including preparing for the session, session format, session content, handouts, and guidelines.

Strategy #5: Encourage the development of a safety plan. Depending on the type of trauma, personal safety can be an issue; work with the client to develop a plan that will help him or her feel in control and prepared for the unexpected. If the trauma was a natural or human-caused disaster, encourage thinking about how family and friends will respond and connect in the event of another crisis. If sexual abuse or rape was the event, encourage thinking about future steps that could help make the client safer. There is a delicate balance between preparation and the realization that one cannot prepare for all possible traumatic events. Nonetheless, an action plan can help the client regain a sense of environmental balance.

gain more control over trauma symptoms (and be able to label them as such) by learning more about the client and helping him or her develop new coping skills to handle symptoms when they arise and stay more grounded when flooded with feelings or memories.

A second aspect is ***safety in the environment***. Trauma reactions can be triggered by sudden loud sounds (e.g., television at high volume, raised voices), tension between people, certain smells, or casual touches that are perceived as invasions of physical boundaries. The vulnerability of exposing one's history in the treatment setting can manifest in the client as feeling physically vulnerable and unsafe in the treatment environment. Sudden or inadequately explained treatment transitions, such as moving from one level of treatment to another or changing counselors, can also evoke feelings of danger, abandonment, or instability. Early in treatment, trauma survivors generally value routine and predictability. The counselor should recognize these needs and respond appropriately by offering information in advance, providing nonshaming responses to a client's reactions to stimuli in his or her environment, and helping the client build a daily structure that feels safe.

A third aspect of safety is ***preventing a recurrence of trauma***. People with histories of trauma and substance abuse are more likely to engage in high-risk behaviors and to experience subsequent traumas. Early treatment should focus on helping clients stop using unsafe coping mechanisms, such as substance abuse, self-harm, and other self-destructive behaviors, and replacing them with safe and healthy coping strategies. Helping clients learn to protect themselves in reasonable ways is a positive goal of treatment.

Prevent Retraumatization

A key objective in TIC is to prevent retraumatization generated by intervention and treatment practices and policies. Unfortunately, treatment settings and clinicians can

Advice to Counselors: Strategies To Prevent Retraumatization

Strategy #1: Be sensitive to the needs of clients who have experienced trauma regarding behaviors in the treatment setting that might trigger memories of the trauma.

Strategy #2: Do not ignore clients' symptoms and demands when clients with trauma histories act out in response to triggered trauma memories; doing so may replicate the original traumatic experience.

Strategy #3: Be mindful that efforts to control and contain a client's behaviors in treatment can produce an abnormal reaction, particularly for trauma survivors for whom being trapped was part of the trauma experience.

Strategy #4: Listen for specific triggers that seem to be driving the client's reaction. An important step in recovery is helping the client identify these cues and thereby reach a better understanding of reactions and behaviors.

unintentionally create retraumatizing experiences (for a review of traumas that can occur when treating serious mental illness, see Frueh et al., 2005). For instance, compassionate inquiry into a client's history can seem similar to the interest shown by a perpetrator many years before. Direct confrontation by counselors about behaviors related to substance abuse can be seen, by someone who has been repeatedly physically assaulted, as provocation building up to assault. Counselor and program efforts to help clients constrain destructive behaviors can be interpreted as efforts to control and dominate the individual. Intrusive shaming or insensitive behavior demonstrated by another client in the program can threaten a trauma survivor whose boundaries have been disregarded in the past—thus making the experience of treatment feel dangerous rather than safe. Some staff and agency issues that can result in retraumatization include:

- Disrespectfully challenging reports of abuse or other traumatic events.
- Discounting a client's report of a traumatic event.
- Using isolation.
- Using physical restraints.
- Allowing the abusive behavior of one client toward another to continue without intervention.
- Labeling intense rage and other feelings as pathological.
- Minimizing, discrediting, or ignoring client responses.
- Disrupting counselor–client relationships by changing counselors' schedules and assignments.
- Obtaining urine specimens in a nonprivate and/or disrespectful manner.
- Having clients undress in the presence of others.
- Being insensitive to a client's physical or emotional boundaries.
- Inconsistently enforcing rules and allowing chaos in the treatment environment.
- Applying rigid agency policies or rules without an opportunity for clients to question them.
- Accepting agency dysfunction, including a lack of consistent, competent leadership.

Provide Psychoeducation

Trauma-informed education informs clients about traumatic stress and trauma-related symptoms and disorders as well as the related consequences of trauma exposure. It focuses on giving information to clients to help normalize presenting symptoms, to highlight potential short-term and long-term consequences of trauma and various paths to recovery, and to underscore the message that recovery is possible. Education frequently takes place prior to or immediately following an initial screening as a way to prepare clients

Advice to Counselors: Strategies To Implement Psychoeducation

Strategy #1: Remember that this may be the client's first experience with treatment. It's easy to use program or clinical jargon when you're around it every day, but most individuals who seek help are unfamiliar with clinical language, how the program works, and treatment objectives. Psychoeducation begins with understanding the client's expectations and reasons for seeking help, followed by educating the client and other family members about the program. Remember that this is all new for them.

Strategy #2: After obtaining acknowledgment of a trauma history, provide an overview of common symptoms and consequences of traumatic stress, regardless of whether the client affirms having trauma-related symptoms. It is equally important to educate the client on resilience factors associated with recovery from trauma (Wessely et al., 2008). A trauma-informed perspective provides a message that trauma reactions are normal responses to an abnormal situation.

Strategy #3: Develop a resource box that provides an array of printed or multimedia educational materials that address the program, specific symptoms and tools to combat trauma-related symptoms, treatment options and therapy approaches, advantages of peer support, and steps in developing specific coping strategies.

Strategy #4: Develop a rotating educational group that matches services and client schedules to complement treatment. Remember that education can play a pivotal role in enhancing motivation, in normalizing experiences, and in creating a sense of safety as individuals move further into treatment. For some survivors, education can be a powerful intervention or prevention strategy.

for hearing results or to place the screening and subsequent assessment findings in proper context. Education in and of itself, however, does not necessarily constitute a stand-alone treatment; rather, it can be conceptualized as a first step and/or component of more comprehensive treatment. Nonetheless, education may be a prevention and intervention strategy for individuals who have histories of trauma without current consequences or symptoms and/or those who have reported a resolution of past trauma(s). For example, some clients may have significantly delayed onset of traumatic stress symptoms. In this scenario, earlier education can enhance recognition of symptoms and ease the path of seeking treatment.

Some clients do not recognize the link between their current difficulties and their trauma histories; education can help them understand the possible origin of their difficulties. Psychoeducation presents trauma-related symptoms that follow a trauma as normal reactions. By identifying the source of clients' current difficulties and framing them as normal thoughts, emotions, and behaviors in response to trauma, many trauma survivors report a reduction in the intensity of the difficulties or symptoms. Often, a client will express relief that his or her reactions are normal. You may find the U.S. Department of Veterans Affairs (VA) National Center on PTSD's educational handouts on traumatic stress reactions useful.

Psychoeducation goes beyond the identification of traumatic stress symptoms and/or learning about the psychological, cognitive, and physical impacts of trauma. Numerous curricula are available that use psychoeducation as a first-line or complementary approach to trauma-specific therapies to enhance coping strategies in key areas, including safety, emotional regulation, help-seeking, avoidant behavior, and so forth. An example is S.E.L.F., a trauma-informed psychoeducational group curriculum with educational components related to trauma recovery in the following

Case Illustration: Linda

Linda served as an Army nurse in an evacuation hospital in Vietnam. She reported her postdeployment adjustment as difficult and isolating but denied any significant symptoms of traumatic stress throughout her life. Four years ago, Linda sought treatment for alcohol dependence; during the intake, she recalls denying trauma-related symptoms. "I distinctly remember the session," she recounts. "The counselor first took my history but then gave information on typical symptoms and reactions to trauma. I thought, 'Why do I need to hear this? I've survived the worst trauma in my life.' I didn't see the value of this information. Then 3 weeks ago, I began to have recurrent nightmares, the same graphic type I occasionally had when I was in Vietnam. Since then, I've been very anxious, reliving horrible scenes that I'd experienced as a nurse and postponing going to bed in fear of having the dreams again. I didn't understand it. I am 70 years old, and the war happened a long time ago. Then I began putting it together. Recently, the emergency helicopter flight pattern and approach to the area's hospital changed. I began hearing the helicopter periodically in my living room, and it reminded me of Vietnam. I knew then that I needed help; I couldn't stop shaking. I felt as if I was losing control of my emotions. I remembered how the intake counselor took the time to explain common symptoms of trauma. That's why I'm here today."

"This might not sound like a big deal, but for many people relationships have become all about getting: telling your problem story and then getting help with it. There is little, if any, emphasis placed on giving back. That's a big deal!!! Service relationships are like a one way street and both people's roles are clearly defined. But in 'regular' relationships in your community, people give and take all the time. No one is permanently on the taking side or the giving side. This exchange contributes to people feeling ok about being vulnerable (needing help) as well as confident about what they're offering. For many of us, being the role of 'getter' all the time has shaken our confidence, making us feel like we have nothing worthwhile to contribute. Peer support breaks that all down. It gets complicated somewhat when one of us is paid, but modeling this kind of relationship in which both of us learn, offers us the real practice we need to feel like a 'regular' community member as opposed to an 'integrated mental patient'."

(Mead, 2008, p.7)

areas: creating **S**afety, regulating **E**motions, addressing **L**oss, and redefining the **F**uture (Bloom, Foderaro, & Ryan, 2006).

Offer Trauma-Informed Peer Support

Living with a history of trauma can be isolating and consuming. The experience of trauma can reinforce beliefs about being different, alone, and marred by the experience. At times, behavioral health treatment for trauma-related effects can inadvertently reinforce these beliefs. Simply engaging in treatment or receiving specialized services (although warranted) can further strengthen clients' beliefs that there is something wrong with them. Formalized peer support can enhance the treatment experience. Treatment plus peer support can break the cycle of beliefs that reinforce traumatic stress (e.g., believing that one is permanently damaged; that nobody could understand; that no one should or could tolerate one's story). Peer support provides opportunities to form mutual relationships; to learn how one's history shapes perspectives of self, others, and the future; to move beyond trauma; and to mirror and learn alternate coping strategies. Peer support defines recovery as an

Advice to Counselors: Strategies To Enhance Peer Support

Strategy #1: Provide education on what peer support is and is not. Roles and expectations of peer support can be confusing, so providing clarification in the beginning can be quite useful. It is important to provide initial education about peer support and the value of using this resource.

Strategy #2: Use an established peer support curriculum to guide the peer support process. For example, *Intentional Peer Support: An Alternative Approach* (Mead, 2008) is a workbook that highlights four main tasks for peer support: building connections, understanding one's worldview, developing mutuality, and helping each other move toward set desires and goals. This curriculum provides extensive materials for peer support staff members as well as for the individuals seeking peer support.

interactive process, not as a definitive moment wherein someone fixes the "problem."

Normalize Symptoms

Symptoms of trauma can become serious barriers to recovery from substance use and mental disorders, including trauma-related ones. Counselors should be aware of how trauma symptoms can present and how to respond to them when they do appear. A significant step in addressing symptoms is normalizing them. People with traumatic stress symptoms need to know that their symptoms are not unique and that their reactions are common to their experience(s). Often, normalizing symptoms gives considerable relief to clients who may have thought that their symptoms signified some pervasive, untreatable mental disorder.

Advice to Counselors: Strategies To Normalize Symptoms

Strategy #1: Provide psychoeducation on the common symptoms of traumatic stress.

Strategy #2: Research the client's most prevalent symptoms specific to trauma, and then provide education to the client. For example, an individual who was conscious and trapped during or as a result of a traumatic event will more likely be hypervigilant about exits, plan escape routes even in safe environments, and have strong reactions to interpersonal and environmental situations that are perceived as having no options for avoidance or resolution (e.g., feeling stuck in a work environment where the boss is emotionally abusive).

Strategy #3: First, have the client list his or her symptoms. After each symptom, ask the client to list the negative and positive consequences of the symptom. Remember that symptoms serve a purpose, even if they may not appear to work well or work as well as they had in the past. Focus on how the symptoms have served the client in a positive way (see Case Illustration: Hector). This exercise can be difficult, because clients as well as counselors often don't focus on the value of symptoms.

Case Illustration: Hector

Hector was referred to a halfway house specializing in co-occurring disorders after inpatient treatment for methamphetamine dependence and posttraumatic stress disorder (PTSD). In the halfway house, he continued to feel overwhelmed with the frequency and intensity of flashbacks. He often became frustrated, expressing anger and a sense of hopelessness, followed by emotional withdrawal from others in the house. Normalization strategy #3 was introduced in the session. During this exercise, he began to identify many negative aspects of flashbacks. He felt that he couldn't control the occurrence of flashbacks even though he wanted to, and he realized that he often felt shame afterward. In the same exercise, he was also urged to identify positive aspects of flashbacks. Although this was difficult, he realized that flashbacks were clues about content that he needed to address in trauma-specific treatment. "I realized that a flashback, for me, was a billboard advertising what I needed to focus on in therapy."

Identify and Manage Trauma-Related Triggers

Many clients who have traumatic stress are caught off guard with intrusive thoughts, feelings, sensations, or environmental cues of the trauma. This experience can be quite disconcerting, but often, the individual does not draw an immediate connection between the internal or external trigger and his or her reactions. At other times, the trigger is so potent that the individual is unable to discern the present trigger from the past trauma and begins to respond as if the trauma is reoccurring. Key steps in identifying triggers are to reflect back on the situation, surroundings, or sensations prior to the strong reaction. By doing so, you and your client may be able to determine the connections among these cues, the past trauma(s), and the client's reaction. Once the cue is identified, discuss the ways in which it is connected to past trauma. For some cues, there will be an obvious and immediate connection (e.g., having someone say "I love you" in a significant relationship as an adult and connecting this to an abuser who said the same thing prior to a sexual assault). Other

Advice to Counselors: Strategies To Identify and Manage Trauma-Related Triggers

Strategy #1: Use the Sorting the Past From the Present technique for cognitive realignment (Blackburn, 1995) to help separate the current situation from the past trauma. Identify one trigger at a time, and then discuss the following questions with the client:

- When and where did you begin to notice a reaction?
- How does this situation remind you of your past history or past trauma?
- How are your reactions to the current situation similar to your past reactions to the trauma(s)?
- How was this current situation different from the past trauma?
- How did you react differently to the current situation than to the previous trauma?
- How are you different today (e.g., factors such as age, abilities, strength, level of support)?
- What choices can you make that are different from the past and that can help you address the current situation (trigger)?

After reviewing this exercise several times in counseling, put the questions on a card for the client to carry and use outside of treatment. Clients with substance use disorders can benefit from using the same questions (slightly reworded) to address relapse triggers.

Strategy #2: After the individual identifies the trigger and draws connections between the trigger and past trauma, work with him or her to establish responses and coping strategies to deal with triggers as they occur. Initially, the planned responses will not immediately occur after a trigger, but with practice, the planned responses will move closer to the time of the trigger. Some strategies include an acronym that reflects coping strategies (Exhibit 1.5-1), positive self-talk generated by cognitive–behavioral covert modeling exercises (rehearsal of coping statements), breathing retraining, and use of support systems (e.g., calling someone).

Strategy #3: Self-monitoring is any strategy that asks a client to observe and record the number of times something happens, to note the intensity of specific experiences, or to describe a specific behavioral, emotional, or cognitive phenomenon each time it occurs. For individuals with histories of trauma, triggers and flashbacks can be quite frightening, intense, and powerful. Even if the client has had just one or two triggers or flashbacks, he or she may perceive flashbacks as happening constantly. Often, it takes time to recover from these experiences. Using self-monitoring and asking the client to record each time a trigger occurs, along with describing the trigger and its intensity level (using a scale from 1–10), clients and counselors will gain an understanding of the type of triggers present and the level of distress that each one produces. Moreover, the client may begin to see that the triggers don't actually happen all the time, even though they may seem to occur frequently.

Exhibit 1.5-1: The OBSERVATIONS Coping Strategy

- Take a moment to just ***Observe*** what is happening. Pay attention to your body, your senses, and your environment.
- Focus on your ***Breathing***. Allow your feelings and sensations to wash over you. Breathe.
- Name the ***Situation*** that initiated your response. In what way is this situation familiar to your past? How is it different?
- Remember that ***Emotions*** come and go. They may be intense now, but later they will be less so. Name your feelings.
- ***Recognize*** that this situation does not define you or your future. It does not dictate how things will be, nor is it a sign of things to come. Even if it is familiar, it is only one event.
- ***Validate*** your experience. State, at least internally, what you are feeling, thinking, and experiencing.
- ***Ask*** for help. You don't have to do this alone. Seek support. Other people care for you. Let them!
- ***This*** too shall pass. Remember: There are times that are good and times that are not so good. This hard time will pass.
- ***I*** can handle this. Name your strengths. Your strengths have helped you survive.
- Keep an ***Open*** mind. Look for and try out new solutions.
- ***Name*** strategies that have worked before. Choose one and apply it to this situation.
- Remember you have survived. You are a ***Survivor***!

cues will not be as obvious. With practice, the client can begin to track back through what occurred immediately before an emotional, physical, or behavioral reaction and then examine how that experience reminds him or her of the past.

Draw Connections

Mental health and substance abuse treatment providers have historically underestimated the effects of trauma on their clients for many reasons. Some held a belief that substance

Advice to Counselors: Strategies To Help Clients Draw Connections

Strategy #1: Writing about trauma can help clients gain awareness of their thoughts, feelings, and current experiences and can even improve physical health outcomes (Pennebaker, Kiecolt-Glaser, & Glaser, 1988; Smyth, Hockemeyer, & Tulloch, 2008). Although this tool may help some people draw connections between current experiences and past traumas, it should be used with caution; others may find that it brings up too much intense trauma material (especially among vulnerable trauma survivors with co-occuring substance abuse, psychosis, and current domestic violence). Journal writing is safest when you ask clients to write about present-day specific targets, such as logging their use of coping strategies or identifying strengths with examples. Writing about trauma can also be done via key questions or a workbook that provides questions centered upon trauma experiences and recovery.

Strategy #2: Encourage clients to explore the links among traumatic experiences and mental and substance use disorders. Recognition that a mental disorder or symptom developed after the trauma occurred can provide relief and hope that the symptoms may abate if the trauma is addressed. Ways to help clients connect substance use with trauma histories include (Najavits, 2002b; Najavits, Weiss, & Shaw, 1997):

- Identifying how substances have helped "solve" trauma or PTSD symptoms in the short term (e.g., drinking to get to sleep).
- Teaching clients how trauma, mental, and substance use disorders commonly co-occur so that they will not feel so alone and ashamed about these issues.
- Discussing how substance abuse has impeded healing from trauma (e.g., by blocking feelings and memories).
- Helping clients recognize trauma symptoms as triggers for relapse to substance use and mental distress.
- Working on new coping skills to recover from trauma and substance abuse at the same time.
- Recognizing how both trauma and substance abuse often occur in families through multiple generations.

abuse should be addressed before attending to any co-occurring conditions. Others did not have the knowledge and training to evaluate trauma issues or were uncomfortable or reluctant to discuss these sensitive issues with clients (Ouimette & Brown, 2003). Similarly, in other behavioral health settings, clinicians sometimes address trauma-related symptoms but do not have experience or training in the treatment of substance abuse.

So too, people who have histories of trauma will often be unaware of the connection between the traumas they've experienced and their traumatic stress reactions. They may notice depression, anger, or anxiety, or they may describe themselves as "going crazy" without being able to pinpoint a specific experience that produced the trauma symptoms. Even if clients recognize the events that precipitated their trauma symptoms, they may not understand how others with similar experiences can have different reactions. Thus, a treatment goal for trauma survivors is helping them gain awareness of the connections between their histories of trauma and subsequent consequences. Seeing the connections can improve clients' ability to work on recovery in an integrated fashion.

Teach Balance

You and your clients need to walk a thin line when addressing trauma. Too much work focused on highly distressing content can turn a desensitization process into a session whereby the client dissociates, shuts down, or becomes emotionally overwhelmed. On the other hand, too little focus by the client or counselor can easily reinforce avoidance and confirm the client's internal belief that it is too dangerous to deal with the aftermath of the trauma. Several trauma-specific theories offer guidelines on acceptable levels of distress associated with the traumatic content that the therapy addresses. For example, some traditional desensitization processes start at a very low level of subjective distress, gradually working up through a hierarchy of trauma memories and experiences until those experiences produce minimal reactions when paired with some coping strategy, such as relaxation training. Other desensitization processes start at a higher level of intensity to provide more rapid extinction of traumatic associations and to decrease the risk of avoidance—a behavior that reinforces traumatic stress.

> The Subjective Units of Distress Scale (SUDS) uses a 0 10 rating scale, with 0 representing content that causes no or minimal distress and 10 representing content that is exceptionally distressing and overwhelming.
>
> (Wolpe & Abrams, 1991)

Working with trauma is a delicate balancing act between the development and/or use of coping strategies and the need to process the traumatic experiences. Individuals will choose different paths to recovery; it's a myth that every traumatic experience needs to be expressed and every story told. For some individuals, the use of coping skills, support, and spirituality are enough to recover. Regardless of theoretical beliefs, counselors must teach

Advice to Counselors: Strategy To Teach Balance

Strategy #1: Teach and use the SUDS in counseling. This scale can be useful from the outset as a barometer for the client and counselor to measure the level of distress during and outside of sessions. It provides a common language for the client and counselor, and it can also be used to guide the intensity of sessions. SUDS can tangibly show a client's progress in managing experiences. Without a scale, it is more difficult to grasp that a distressing symptom or circumstance is becoming less and less severe without some repeated measure.

coping strategies as soon as possible. Retraumatization is a risk whenever clients are exposed to their traumatic histories without sufficient tools, supports, and safety to manage emotional, behavioral, and physical reactions.

Build Resilience

Survivors are resilient! Often, counselors and clients who are trauma survivors focus on the negative consequences of trauma while failing to recognize the perseverance and attributes that have helped them survive. It is natural to focus on what's not working rather than what has worked. To promote growth after trauma and establish a strengths-based approach, focus on building on clients' resilience. Current resilience theories claim that building or reinforcing resilience prevents further development of trauma-related symptoms and disorders. The following *Advice to Counselors* box is adapted from the American Psychological Association's 2003 statement on resilience.

Advice to Counselors: Strategies To Build Resilience

Strategy #1: Help clients reestablish personal and social connections. Access community and cultural resources; reconnect the person to healing resources such as mutual-help groups and spiritual supports in the community.

Strategy #2: Encourage the client to take action. Recovery requires activity. Actively taking care of one's own needs early in treatment can evolve into assisting others later on, such as by volunteering at a community organization or helping military families.

Strategy #3: Encourage stability and predictability in the daily routine. Traumatic stress reactions can be debilitating. Keeping a daily routine of sleep, eating, work, errands, household chores, and hobbies can help the client see that life continues. Like exercise, daily living skills take time to take hold as the client learns to live through symptoms.

Strategy #4: Nurture a positive view of personal, social, and cultural resources. Help clients recall ways in which they successfully handled hardships in the past, such as the loss of a loved one, a divorce, or a major illness. Revisit how those crises were addressed.

Strategy #5: Help clients gain perspective. All things pass, even when facing very painful events. Foster a long-term outlook; help clients consider stress and suffering in a spiritual context.

Strategy #6: Help maintain a hopeful outlook. An optimistic outlook enables visions of good things in life and can keep people going even in the hardest times. There are positive aspects to everyone's life. Taking time to identify and appreciate these enhances the client's outlook and helps him or her persevere.

Strategy #7: Encourage participation in peer support, 12-Step, and other mutual-help programs.

Source: American Psychological Association, 2003.

Address Sleep Disturbances

Sleep disturbances are one of the most enduring symptoms of traumatic stress and are a particularly common outcome of severe and prolonged trauma. Sleep disturbances increase one's risk of developing traumatic stress; they significantly alter physical and psychological processes, thus causing problems in daytime functioning (e.g., fatigue, cognitive difficulty, excessive daytime sleepiness). People with sleep disturbances have worse general health and quality of life. The cardiovascular and immune systems, among others, may be affected as well. Sleep disturbances can worsen traumatic stress symptoms and interfere with healing by impeding the brain's ability to process and consolidate traumatic memories (Caldwell & Redeker, 2005).

Sleep disturbances vary among trauma survivors and can include decreased ability to stay asleep, frequent awakenings, early morning unintentional awakening, trouble falling asleep, poor quality of sleep, and disordered

Advice to Counselors: Strategies To Conduct a Sleep Intervention

Strategy #1: Conduct a sleep history assessment focused first on the client's perception of his or her sleep patterns. Assess whether there is difficulty initiating or staying asleep, a history of frequent or early morning awakenings, physically restless sleep, sleepwalking, bedtime aversion, and/or disruptive physical and emotional states upon awakening (e.g., confusion, agitation, feeling unrested). Also determine total sleep time, pattern of nightmares, and use of medications, alcohol, and/or caffeine (see Moul, Hall, Pikonis, & Buysse, 2004, for a review of self-report measures).

Strategy #2: Use a sleep hygiene measure to determine the presence of habits that typically interfere with sleep (e.g., falling asleep while watching television). The National Sleep Foundation Web site (http://www.sleepfoundation.org) provides simple steps for promoting good sleep hygiene.

Strategy #3: Provide education on sleep hygiene practices. Introduce clients to the idea that practicing good sleep hygiene is one step toward gaining control over their sleep disturbances.

Strategy #4: Reassess sleep patterns and history during the course of treatment. Sleep patterns often reflect current client status. For example, clients who are struggling are more likely to have disturbed sleep patterns; sleep disturbances significantly influence clients' mental health status.

Strategy #5: Use interventions such as nightmare rehearsals to target recurrent nightmares. There are numerous examples of imagery-based nightmare rehearsals. Clients may be instructed to rehearse repetitively the recurrent nightmare a few hours before bedtime. In this instruction, the client either rehearses the entire nightmare with someone or visualizes the nightmare several times to gain control over the material and become desensitized to the content. Other strategies involve imagining a change in the outcome of the nightmare (e.g., asking the client to picture getting assistance from others, even though his or her original nightmare reflects dealing with the experience alone).

breathing during sleep (Caldwell & Redeker, 2005). Most traumatic stress literature focuses on nightmares, insomnia, and frequent awakenings. These disturbances are connected to two main symptoms of traumatic stress: hyperarousal (which causes difficulty in falling and remaining asleep) and reexperiencing the trauma (e.g., through recurrent nightmares). Other sleep disturbances trauma survivors report include sleep avoidance or resistance to sleep (see Case Illustration: Selena), panic awakenings, and restless or unwanted body movements (e.g., hitting your spouse unintentionally in bed while asleep; Habukawa, Maeda, & Uchimura, 2010).

Case Illustration: Selena

Selena initially sought treatment for ongoing depression (dysthymia). During treatment, she identified being sexually assaulted while attending a party at college. At times, she blames herself for the incident because she didn't insist that she and her girlfriends stay together during the party and on the way back to their dorm afterward. Selena reported that she only had two drinks that night: "I could never manage more than two drinks before I wanted to just sleep, so I never drank much socially." She was assaulted by someone she barely knew but considered a "big brother" in the brother fraternity of her sorority. "I needed a ride home. During that ride, it happened," she said. For years thereafter, Selena reported mild bouts of depression that began lasting longer and increasing in number. She also reported nightmares and chronic difficulty in falling asleep. In therapy, she noted avoiding her bed until she's exhausted, saying, "I don't like going to sleep; I know what's going to happen." She describes fear of sleeping due to nightmares. "It's become a habit at night. I get very involved in playing computer games to lose track of time. I also leave the television on through the night because then I don't sleep as soundly and have fewer nightmares. But I'm always exhausted."

Build Trust

Some traumatic experiences result from trusting others (e.g., interpersonal trauma). In other cases, trust was violated during or after the traumatic experience, as in cases when help was late to arrive on the scene of a natural disaster. This lack of trust can leave individuals alienated, socially isolated, and terrified of developing relationships. Some feel that the trauma makes them different from others who haven't had similar experiences. Sometimes, a client's trust issues arise from a lack of trust in self—for instance, a lack of trust in one's perceptions, judgment, or memories. People who have also experienced severe mental or substance use disorders may have difficulty trusting others because, during the course of their illness, they felt alienated or discriminated against for behaviors and emotions generated by or associated with the disorders.

Some client groups (e.g., gay, lesbian, and bisexual clients; people from diverse cultures; those with serious mental illness) evidence significant mistrust because their trust has been repeatedly violated in the past. Traumatic experiences then compound this mistrust. Mistrust can come from various sources, is usually unstated, and, if left unaddressed, can impede treatment. For example, some clients leave treatment early or do not engage in potentially beneficial treatments. Others avoid issues of trust and commitment by leaving treatment when those issues begin to arise.

Establishing a safe, trusting relationship is paramount to healing—yet this takes time in the counseling process. Counselors and other behavioral health professionals need to be consistent throughout the course of treatment; this includes maintaining consistency in the parameters set for availability, attendance, and level of empathy. Trust is built on behavior shown inside and outside of treatment; you should immediately address any behavior that may even slightly injure the relationship (e.g., being 5 minutes late for an appointment, not responding to a phone message in a timely manner, being distracted in a session).

Advice to Counselors: Strategies To Build Trust

Strategy #1: Clients can benefit from a support or counseling group composed of other trauma survivors. By comparing themselves with others in the group, they can be inspired by those who are further along in the recovery process and helpful to those who are not faring as well as they are. These groups also motivate clients to trust others by experiencing acceptance and empathy.

Strategy #2: Use conflicts that arise in the program as opportunities. Successful negotiation of a conflict between the client and the counselor is a major milestone (van der Kolk, McFarlane, & Van der Hart, 1996). Helping clients understand that conflicts are healthy and inevitable in relationships (and that they can be resolved while retaining the dignity and respect of all involved) is a key lesson for those whose relationship conflicts have been beset by violence, bitterness, and humiliation.

Strategy #3: Prepare clients for staff changes, vacations, or other separations. Some clients may feel rejected or abandoned if a counselor goes on vacation or is absent due to illness, especially during a period of vulnerability or intense work. A phone call to the client during an unexpected absence can reinforce the importance of the relationship and the client's trust. You can use these opportunities in treatment to help the client understand that separation is part of relationships; work with the client to view separation in a new light.

Strategy #4: Honor the client–counselor relationship, and treat it as significant and mutual. You can support the development of trust by establishing clear boundaries, being dependable, working with the client to define explicit treatment goals and methods, and demonstrating respect for the client's difficulty in trusting you and the therapeutic setting.

Support Empowerment

Strong feelings of powerlessness can arise in trauma survivors seeking to regain some control of their lives. Whether a person has survived a single trauma or chronic trauma, the survivor can feel crushed by the weight of powerlessness. Mental illness and substance abuse, too, can be disempowering; clients may feel that they've lost control over their daily lives, over a behavior such as drug use, or over powerful emotions such as fear, sadness, or anger. Empowerment means helping clients feel greater power and control over their lives, as long as such control is within safe and healthy bounds. A key facet of empowerment is to help clients build on their strengths. Empowerment is more than helping clients discover what they "should" do; it is also helping them take the steps they feel ready to take.

Case Illustration: Abby

Abby, a 30-year-old, nervous-looking woman, is brought by her parents to a community mental health clinic near their home in rural Indiana. During the intake process, the counselor learns that Abby is an Army Reservist who returned from 12 months of combat duty 3 years ago. The war experience changed her in many ways. Her deployment pulled her away from veterinary school as well as the strong emotional support of family, friends, and fellow classmates. She got along with her unit in Iraq and had no disciplinary problems. While there, she served as a truck driver in the Sunni Triangle. Her convoy was attacked often by small arms fire and was once struck by an improvised explosive device. Although Abby sustained only minor injuries, two of her close friends were killed. With each successive convoy, her level of fear and foreboding grew, but she continued performing as a driver.

Since returning to the United States, she has mostly stayed at home and has not returned to school, although she is helping out on the farm with various chores. Abby has isolated herself from both family members and lifelong friends, saying she doesn't think others can understand what she went through and that she prefers being alone. She reports to her parents and the counselor that she is vaguely afraid to be in cars and feels most comfortable in her room or working alone, doing routine tasks, at home. Abby also says that she now understands how fragile life can be.

She has admitted to her parents that she drinks alcohol on a regular basis, something she did not do before her deployment, and that on occasion, she has experienced blackouts. Abby feels she needs a drink before talking with strangers or joining in groups of friends or family. She confided to her father that she isolates herself so that she can drink without having to explain her drinking to others.

The counselor recognizes Abby's general sense of lacking internal control and feeling powerless over what will happen to her in the future. He adopts a motivational interviewing style to establish rapport and a working alliance with Abby. During sessions, the counselor asks Abby to elaborate on her strengths; he reinforces strengths that involve taking action in life, positive self-statements, and comments that deal with future plans. He also introduces Abby to an Iraq War veteran who came home quite discouraged about putting his life together but has done well getting reintegrated. The counselor urges Abby go to the local VA center so that she can meet and bond with other recently returned veterans. He also encourages Abby to attend Alcoholics Anonymous meetings, emphasizing that she won't be pressured to talk or interact with others more than she chooses to.

The counselor continues to see Abby every week and begins using cognitive–behavioral techniques to help her examine some of her irrational fears about not being able to direct her life. He asks Abby to keep a daily diary of activities related to achieving her goals of getting back to school and reestablishing a social network. In each session, Abby reviews her progress using the diary as a memory aid, and the counselor reinforces these positive efforts. After 4 months of treatment, Abby reenrolls in college and is feeling optimistic about her ability to achieve her career plans.

Advice to Counselors: Strategies To Support Empowerment

Strategy #1: Offer clients information about treatment; help them make informed choices. Placing appropriate control for treatment choices in the hands of clients improves their chances of success.

Strategy #2: Give clients the chance to collaborate in the development of their initial treatment plan, in the evaluation of treatment progress, and in treatment plan updates. Incorporate client input into treatment case consultations and subsequent feedback.

Strategy #3: Encourage clients to assume an active role in how the delivery of treatment services occurs. An essential avenue is regularly scheduled and structured client feedback on program and clinical services (e.g., feedback surveys). Some of the most effective initiatives to reinforce client empowerment are the development of peer support services and the involvement of former clients in parts of the organizational structure, such as the advisory board or other board roles.

Strategy #4: Establish a sense of self-efficacy in clients; their belief in their own ability to carry out a specific task successfully—is key. You can help clients come to believe in the possibility of change and in the hope of alternative approaches to achieving change. Supporting clients in accepting increasing responsibility for choosing and carrying out personal change can facilitate their return to empowerment (Miller & Rollnick, 2002).

Acknowledge Grief and Bereavement

The experience of loss is common after traumas, whether the loss is psychological (e.g., no longer feeling safe) or physical (e.g., death of a loved one, destruction of community, physical impairment). Loss can cause public displays of grief, but it is more often a private experience. Grieving processes can be emotionally overwhelming and can lead to increased substance use and other impulsive behaviors as a way to manage grief and other feelings associated with the loss. Even for people who experienced trauma years prior to treatment, grief is still a common psychological issue. Delayed or absent reactions of acute grief can cause exhaustion, lack of strength, gastrointestinal symptoms, and avoidance of emotions.

Risk factors of chronic bereavement (grief lasting more than 6 months) can include:

- Perceived lack of social support.
- Concurrent crises or stressors (including reactivation of PTSD symptoms).
- High levels of ambivalence about the loss.
- An extremely dependent relationship prior to the loss.
- Loved one's death resulting from disaster: unexpected, untimely, sudden, and shocking (New South Wales Institute of Psychiatry & Centre for Mental Health, 2000).

Advice to Counselors: Strategies To Acknowledge and Address Grief

Strategy #1: Help the client grieve by being present, by normalizing the grief, and by assessing social supports and resources.

Strategy #2: When the client begins to discuss or express grief, focus on having him or her voice the losses he or she experienced due to trauma. Remember to clarify that losses include internal experiences, not just physical losses.

Strategy #3: For a client who has difficulty connecting feelings to experiences, assign a feelings journal in which he or she can log and name each feeling he or she experiences, rate the feeling's intensity numerically, and describe the situation during which the feeling occurred. The client may choose to share the journal in an individual or group session.

Strategy #4: Note that some clients benefit from developing a ritual or ceremony to honor their losses, whereas others prefer offering time or resources to an association that represents the loss.

Monitor and Facilitate Stability

Stability refers to an ongoing psychological and physical state whereby one is not overwhelmed by disruptive internal or external stimuli (Briere & Scott, 2006b). It's common for individuals to have an increase in symptoms, distress, or impairment when dealing with the impact of their trauma or talking about specific aspects of their trauma. There is a thin line that the client and counselor need to negotiate and then walk when addressing trauma. Too much work focused on highly distressing content can turn a desensitization process into a session that causes the client to dissociate, shut down, or become emotionally overwhelmed. On the other hand, too little focus by the client or counselor can easily reinforce avoidance and confirm the client's internal belief that it is too dangerous to deal with the aftermath of the trauma.

Advice to Counselors: Strategies To Monitor and Facilitate Stability

Strategy #1: If destabilization occurs during the intake process or treatment, stop exploring the material that triggered the reaction, offer emotional support, and demonstrate ways for the client to self-soothe.

Strategy #2: Seek consultation from supervisors and/or colleagues (e.g., to explore whether a new case conceptualization is needed at this point).

Strategy #3: Refer the client for a further assessment to determine whether a referral is necessary for trauma-specific therapy or a higher level of care, or use of multiple levels of care (e.g., intensive outpatient care, partial hospitalization, residential treatment).

Strategy #4: Focus on coping skills and encourage participation in a peer support program.

Strategy #5: When a client becomes agitated and distressed, carefully explore with the client what is causing this state. When such feelings arise because of current threats in the client's life or environment, it is dangerous to halt or soothe away responses that act as warning signals (Pope & Brown, 1996). When a client is in a situation involving domestic violence, lives in a dangerous neighborhood, or has run out of money for food, he or she requires direct and concrete assistance rather than simple emotional support.

Source: Briere & Scott, 2006b.

Managing Destabilization

When a client becomes destabilized during a session, you can respond in the following manner: "Let's slow down and focus on helping you be and feel safe. What can we do to allow you to take care of yourself at this moment? Then, when you feel ready, we can decide what to focus on next."

Clients should have some psychological stability to engage in trauma-related work. An important distinction can be made between a normative increase in symptoms (e.g., the typical up-and-down course of traumatic stress reactions or substance abuse) and destabilization (dangerous, significant decrease in functioning). Signs of destabilization include (Green Cross Academy of Traumatology, 2007; Najavits, 2002b):

- Increased substance use or other unsafe behavior (e.g., self-harm).
- Increased psychiatric symptoms (e.g., depression, agitation, anxiety, withdrawal, anger).
- Increased symptoms of trauma (e.g., severe dissociation).
- Helplessness or hopelessness expressed verbally or behaviorally.
- Difficulty following through on commitments (e.g., commitment to attend treatment sessions).
- Isolation.
- Notable decline in daily activities (e.g., self-care, hygiene, care of children or pets, going to work).

Treatment Issues

The treatment environment itself can significantly affect how clients experience traumatic stress and how the client responds to treatment. Some specific issues related to working with trauma survivors in a clinical setting are discussed in the following sections.

Client Engagement

A lack of engagement in treatment is the client's inability to make progress toward treatment goals, deal with important topics in treatment, or complete treatment. Clients who have histories of trauma will express ambivalence about treatment similarly to others, except that clients who have traumatic stress can feel more "stuck" and perceive themselves as having fewer options. In addition, clients may be avoiding engagement in treatment because it is one step closer to addressing their trauma. You should attend to the client's motivation to change, implement strategies that address ambivalence toward treatment, and use approaches that help clients overcome avoidant behavior.

Advice to Counselors: Strategies To Foster Engagement

Strategy #1: According to Mahalik (2001), the standard method of handling clients' lack of engagement is exploring it with them, clarifying the situation through discussion with them, reinterpreting (e.g., from "can't" to "won't" to "willing"), and working through the situation toward progress.

Strategy #2: To improve engagement into treatment, try motivational interviewing and enhancement techniques. For additional information on such techniques, see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (Center for Substance Abuse Treatment [CSAT], 1999b).

Pacing and Timing

Although your training or role as a counselor may prohibit you from providing trauma-specific services, you must still be prepared for the fact that clients are not as focused on when or where it is most appropriate to address trauma—they want relief, and most lay and professional people have been taught that the only path to recovery is disclosure. Some clients are reluctant to talk about anything associated with their histories of trauma. Other clients immediately want to delve into the memories of their trauma without developing a safe environment. The need to gain any relief for the traumatic stress pushes some individuals to disclose too quickly, without having the necessary support and coping skills to manage the intensity of their memories. Clients who enter treatment and immediately disclose past trauma often don't return because the initial encounter was so intense or because they experienced considerable emotional distress for several days afterward and/or in anticipation of the next session.

Proper pacing of sessions, disclosure, and intensity is paramount. Clients who immediately disclose without proper safety nets are actually retraumatizing themselves by reliving the experience without adequate support—often placing themselves in the same circumstances that occurred during the actual traumas they experienced. Although you should not adamantly direct clients not to talk about what happened, it is important to discuss with the clients, even if you have to interrupt them empathically and respectfully, the potential consequences of disclosing too soon and too fast. Ask whether they have done this before, and then inquire about the outcome. Reinforce with clients that trauma heals when there are support, trust, and skills in place to manage the memories of the traumatic experiences. Ideally, disclosure begins after these elements are secured, but realistically, it is a

Advice to Counselors: Strategies To Establish Appropriate Pacing and Timing

Strategy #1: Frequently discuss and request feedback from clients about pacing and timing. Moving too quickly into discussion of the trauma can increase the risk of dissociation, overactivation of memories, and feeling overwhelmed.

Strategy #2: Use the SUDS as a barometer of intensity to determine the level of work.

Strategy #3: Slowly increase the speed of interventions and continually adjust the intensity of interventions; move in and out of very intense work, or use strategies that decrease the intensity when necessary. One approach that typically decreases the intensity of traumatic memories is to ask the individual to imagine that he or she is seeing the scene through a window or on a television screen. This helps decrease intensity and the risk of dissociation. It provides an opportunity for the client to view the trauma from a different perspective and a strategy to use outside of treatment to shift from reliving the trauma to observing it from a neutral position.

Strategy #4: Monitor clients to ensure that treatment does not overwhelm their internal capacities, retraumatize them, or result in excessive avoidance; make sure therapy occurs in the "therapeutic window" (Briere & Scott, 2006b).

Strategy #5: Be alert to signs that discussions of trauma, including screening, assessment, and intake processes, are going too fast. Mild to moderate signs are:
- Missing counseling appointments after discussions of important material.
- Periods of silence.
- Dissociation.
- Misunderstanding what are usually understandable concepts.
- Redirecting the focus of the discussion when certain issues arise.

Strategy #6: Observe the client's emotional state. Slow down; seek consultation if the client exhibits:
- Persistent resistance to addressing trauma symptoms.
- Repetitive flashbacks.
- Increase in dissociation.
- Regression.
- Difficulty in daily functioning (e.g., trouble maintaining everyday self-care tasks).
- Substance use relapses.
- Self-harm or suicidal thoughts/behaviors (e.g., talking about suicide).

Strategy #7: Use caution and avoid (Briere, 1996b, p. 115):
- Encouraging clients to describe traumatic material in detail before they can deal with the consequences of disclosure.
- Using overly stressful interventions (e.g., intensive role-plays, group confrontation, guided imagery).
- Confrontations or interpretations that are too challenging given the client's current functioning.
- Demanding that the client work harder and stop resisting.

Source: Strategies 1–6: Green Cross Academy of Traumatology, 2001. Adapted with permission.

balancing act for both the counselor and client as to when and how much should be addressed in any given session. Remember not to inadvertently give a message that it is too dangerous to talk about trauma; instead, reinforce the importance of addressing trauma without further retraumatization.

Length of Treatment

Many factors influence decisions regarding the length of treatment for a given client. Severity of addiction, type of substance abused, type of trauma, age at which the trauma occurred, level of social support, and the existence of

mental disorders all influence length of treatment. External factors, such as transportation and childcare, caps on insurance coverage, and limitations in professional resources, can also affect length of treatment. In general, longer treatment experiences should be expected for clients who have histories of multiple or early traumas, meet diagnostic criteria for multiple Axis I or Axis II diagnoses, and/or require intensive case management. Most of the empirically studied and/or manual-based models described in the next chapter are short-term models (e.g., lasting several months); however, ongoing care is indicated for clients with more complex co-occurring trauma disorders.

Traumatic Memories

One of the most controversial issues in the trauma field is the phenomenon of "recovered memories" or "traumatic amnesia" (Brewin, 2007). Practitioners working with traumatized individuals are particularly concerned about the possibility of new memories of the traumatic event emerging during the course of therapy and the possibility of these memories being induced by the clinician. Scientific reviews indicate that people can experience amnesia and delayed recall for some memories of a wide variety of traumas, including military combat and prisoner of war experiences, natural disasters and accidents, childhood sexual abuse, and political torture (Bowman & Mertz, 1996; Brewin, 2007; Karon & Widener, 1997; McNally, 2005). In some cases, the survivor will not remember some of what happened, and the counselor may need to help the client face the prospect of never knowing all there is to know about the past and accept moving on with what is known.

Memories of Trauma

Points for counselors to remember are:

- Some people are not able to completely remember past events, particularly events that occurred during high-stress and destabilizing moments.
- In addition to exploring the memories themselves, it can be beneficial to explore how a memory of an event helps the client understand his or her feeling, thinking, and behaving in the present.
- Persistently trying to recall all the details of a traumatic event can impair focus on the present.

Legal Issues

Legal issues can emerge during treatment. A client, for instance, could seek to prosecute a perpetrator of trauma (e.g., for domestic violence) or to sue for damages sustained in an accident or natural disaster. The counselor's role is not to provide legal advice, but rather, to offer support during the process and, if needed, refer the client to appropriate legal help (see Advice to Counselors box on p. 131). A legal matter can dominate the treatment atmosphere for its duration. Some clients have difficulty making progress in treatment until most or all legal matters are resolved and no longer act as ongoing stressors.

Forgiveness

Clients may have all sorts of reactions to what has happened to them. They may feel grateful for the help they received, joy at having survived, and dedication to their recovery. At the other extreme, they may have fantasies of revenge, a loss of belief that the world is a good place, and feelings of rage at what has happened. They may hold a wide variety of beliefs associated with these feelings.

One issue that comes up frequently among counselors is whether to encourage clients to forgive. The issue of forgiveness is a very delicate one. It is key to allow survivors their feelings, even if they conflict with the counselor's own responses. Some may choose to forgive the perpetrator, whereas others may remain angry or seek justice through the courts and other legal means. Early in recovery from

Advice to Counselors: Strategies To Manage Traumatic Memories

Strategy #1: Most people who were sexually abused as children remember all or part of what happened to them, although they do not necessarily fully understand or disclose it. Do not assume that the role of the clinician is to investigate, corroborate, or substantiate allegations or memories of abuse (American Psychiatric Association [APA], 2000b).

Strategy #2: Be aware that forgotten memories of childhood abuse can be remembered years later. Clinicians should maintain an empathic, nonjudgmental, neutral stance toward reported memories of sexual abuse or other trauma. Avoid prejudging the cause of the client's difficulties or the veracity of the client's reports. A counselor's prior belief that physical or sexual abuse, or other factors, are or are not the cause of the client's problems can interfere with appropriate assessment and treatment (APA, 2000b).

Strategy #3: Focus on assisting clients in coming to their own conclusions about the accuracy of their memories or in adapting to uncertainty regarding what actually occurred. The therapeutic goal is to help clients understand the impact of the memories or abuse experiences on their lives and to reduce their detrimental consequences in the present and future (APA, 2000b).

Strategy #4: Some clients have concerns about whether or not a certain traumatic event did or did not happen. In such circumstances, educate clients about traumatic memories, including the fact that memories aren't always exact representations of past events; subsequent events and emotions can have the effect of altering the original memory. Inform clients that it is not always possible to determine whether an event occurred but that treatment can still be effective in alleviating distress.

Strategy #5: There is evidence that suggestibility can be enhanced and pseudomemories can develop in some individuals when hypnosis is used as a memory enhancement or retrieval strategy. Hypnosis and guided imagery techniques can enhance relaxation and teach self-soothing strategies with some clients; however, use of these techniques is not recommended in the active exploration of memories of abuse (Academy of Traumatology, 2007).

Strategy #6: When clients are highly distressed by intrusive flashbacks of delayed memories, help them move through the distress. Teach coping strategies and techniques on how to tolerate strong affect and distress (e.g., mindfulness practices).

trauma, it is best to direct clients toward focusing on stabilization and a return to normal functioning; suggest that, if possible, they delay major decisions about forgiveness until they have a clearer mind for making decisions (Herman, 1997). Even in later stages of recovery, it's not essential for the client to forgive in order to recover. Forgiveness is a personal choice independent of recovery. Respect clients' personal beliefs and meanings; don't push clients to forgive or impose your own beliefs about forgiveness onto clients.

In the long-term healing process, typically months or years after the trauma(s), forgiveness may become part of the discussion for some people and some communities. For example, in South Africa, years after the bitter and bloody apartheid conflicts, a Truth and Reconciliation Commission was established by the Government. Public hearings created dialog and aired what had been experienced as a means, ultimately, to promote forgiveness and community healing. By addressing very difficult topics in public, all could potentially benefit from the discourse. Similarly, a parental survivor of the Oklahoma City bombing was, at first, bitter about his daughter's early, unfair, and untimely death. Today, he gives talks around the world about the abolition of the death penalty. He sat with convicted

Advice to Counselors: Strategies To Manage Legal Proceedings

Strategy #1: If you're aware of legal proceedings, you can play a key role in helping your client prepare emotionally for their impact, such as what it might be like to describe the trauma to a judge or jury, or how to cope with seeing the perpetrator in court. When helping a client prepare, however, be careful not to provide legal advice.

Strategy #2: Help clients separate a successful legal outcome from a successful treatment outcome. If clients connect these two outcomes, difficulties can arise. For example, a client may discontinue treatment after his or her assailant is sentenced to serve prison time, believing that the symptoms will abate without intervention.

Strategy #3: If clients express interest in initiating a civil or criminal suit, encourage them to consider the ways in which they are and are not prepared for this, including their own mental states, capacity for resilience, and inevitable loss of confidentiality (Pope & Brown, 1996). Inform clients coping with legal issues that involvement in the legal process can be retraumatizing.

Strategy #4: Emphasize, for trauma survivors who are involved in legal proceedings against an assailant, that "not guilty" is a legal finding—it is based on the degree of available evidence and is not a claim that certain events in question did not occur. They should also receive, from an attorney or other qualified individual, information on:

- The nature of the legal process as it pertains to the clients' specific cases.
- The estimated duration and cost of legal services, if applicable.
- What to expect during police investigations.
- Court procedures.
- Full information on all possible outcomes.
- What to expect during cross-examination.

Strategy #5: Counselors can be called on to assist with a legal case involving trauma. The court may require you to provide treatment records, to write a letter summarizing your client's progress, or to testify at a trial. Always seek supervisory and legal advice in such situations and discuss with the client the possible repercussions that this might have for the therapeutic relationship. As a general rule, it is best practice to avoid dual roles or relationships.

bomber Timothy McVeigh's father while the man's son was executed in Indiana at a Federal prison several years after the bombing. For this man, forgiveness and acceptance helped him attain personal peace. Other trauma survivors may choose never to forgive what happened, and this, too, is a legitimate response.

Culturally and Gender Responsive Services

Culture is the lens through which reality is interpreted. Without an understanding of culture, it is difficult to gauge how individuals organize, interpret, and resolve their traumas. The challenge is to define how culture affects individuals who have been traumatized.

Increased knowledge of PTSD (Wilson & Tang, 2007), mental illness, and substance use disorders and recovery (Westermeyer, 2004) requires behavioral health practitioners to consider the complicated interactions between culture, personality, mental illness, and substance abuse in adapting treatment protocols. This section offers some general guidelines for working with members of cultures other than one's own. Treatment for traumatic stress, mental illness, substance use disorders, and co-occurring trauma-related symptoms is more effective if it is culturally responsive.

The U.S. Department of Health and Human Services (2003) has defined the term "cultural competence" as follows:

> Cultural competence is a set of values, behaviors, attitudes, and practices within a system, organization, program, or among individuals that enables people to work effectively across cultures. It refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time (p. 12).

Cultural competence is a process that begins with an awareness of one's own culture and beliefs and includes an understanding of how those beliefs affect one's attitudes toward people of other cultures. It is rooted in respect, validation, and openness toward someone whose social and cultural background is different from one's own. For a thorough review of cultural competence, see the planned TIP, *Improving Cultural Competence* (Substance Abuse and Mental Health Services Administration [SAMHSA], planned c).

Cultural Competence

Cultural competence includes a counselor's knowledge of:

- Whether the client is a survivor of cultural trauma (e.g., genocide, war, government oppression, torture, terrorism).
- How to use cultural brokers (i.e., authorities within the culture who can help interpret cultural patterns and serve as liaisons to those outside the culture).
- How trauma is viewed by an individual's sociocultural support network.
- How to differentiate PTSD, trauma-related symptoms, and other mental disorders in the culture.

For more specific information on cultural competence in trauma therapy, see Brown (2008).

In some cultures, an individual's needs take precedence over group needs (Hui & Triandis, 1986), and problems are seen as deriving from the self. In other cultures, however, complex family, kin, and community systems take precedence over individual needs. Considerable heterogeneity exists within and across most ethnic subcultures and across lines of gender, class, age, and political groups (CSAT, 1999b). Subcultures abound in every culture, such as gangs; populations that are homeless or use substances; orphaned or disenfranchised people; religious, ethnic, and sexual minorities; indigenous people; and refugee and immigrant populations. Some subcultures have more in common with similar subcultures in other countries than with their own cultures (e.g., nonheterosexual populations).

Trauma and substance abuse can themselves be a basis for affiliation with a subculture. De Girolamo (1993) reports that "disaster subcultures" exist within many cultures. These cultures of victimization, like all subcultures, have unique worldviews, codes of conduct, and perceptions of the larger society. In a disaster subculture, people are, to some extent, inured to disaster and heedless of warnings of impending disaster. For example, riverbank erosion in Bangladesh displaces thousands of people each year, yet few believe that it is a serious problem or that the displacement will be permanent (Hutton, 2000). Israelis who have lived with unpredictable violence for many years behave differently in public areas and have adapted to different norms than people who don't commonly experience violence (Young, 2001).

Many people identify with more than one subculture. Some identify with a particular culture or subculture, but not with all of its values. Individual identities are typically a mosaic of factors, including developmental achievements, life experiences, behavioral health histories, traumatic experiences, and

alcohol and illicit drug use; levels of acculturation and/or assimilation vary from one individual to the next as well.

Importance of the trauma aftermath

Counselors working in the immediate aftermath of trauma—whether individual, group, or community in nature—face many challenges. For example, survivors may be forced to adjust without access to other health services, employment, support, or insurance. In these instances, counselors must often work with individuals and communities coping with the trauma while struggling daily to meet basic needs. Research suggests that reestablishing ties to family, community, culture, and spiritual systems can not only be vital to the individual, but can also influence the impact of the trauma upon future generations. For example, Baker and Gippenreiter (1998) studied the descendants of people victimized by Joseph Stalin's purge. They found that families who were able to maintain a sense of connection and continuity with grandparents affected by the purge experienced fewer negative effects than did those who were emotionally or physically severed from their grandparents. The researchers also found that whether the grandparents survived was less important than the connection the grandchildren managed to keep to their past. Ties to family and community can also have an adverse effect, especially if the family or community downplays the trauma or blames the victim. Counselors need to have a full understanding of available support before advocating a particular approach.

Treatment strategies

Many traditional healing ways have been damaged, forgotten, or lost—yet much wisdom remains. Drawing on the best traditional and contemporary approaches to human distress and defining culturally competent curricula regarding identity and healing (Huriwai, 2002; Wilson & Tang, 2007) both require respect and appreciation for the many ways in which various people characterize and resolve trauma and how they use addictive substances to bear the burdens of human distress.

Community-Based Treatment for Native American Historical Trauma

Key beliefs in community healing:

- Clients carry childhood pain that has led to adult dysfunction.
- Childhood pain must be confronted, confessed, and addressed, if relief is to be obtained.
- Cathartic expression is the initial step in the healing journey toward a lifelong pursuit of introspection and self-improvement.
- The healing journey entails reclamation of indigenous heritage, identity, spirituality, and practices to remedy the pathogenic effects of colonization and other sources of historical trauma.

Source: Gone, 2009.

It is not yet known how well existing PTSD treatments work for individuals who identify primarily with cultures other than mainstream American culture. It is possible that such treatments do work for clients of other cultures, though some cultural adaptation and translation may be required. For example, some PTSD treatments that have been used with subculture groups without adaptation other than language translation and that appear to be effective across cultures include eye movement desensitization and reprocessing (Bleich, Gelkopf, & Solomon, 2003) and Seeking Safety (Daouest et al., 2012).

Gender

Gender differences exist in traumatic stress, mental disorders, and substance use disorders. For example, women have higher rates of PTSD, whereas men have higher rates of substance abuse (Kessler, Chiu, Demler, Merikangas, & Walters, 2005; Stewart, Ouimette, & Brown, 2002; Tolin & Foa, 2006).

Working With Clients From Diverse Cultures: Trauma and Substance Abuse

- In socially appropriate ways, educate clients, their loved ones, and possibly members of their extended community about the relationship between substance abuse and PTSD, how substance abuse is often used to cope with trauma, and what treatment entails.
- Make serious efforts to connect clients to supportive and understanding people (preferably within culturally identified groups).
- Help clients understand that many who have not experienced trauma or do not have substance use disorders will not understand the psychological, spiritual, and interpersonal insights that they have gained during their recovery processes.

The types of interpersonal trauma experienced by men and by women are often different. A number of studies (Kimerling, Ouimette, & Weitlauf, 2007) indicate that men experience more combat and crime victimization and women experience more physical and/or sexual assault—implying that men's traumas often occur in public, whereas the traumatization of women is more likely to take place in a private setting, such as a home. Men's abusers are more often strangers. Those who abuse women, on the other hand, are more often in a relationship with them. Women (and girls) often are told, "I love you," during the same time period when the abuse occurs. However, women now serve in the military and thus are increasingly subject to some of the same traumas as men and also to military sexual trauma, which is much more common for women to experience. Similarly, men can be subject to domestic violence or sexual abuse.

In treatment, gender considerations are relevant in a variety of ways, including, but not limited to, the role and impact of societal gender stereotypes upon assessment processes, treatment initiation, and engagement of services (e.g., peer support systems); the selection and implementation of gender-specific and gender-responsive approaches for both men and women at each level of intervention; and the best selection of trauma-related interventions that account for gender-specific differences related to traumatic stress. For an extensive review and discussion of gender-specific and gender-responsive care for traumatic stress and substance use, see the TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT, 2009d), and TIP 56, *Addressing the Specific Behavioral Health Needs of Men* (SAMHSA, 2013a).

Beyond the complexities of gender considerations, one must also consider whether clients should be given the choice of working with a male or a female counselor. Some clients who have been traumatized have no preference, particularly if their trauma wasn't associated with gender (e.g., a natural disaster, act of terrorism, fire, serious accident). If gender did play a role in trauma (e.g., childhood sexual abuse), clients can have strong fears of working with a counselor who is the same gender as the perpetrator. Many women who experienced sexual abuse (whose perpetrators are typically men) feel uncomfortable being treated by men because of the intense emotions that can be evoked (e.g., anger, fear). Men who experienced sexual abuse (whose perpetrators are also typically men) can feel uncomfortable for the same reasons, or they may feel shame when talking to men due to feelings evoked about masculinity, homosexuality, and so forth. However, not all clients with trauma histories prefer female therapists.

Discuss with clients the possible risks (e.g., initial emotional discomfort) and benefits of being treated by a woman or man (e.g., developing a therapeutic relationship with a man might challenge a client's belief that all men are dangerous), and, if possible, let them then choose the gender of their counselor. Tell

them that if they experience initial emotional discomfort, and the discomfort does not decrease, they can switch to a counselor of the opposite gender. For group therapy that focuses on trauma, similar considerations apply. Generally, gender-specific groups are recommended when possible, but mixed-gender groups also work. Gender also comes into play in substance abuse treatment. Research and clinical observation indicate that significant gender differences occur in many facets of substance abuse and its treatment. For example, men and women experience different physical repercussions of substance use (e.g., women have more health problems), different trajectories (e.g., women become addicted more quickly), and different treatment considerations (e.g., traditional substance abuse treatment was designed for men).

Sexual orientation

Lesbian, gay, bisexual, and transgender (LGBT) clients face specific issues in behavioral health treatment settings, including histories of abuse and discrimination relating to sexual orientation, homophobia in treatment on the part of counselors or other clients, potential difficulty addressing traumatic experiences related to their sexuality or sexual orientation, and often, a significant lack of trust toward others. LGBT people sometimes think that others can't understand them and their specific needs and thus are reluctant to engage in treatment programs in which the clientele is predominantly heterosexual. Some clients react with judgment, anger, or embarrassment when an LGBT client attempts to describe sexual trauma relating to homosexual behavior, making it even harder for LGBT clients to describe their experiences.

Often, individual counseling can address issues the LGBT client isn't comfortable discussing in group treatment. "Providing one-on-one services may decrease the difficulty of mixing heterosexual and LGBT clients in treatment groups and decrease the likelihood that heterosexism or homophobia will become an issue" (CSAT, 2001, p. 56). For more on treating LGBT individuals, see *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals* (CSAT, 2001).

Making Referrals to Trauma-Specific Services

Many people who experience trauma do not exhibit persistent traumatic stress symptoms. In fact, people do recover on their own. So how do you determine who is at higher risk for developing more persistent symptoms of traumatic stress, trauma-related disorders, and traumatic stress disorders? One main factor is the severity of symptoms at the time of screening and assessment. Other factors, beyond trauma characteristics and pretrauma individual characteristics, to consider in making referrals include (Ehlers & Clark, 2003):

- Cognitive appraisals that are excessively negative regarding trauma sequelae, including consequences, changes after the event(s), responses of other people to the trauma, and symptoms.
- Acknowledgment of intrusive memories.
- Engagement in behaviors that reinforce or prevent resolution of trauma, including avoidance, dissociation, and substance use.
- History of physical consequences of trauma (e.g., chronic pain, disfigurement, health problems).
- Experiences of more traumas or stressful life events after the prior trauma.
- Identification of co-occurring mood disorders or serious mental illness.

The next chapter provides an overview of trauma-specific services to complement this chapter and to provide trauma-informed counselors with a general knowledge of trauma-specific treatment approaches.

6 Trauma-Specific Services

IN THIS CHAPTER

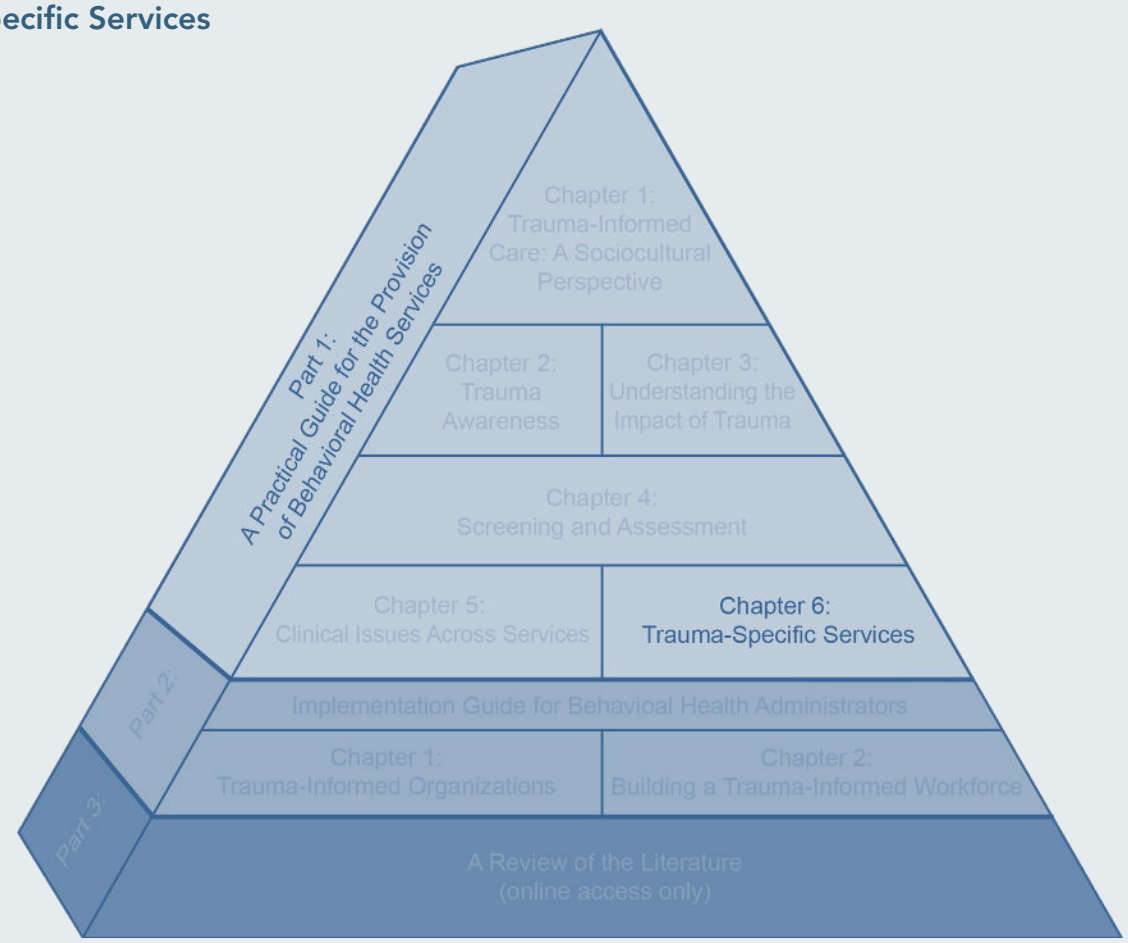
- Introduction
- Trauma Specific Treatment Models
- Integrated Models for Trauma
- Emerging Interventions
- Concluding Note

This chapter covers various treatment approaches designed specifically to treat trauma-related symptoms, trauma-related disorders, and specific disorders of traumatic stress. The models presented do not comprise an exhaustive list, but rather, serve as examples. These models require training and supervised experience to be conducted safely and effectively. The chapter begins with a section on trauma-specific treatment models, providing a brief overview of interventions that can be delivered immediately after a trauma, as well as trauma-specific interventions for use beyond the immediate crisis. The second segment focuses on integrated care that targets trauma-specific treatment for mental, substance use, and co-occurring disorders. Even though entry-level, trauma-informed behavioral health service providers are unlikely to be in a position to use these interventions, having some knowledge of them is nevertheless important. Currently, more research is needed to tease out the most important ingredients of early interventions and their role in the prevention of more pervasive traumatic stress symptoms. More science-based evidence is available for trauma-specific treatments that occur and extend well beyond the immediate reactions to trauma. The last part of the chapter provides a brief review of selected emerging interventions that have not been covered elsewhere in this Treatment Improvement Protocol (TIP).

Introduction

Trauma-specific therapies vary in their approaches and objectives. Some are present focused, some are past focused, and some are combinations (Najavits, 2007a). Present-focused approaches primarily address current coping skills, psychoeducation, and managing symptoms for better functioning. Past-focused approaches primarily focus on telling the trauma story to understand the impact of the trauma on how the person functions today, experiencing emotions that were too overwhelming to experience in the past, and helping clients more effectively cope in the present with their

Trauma-Informed Care Framework in Behavioral Health Services—Trauma-Specific Services



traumatic experiences. Clients participating in present-focused approaches may reveal some of their stories; past-focused approaches emphasize how understanding the past influences current behavior, emotion, and thinking, thereby helping clients cope more effectively with traumatic experiences in the present.

The distinction between these approaches lies in the primary emphasis of the approach. Depending on the nature of the trauma and the specific needs of the client, one approach may be more suitable than the other. For instance, in short-term treatment for clients in early recovery from mental illness and/or substance abuse, present-focused, cognitive–behavioral, or psychoeducational approaches are generally more appropriate. For clients who are stable in their recovery and have histories of developmental trauma where much of the trauma has been repressed, a past-focused orientation may be helpful. Some clients may benefit from both types, either concurrently or sequentially.

This chapter discusses a number of treatment models, general approaches, and techniques. A treatment model is a set of practices designed to alleviate symptoms, promote psychological well-being, or restore mental health. Treatment techniques are specific procedures that can be used as part of a variety of models. Some models and techniques described in this chapter can be used with groups, some with individuals, and some with both. This chapter is selective rather than comprehensive; additional models are described in the literature. See, for example, the PILOTS database on the Web site of the National Center for PTSD

(NCPTSD; http://www.ptsd.va.gov) for treatment literature related to trauma and posttraumatic stress disorder (PTSD). For an overview of models for use with both adult and child populations, refer to *Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services* (Center for Mental Health Services, 2008).

Some treatments discussed in this chapter are described as evidence based. Because research on integrated treatment models is so new, many have only been examined in a few studies. Given these circumstances and the fact that an outcome study provides only limited evidence of efficacy, the term "evidence based" should be interpreted cautiously. Additional scientific study is needed to determine whether some treatments discussed herein are, in fact, evidence based. A good resource for evaluating evidence-based, trauma-specific treatment models is *Effective Treatments for PTSD* (Foa, Keane, Friedman, & Cohen, 2009). Although evidence-based interventions should be a primary consideration in selecting appropriate treatment models for people with symptoms of trauma that co-occur with mental and substance use disorders (see Allen, 2001, for an indepth discussion of trauma and serious mental illness), other factors must also be weighed, including the specific treatment needs of the client; his or her history of trauma, psychosocial and cultural background, and experiences in prior trauma treatment; the overall treatment plan for the client; and the competencies of the program's clinical staff. Although behavioral health counselors can prepare to help their clients address some of the issues discussed in Chapter 5, specialized training is necessary to provide treatment for co-occurring substance use and mental disorders related to trauma.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has created the National Registry of Evidence-Based Programs and Practices (NREPP) as a resource for reviewing and identifying effective treatment programs. Programs can be nominated for consideration as co-occurring disorders programs or substance abuse prevention or treatment programs, and their quality of evidence, readiness for dissemination, and training considerations are then reviewed. For more detailed information, including details about several evidence-based co-occurring trauma treatment programs, visit the NREPP Web site (http://www.nrepp.samhsa.gov). Program models for specialized groups, such as adolescents, can also be found on the NREPP Web site. For specific research-oriented information on trauma-specific treatments, refer to Part 3 of this TIP, which provides a literature review and links to select abstracts (available online).

Federal Agencies

Both the American Red Cross and the Federal Emergency Management Agency (FEMA) respond to disasters. Behavioral health service providers should understand the basics about these major emergency response agencies. For example, the Red Cross can respond rapidly with funding for food, shelter, and immediate needs, whereas FEMA assistance requires a period of gearing up but provides for longer-term needs. SAMHSA, along with other Federal agencies, assists FEMA in a number of areas of emergency response planning activities. See also SAMHSA's Disaster Technical Assistance Center Web site (http://www.samhsa.gov/dtac) and Technical Assistance Publication 34, *Disaster Planning Handbook for Behavioral Health Treatment Programs* (SAMHSA, 2013).

Trauma-Specific Treatment Models

Immediate Interventions

Intervention in the first 48 hours

The acute intervention period comprises the first 48 hours after a traumatic event. In a

"One day I was called out of bed at 5:00 a.m. to go to a town approximately 30 miles away because a levee had broken…. By 6:00 a.m., my colleagues and I were there with many of the townspeople, with helicopters flying overhead, with trucks going in and out by the main road trying to empty the factories. When we got there, as far as you could see was farmland. By 11 a.m., you could see a 'lake' in the distance. By 2 p.m., the water was on the edge of the town. Being there, at that town, before, during, and after the water came was probably the most valuable function we performed. We were able to share in the grief of the hundreds of people as we stayed with them while their fields, houses, and workplaces were flooded. We witnessed the death of a town, and the people reacted with disbelief, anger, sadness, and numbness. Each person had a different story, but all grieved, and we provided many an opportunity to express it. People cried as the water started rising into their houses. Some had to watch. Some had to leave. At times it was utterly silent as we all waited. There was a woman whose parents sent her away during the floods of '43 and she had been angry for 50 years about it. She was determined that her children and grandchildren would see everything. I spent 12 hours that day just giving support, listening, giving information, and sometimes shedding a tear or two myself."

—Rosemary Schwartzbard, Ph.D., responder to floods along the Mississippi River in 1993

Source: Schwartzbard, 1997.

disaster, rescue operations usually begin with local agencies prior to other organizations arriving on the scene. Law enforcement is likely to take a primary role on site. Whether it is a disaster, group trauma, or individual trauma (including a trauma that affects an entire family, such as a house fire), a hierarchy of needs should be established: survival, safety, security, food, shelter, health (physical and mental), orientation of survivors to immediate local services, and communication with family, friends, and community (National Institute of Mental Health, 2002). In this crucial time, appropriate interventions include educating survivors about resources; educating other providers, such as faith-based organizations and social service groups, to screen for increased psychological effects including use of substances; and use of a trauma response team that assists clients with their immediate needs. No formal interventions should be attempted at this time, but a professionally trained, empathic listener can offer solace and support (Litz & Gray, 2002).

Basic needs

Basic necessities, such as shelter, food, and water, are key to survival and a sense of safety. It is important to focus on meeting these basic needs and on providing a supportive environment. Clients' access to prescribed medications may be interrupted after a trauma, particularly a disaster, so providers should identify clients' medication needs for preexisting physical and mental disorders, including methadone or other pharmacological treatment for substance use. For example, after September 11, 2001, substance abuse treatment program administrators in New York had to seek alternative methadone administration options (Frank, Dewart, Schmeidler, & Demirjian, 2006).

Psychological first aid

The psychological first aid provided in the first 48 hours after a disaster is designed to ensure safety, provide an emotionally supportive environment and activities, identify those with high-risk reactions, and facilitate communication, including strong, reassuring leadership immediately after the event. The primary helping response of psychological first aid is to provide a calm, caring, and supportive environment to set the scene for psychological recovery. It is also essential that all those first responding to a trauma—rescue workers, medical professionals, behavioral health workers (including substance abuse counselors), journalists, and volunteers—be familiar with relevant aspects of traumatic stress. Approaching

Advice to Counselors: Core Actions in Preparing To Deliver Psychological First Aid

- Contact and engagement
- Safety and comfort
- Stabilization
- Information gathering: Current needs and concerns
- Practical assistance
- Connection with social supports
- Information on coping
- Linkage with collaborative services

Source: National Child Traumatic Stress Network & NCPTSD, 2012.

survivors with genuine respect, concern, and knowledge increases the likelihood that the caregiver can (NCPTSD, 2002):

- Answer questions about what survivors may be experiencing.
- Normalize their distress by affirming that what they are experiencing is normal.
- Help them learn to use effective coping strategies.
- Help them be aware of possible symptoms that may require additional assistance.
- Provide a positive experience that will increase their chances of seeking help if they need it in the future.

Clinical experience suggests that care be taken to respect a survivor's individual method of coping; some may want information, for example, whereas others do not. Similarly, some may want to talk about the event, but others won't. An excellent guide to providing psychological first aid is available online from the Terrorism and Disaster Branch of the National Child Traumatic Stress Network (http://www.nctsn.org/content/psychological-first-aid).

Critical incident stress debriefing

Initially developed for work with first responders and emergency personnel, critical incident stress debriefing (CISD; Mitchell & Everly, 2001) is now widely used and encompasses various group protocols used in a variety of settings. This facilitator-led group intervention is for use soon after a traumatic event with exposed people. The goal is to provide psychological closure by encouraging participants to talk about their experiences and then giving a didactic presentation on common stress reactions and management.

The widespread use of CISD has occurred despite the publication of conflicting results regarding its efficacy. Claims that single-session psychological debriefing can prevent development of chronic negative psychological sequelae are not empirically supported (van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002). Some controlled studies suggest that it may impede natural recovery from trauma (McNally, Bryant, & Ehlers, 2003). Other research suggests emphasizing screening to determine the need for early interventions. Mitchell and Everly (2001) point out that many of the studies showing negative

Advice to Counselors: Evidence Related to Immediate Interventions

Evidence related to immediate interventions suggests that:

- Early, brief, focused psychotherapeutic intervention provided in an individual or group format can reduce distress in bereaved spouses, parents, and children.
- Selected cognitive–behavioral approaches may help reduce the incidence, duration, and severity of acute stress disorder (ASD), PTSD, and depression in trauma survivors.
- A one-session individual recital of events and expression of emotions evoked by a traumatic event does not consistently reduce risk of later developing PTSD. In fact, it may increase the risk for adverse outcomes. Perhaps CISD hinders the natural recovery mechanisms that restore pretrauma functioning (Bonanno, 2004).
- The focus initially should be upon screening with follow-up as indicated.

results were not conducted with first responders; that is, CISD may be appropriate for some, but not all, groups. A recent study of 952 U.S. peacekeepers and CISD by the U.S. Army Research Unit–Europe (Adler et al., 2008) found mixed results.

Interventions Beyond the Initial Response to Trauma

In the interest of increasing your overall familiarity with relevant approaches, the following sections review several traumatic stress treatment approaches that counselors will most likely encounter when collaborating with clinicians or agencies that specialize in trauma-specific services and treating traumatic stress.

Cognitive–behavioral therapies

Most PTSD models involve cognitive–behavioral therapy (CBT) that integrates cognitive and behavioral theories by incorporating two ideas: first, that cognitions (or thoughts) mediate between situational demands and one's attempts to respond to them effectively, and second, that behavioral change influences acceptance of altered cognitions about oneself or a situation and establishment of newly learned cognitive–behavioral interaction patterns. In practice, CBT uses a wide range of coping strategies.

There are many different varieties of CBT. CBT originated in the 1970s (Beck, Rush, Shaw & Emery, 1979; Ellis & Harper, 1975) and has expanded since then to address various populations, including people who use substances, people who experience anxiety, people with PTSD or personality disorders, children and adolescents, individuals involved in the criminal justice system, and many others. CBT has also been expanded to include various techniques, coping skills, and approaches, such as dialectical behavior therapy (DBT; Linehan, 1993), Seeking Safety (Najavits, 2002a), and mindfulness (Segal, Williams, & Teasdale, 2002). Traditional CBT emphasizes symptom reduction or resolution, but recent CBT approaches have also emphasized the therapeutic relationship, a particularly important dynamic in trauma treatment (Jackson, Nissenson, & Cloitre, 2009).

A widely accepted framework in treating trauma, substance use disorders, and mental illness categorizes therapies as single (treatment of only one disorder), sequential (treatment of one disorder first, then the other), or parallel (concurrent treatment of multiple disorders delivered by separate clinicians or in separate programs that do not necessarily address the interactions between symptoms and disorders).

CBT has been applied to the treatment of trauma and has also been widely and effectively used in the treatment of substance use. A review of efficacy research on CBT for PTSD is provided by Rothbaum, Meadows, Resick, and Foy (2000). Najavits and colleagues (2009) and O'Donnell and Cook (2006) offer an overview of CBT therapies for treating PTSD and substance abuse. In addition, a free online training resource incorporating CBT for traumatized children within the community, Trauma-Focused CBT, is available from the Medical University of South Carolina (http://tfcbt.musc.edu/).

Cognitive processing therapy

Cognitive processing therapy (CPT) is a manualized 12-session treatment approach that can be administered in a group or individual setting (Resick & Schnicke, 1992, 1993). CPT was developed for rape survivors and combines elements of existing treatments for PTSD, specifically exposure therapy (see the "Exposure Therapy" section later in this chapter) and cognitive therapy. The exposure therapy component of treatment consists of

Advice to Counselors: Relaxation Training, Biofeedback, and Breathing Retraining Strategies

Relaxation training, biofeedback, and breathing retraining strategies may help some clients cope with anxiety, a core symptom of traumatic stress. However, no evidence supports the use of relaxation and biofeedback as effective standalone PTSD treatment techniques (Cahill, Rothbaum, Resick, & Follete, 2009). Both are sometimes used as complementary strategies to manage anxiety symptoms elicited by trauma-related stimuli. Breathing retraining uses focused or controlled breathing to reduce arousal. Breathing retraining and relaxation, along with other interventions when necessary, can help clients with ASD. An important caution in the use of breath work with trauma clients is that it can sometimes act as a trigger—for example, given its focus on the body and its potential to remind them of heavy breathing that occurred during assault. Biofeedback, which requires specialized equipment, combines stress reduction strategies (e.g., progressive muscle relaxation, guided imagery) with feedback from biological system measures (e.g., heart rate, hand temperature) that gauge levels of stress or anxiety reduction. Relaxation training, which requires no specialized equipment, encourages clients to reduce anxiety responses (including physiological responses) to trauma-related stimuli; it is often part of more comprehensive PTSD treatments (e.g., prolonged exposure and stress inoculation training [SIT]).

clients writing a detailed account of their trauma, including thoughts, sensations, and emotions that were experienced during the event. The client then reads the narrative aloud during a session and at home. The cognitive therapy aspect of CPT uses six key PTSD themes identified by McCann and Pearlman (1990): safety, trust, power, control, esteem, and intimacy. The client is guided to identify cognitive distortions in these areas, such as maladaptive beliefs.

Results from randomized, placebo-controlled trials for the treatment of PTSD related to interpersonal violence (Resick, 2001; Resick, Nishith, Weaver, Astin, & Feuer, 2002) support the use of CPT. CPT and prolonged exposure therapy models are equally and highly positive in treating PTSD and depression in rape survivors; CPT is superior in reducing guilt (Nishith, Resick, & Griffin, 2002; Resick et al., 2002; Resick, Nishith, & Griffin, 2003). CPT has shown positive outcomes with refugees when administered in the refugees' native language (Schulz, Marovic-Johnson, & Huber, 2006) and with veterans (Monson et al., 2006). However, CPT has not been studied with high-complexity populations such as individuals with substance dependence, homelessness, current domestic violence, serious and persistent mental illness, or suicidality. CPT requires a 3-day training plus consultation (Karlin et al., 2010). Resick and Schicke (1996) published a CPT treatment manual, *Cognitive Processing Therapy for Rape Victims: A Treatment Manual*.

Exposure therapy

Exposure therapy for PTSD asks clients to directly describe and explore trauma-related memories, objects, emotions, or places. Intense emotions are evoked (e.g., sadness, anxiety) but eventually decrease, desensitizing clients through repeated encounters with traumatic material. Careful monitoring of the pace and appropriateness of exposure-based interventions is necessary to prevent retraumatization (clients can become conditioned to fear the trauma-related material even more). Clients must have ample time to process their memories and integrate cognition and affect, so some sessions can last for 1.5 hours or more. For simple cases, exposure can work in as few as 9 sessions; more complex cases may require 20 or more sessions (Foa, Hembree, & Rothbaum, 2007). Various techniques can

Advice to Counselors: Steps for Introducing a Breathing Exercise

Use the following statements to lead clients through a breathing exercise:

- Place your hands on your stomach. As you inhale, breathe deeply but slowly so that your hands rise with your stomach. As you exhale slowly, practice breathing so that your hands drop with your stomach.
- Inhale slowly through your nose with your mouth closed; don't rush or force in the air.
- Exhale slowly through your mouth with your lips in the whistling position.
- Breathe out for twice as long as you breathe in.

expose the client to traumatic material. Two of the more common methods are exposure through imagery and in vivo ("real life") exposure.

The effectiveness of exposure therapy has been firmly established (Rothbaum et al., 2000); however, adverse reactions to exposure therapy have also been noted. Some individuals who have experienced trauma exhibit an exacerbation of symptoms during or following exposure treatments. Even so, the exacerbation may depend on counselor variables during administration. Practitioners of exposure therapy need comprehensive training to master its techniques (Karlin et al., 2010); a counselor unskilled in the methods of this treatment model can not only fail to help his or her clients, but also cause symptoms to worsen.

Exposure therapy is recommended as a first-line treatment option when the prominent trauma symptoms are intrusive thoughts, flashbacks, or trauma-related fears, panic, and avoidance. However, counselors should exercise caution when using exposure with clients who have not maintained stability in managing mental illness symptoms or abstinence from substance use disorders. Studies and routine use of exposure have consistently excluded high-complexity clients such as those with substance dependence, homelessness, current domestic violence, serious and persistent mental illness, or suicidality. The only trial of exposure therapy with a substance dependence sample found that it did not outperform standard substance abuse treatment on most variables (Mills et al., 2012).

Prolonged exposure therapy for PTSD is listed in SAMHSA's NREPP. For reviews of exposure therapy, also see Najavits (2007a) and Institute of Medicine (2008). In addition to prolonged exposure therapy, other therapies incorporate exposure and desensitization techniques, including eye movement desensitization and reprocessing (EMDR; Shapiro, 2001), cognitive processing, and systematic desensitization therapies (Wolpe, 1958).

Eye movement desensitization and reprocessing

EMDR (Shapiro, 2001) is one of the most widely used therapies for trauma and PTSD. The treatment protocols of EMDR have evolved into sophisticated paradigms requiring training and, preferably, clinical supervision. EMDR draws on a variety of theoretical

A Brief Description of EMDR Therapy

Treatment involves three main concentrations (past memories, present disturbances, future actions) and eight phases. Counselors may work with several phases in one session. Each phase is meant to be revisited either in every session or when appropriate (e.g., the closure process is meant to be conducted at the end of every session, in preparation for the next).

- Phase 1: History and Treatment Planning (1-2 sessions)
- Phase 2: Preparation
- Phase 3: Assessment and Reprocessing
- Phase 4: Desensitization
- Phase 5: Installation
- Phase 6: Body Scan
- Phase 7: Closure
- Phase 8: Reevaluation

Source: EMDR Network, 2012.

frameworks, including psychoneurology, CBT, information processing, and nonverbal representation of traumatic memories. The goal of this therapy is to process the experiences that are causing problems and distress. It is an effective treatment for PTSD (Seidler & Wagner, 2006) and is accepted as an evidence-based practice by the U.S. Department of Veterans Affairs (VA), the Royal College of Psychiatrists, and the International Society for Traumatic Stress Studies (Najavits, 2007a); numerous reviews support its effectiveness (e.g., Mills et al., 2012). EMDR values the development of "resource installation" (calming procedures) and engages in exposure work to desensitize clients to traumatic material, using external tracking techniques across the visual field to assist in processing distressing material. Training in EMDR, available through the EMDR Institute, is required before counselors use this treatment. It is listed in SAMHSA's NREPP (EMDR Network, 2012). Thus far, there is no study examining the use of EMDR with clients in substance abuse treatment. See Part 3 of this TIP, available online, to review empirical work on EMDR.

Narrative therapy

Narrative therapy is an emerging approach to understanding human growth and change; it is founded on the premise that individuals are the experts on their own lives and can access their existing intrapsychic and interpersonal resources to reduce the impact of problems in their lives. Developed for the treatment of PTSD resulting from political or community violence, narrative therapy is based on CBT principles, particularly exposure therapy (Neuner, Schauer, Elbert, & Roth, 2002; Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004). This approach views psychotherapy not as a scientific practice, but as a natural extension of healing practices that have been present throughout human history. For a trauma survivor, the narrative, as it is told and retold, expresses the traumatic experience, puts the trauma in the context of the survivor's life, and defines the options he or she has for change. Narrative structure helps clients connect events in their lives, reveals strings of events, explores alternative expressions of trauma, evokes explanations for clients' behaviors, and identifies their knowledge and skills. The use of stories in therapy, with the client as the storyteller, generally helps lessen suffering (McLeod, 1997; White, 2004).

In the substance abuse treatment field, many clients will see a connection between narrative therapy and the process of telling their stories in 12 Step programs, in which reframing life stories of feeling trapped, despairing, and hopeless leads to stories of strength, joy, and hope. Key storytelling points at a 12 Step speaker meeting include describing what an experience was like, what happened, and what it is like now.

Skills training in affective and interpersonal regulation

Skills training in affective and interpersonal regulation (STAIR) is a two-phase cognitive–behavioral model that adapts therapies developed by others into a new package (Cloitre, Koenen, Cohen, & Han, 2002). Phase 1 consists of eight weekly sessions of skills training in affect and interpersonal regulation derived from general CBT and DBT (Linehan, 1993) and adapted to address trauma involving childhood abuse. Session topics are labeling and identifying feelings, emotion management, distress tolerance, acceptance of feelings, identifying trauma-based interpersonal schemas, identifying conflict between trauma-generated feelings and current interpersonal goals, role-plays on issues of power and control, and role-plays on developing flexibility in interpersonal situations. Phase 2 features eight

STAIR Steps

Phase 1, tailored to individual clients, is called Skills Training in Affect Regulation and consists of the following components:

- Psychoeducation: Describe the symptoms of PTSD and explain the treatment rationale.
- Training in experiencing and identifying feelings, triggers, and thoughts, as well as training in mood regulation strategies.
- Learning history: Ask the client the following questions—How did the client deal with traumas past and present? How did the client's family deal with feelings? How did the client's family life affect his or her present difficulty experiencing and identifying feeling?
- Emotion regulation skills: Identify the cognitive, behavioral, and social support modalities for coping. Use data gathered with self-monitoring forms to identify strengths and weaknesses in each coping modality. Teach skills such as breathing retraining, self-statements to reduce fear, and social skill training to improve social support.
- Acceptance and tolerance of negative affect: Motivate clients to face distressing situations related to the trauma that are important to them. Review negative repercussions of avoidance. Discuss tolerating negative affect as a step toward achieving specific goals.
- Schema therapy for improved relationships: Identify relevant schemas learned in childhood. Suggest alternative ways of viewing self and others in current relationships. Use role-playing to teach assertiveness, emphasizing response flexibility based on relative power in each relationship.

Once Phase 1 of STAIR is well learned, clients move to Phase 2, which involves exposure therapy.

Source: Mollick & Spett, 2002.

sessions of modified prolonged exposure using a narrative approach.

Cloitre and colleagues (2002) assigned women with PTSD related to childhood abuse randomly to STAIR or a minimal attention waitlist, excluding clients with current substance dependence as well as other complexities. STAIR participants showed significantly greater gains in affect regulation, interpersonal skills, and PTSD symptoms than the control participants. These gains were maintained through follow-up at 3 and 9 months. However, it is not clear from this study whether DBT and exposure were both needed. Phase 1 therapeutic alliance and negative mood regulation skills predicted Phase 2 exposure success in reducing PTSD, suggesting the importance of establishing a strong therapeutic relationship and emotion regulation skills before conducting exposure work with people who have chronic PTSD.

Stress inoculation training

SIT was originally developed to manage anxiety (Meichenbaum, 1994; Meichenbaum & Deffenbacher, 1988). Kilpatrick, Veronen, and Resick (1982) modified SIT to treat rape survivors based on the idea that the anxiety and fear that rape survivors experience during their trauma generalizes to other objectively safe situations. SIT treatment components include education, skills training (muscle relaxation training, breathing retraining, role-playing, guided self-talk, assertiveness training, and thought stopping [i.e., actively and forcefully ending negative thoughts by thinking

SIT has been used to help individuals cope with the aftermath of exposure to stressful events and on a preventative basis to "inoculate" individuals to future and ongoing stressors (Meichenbaum, 1996). This practice as a preventive strategy is similar to promoting disease resistance through immunizations.

Advice to Counselors: SIT Phases

SIT is a prevention and treatment approach that has three overlapping phases. It is often seen as a complementary approach to other interventions for traumatic stress.

Phase 1: Conceptualization and education. This phase has two main objectives. The initial goal is to develop a collaborative relationship that supports and encourages the client to confront stressors and learn new coping strategies. The next objective is to increase the client's understanding of the nature and impact of his or her stress and awareness of alternative coping skills. Many cognitive strategies are used to meet these objectives, including self-monitoring activities, Socratic questioning, identifying strengths and evidence of resilience, and modeling of coping strategies.

Phase 2: Skill acquisition and rehearsal. This phase focuses on developing coping skills and using coping skills that the individual already possesses. This process includes practice across settings, so that the individual begins to generalize the use of his or her skills across situations through rehearsal, rehearsal, and more rehearsal.

Phase 3: Implementation and following through. The main objective is to create more challenging circumstances that elicit higher stress levels for the client. By gradually increasing the challenge, the client can practice coping strategies that mimic more realistic circumstances. Through successful negotiation, the client builds a greater sense of self-efficacy. Common strategies in this phase include imagery and behavioral rehearsal, modeling, role-playing, and graded in vivo exposure.

Source: Meichenbaum, 2007.

"STOP" and then redirecting thoughts in a more positive direction]), and skills application. The goal is to help clients learn to manage their anxiety and to decrease avoidant behavior by using effective coping strategies. Randomized controlled clinical trials have indicated that SIT reduces the severity of PTSD compared with waitlist controls and shows comparable efficacy to exposure therapy. At follow-up (up to 12 months after treatment), gains were maintained (Foa et al., 1999; Foa, Rothbaum, Riggs, & Murdock, 1991).

Other therapies

Numerous interventions introduced in the past 20 years focus on traumatic stress. For some interventions, the evidence is limited, and for other others, it is evolving. One example is the traumatic incident reduction (TIR) approach. This brief memory-oriented intervention is designed for children, adolescents, and adults who have experienced traumatic stress (Valentine & Smith, 2001). Listed in SAMHSA's NREPP, the intervention is designed to process specific traumatic incidents or problematic themes related to the trauma, including specific feelings, emotions, sensations, attitudes, or pain. It involves having clients talk through the traumatic incident repeatedly with the anticipation that changes in affect will occur throughout the repetitions. TIR is a client-centered approach.

Integrated Models for Trauma

This section covers models specifically designed to treat trauma-related symptoms along with either mental or substance use disorders at the same time. Integrated treatments help clients work on several presenting problems simultaneously throughout the treatment, a promising and recommended strategy (Dass-Brailsford & Myrick, 2010; Najavits, 2002b; Nixon & Nearmy, 2011). Thus far, research is limited, but what is available suggests that integrated treatment models effectively reduce

substance abuse, PTSD symptoms, and other mental disorder symptoms. TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (Center for Substance Abuse Treatment, 2005c), offers a detailed description of integrated treatment. In contrast with integrated models, other model types include single (treatment of only one disorder), sequential (treatment of one disorder first, then the other), or parallel (concurrent treatment of multiple disorders delivered by separate clinicians or in separate programs that do not necessarily address the interactions between symptoms and disorders).

Similar to single models, integrated treatment models are designed for use in a variety of settings (e.g., outpatient, day treatment, and/or residential substance abuse and mental health clinics/programs). Most models listed are manual-based treatments that address trauma-related symptoms, mental disorders, and substance use disorders at the same time. Additional approaches and further details on the selected approaches can be found at NREPP (http://www.nrepp.samhsa.gov).

Addiction and Trauma Recovery Integration Model

The Addiction and Trauma Recovery Integrated Model (ATRIUM; Miller & Guidry, 2001) integrates CBT and relational treatment through an emphasis on mental, physical, and spiritual health. This 12-week model for individuals and groups blends psychoeducational, process, and expressive activities, as well as information on the body's responses to addiction and traumatic stress and the impact of trauma and addiction on the mind and spirit. It helps clients explore anxiety, sexuality, self-harm, depression, anger, physical complaints and ailments, sleep difficulties, relationship challenges, and spiritual disconnection. It was designed primarily for women and focuses on developmental (childhood) trauma and interpersonal violence, but it recognizes that other types of traumatic events occur.

The ATRIUM model consists of three phases of treatment. The first stage, or "outer circle," consists of the counselor collecting data from the client about his or her trauma history, offering psychoeducation on the nature of trauma, and helping the client assess personal strengths. ATRIUM actively discourages the evocation of memories of abuse or other trauma events in this phase. The second stage, or "middle circle," allows clients and counselors to address trauma symptoms more directly and specifically encourages clients to reach out to and engage with support resources in the community. The middle circle also emphasizes learning new information about trauma and developing additional coping skills. The third stage of the program, the "inner circle," focuses on challenging old beliefs that arose as a result of the trauma. For instance, the concept of "nonprotecting bystander" is used to represent the lack of support that the traumatized person experienced at the time of the trauma. This representation is replaced with the "protective presence" of supportive others today.

ATRIUM was used in one of the nine study sites of SAMHSA's Women, Co-Occurring Disorders and Violence Study. Across all sites, trauma-specific models achieved more favorable outcomes than control sites that did not use trauma-specific models (Morrissey et al., 2005). There has not yet been a study of ATRIUM per se, however. A manual describing the theory behind this model in greater depth, as well as how to implement it, is published under the title *Addictions and Trauma Recovery: Healing the Body, Mind, and Spirit* (Miller & Guidry, 2001).

Beyond Trauma: A Healing Journey for Women

Beyond Trauma (Covington, 2003) is a curriculum for women's services based on theory, research, and clinical experience. It was developed for use in residential, outpatient, and correctional settings; domestic violence programs; and mental health clinics. It uses behavioral techniques and expressive arts and is based on relational therapy. Although the materials are designed for trauma treatment, the connection between trauma and substance abuse in women's lives is a theme throughout. Beyond Trauma has a psychoeducational component that defines trauma by way of its process as well as its impact on the inner self (thoughts, feelings, beliefs, values) and the outer self (behavior and relationships, including parenting). Coping skills are emphasized; specific exercises develop emotional wellness.

Concurrent Treatment of PTSD and Cocaine Dependence

Concurrent Treatment of PTSD and Cocaine Dependence (CTPCD) is a 16-session, twice-weekly individual outpatient psychotherapy model designed to treat women and men with co-occurring PTSD and cocaine dependence (Coffey, Schumacher, Brimo, & Brady, 2005). CTPCD combines imagery and in vivo exposure therapy (in which the client becomes desensitized to anxiety-producing stimuli through repeated exposure to them) for the treatment of PTSD with elements of CBT for substance dependence. To balance the dual needs of abstinence skill building and prompt trauma treatment, the first five sessions focus on coping skills for cocaine dependence. Session six transitions into exposure therapy, which begins in earnest in session seven and is combined with CBT for the treatment of substance abuse.

CTPCD helps reduce substance use and PTSD symptoms. The use of any illicit drug, as measured by urine screens, was quite low during the 16-week treatment trial and didn't escalate during the second half of treatment—when most exposure sessions occurred. PTSD symptoms dropped significantly over the course of treatment, as did self-reported depressive symptoms; however, the dropout rate was high (Coffey, Dansky, & Brady, 2003). CTPCD was reformulated into Concurrent Prolonged Exposure (COPE; Mills et al., 2012), which was compared with treatment as usual in a high-complexity clinical sample of individuals who had PTSD and substance dependence. Both treatment conditions resulted in improvements in PTSD with no difference at 3 months (though COPE showed significantly greater improvement at 9 months); moreover, the two conditions did not differ in impact on substance use outcomes, depression, or anxiety.

Integrated CBT

Integrated CBT is a 14-session individual therapy model designed for PTSD and substance use. It incorporates elements such as psychoeducation, cognitive restructuring, and breathing retraining (McGovern, Lamber-Harris, Alterman, Xie, & Meier, 2011). A randomized controlled trial showed that both integrated CBT and individual addiction treatment achieved improvements in substance use and other measures of psychiatric symptom severity with no difference between the treatments.

Seeking Safety

Seeking Safety is an empirically validated, present-focused treatment model that helps clients attain safety from trauma and substance abuse (Najavits, 2002a). The Seeking Safety manual (Najavits, 2002b) offers clinician guidelines and client handouts and is available in

several languages. Training videos and other implementation materials are available online (http://www.seekingsafety.org). Seeking Safety is flexible; it can be used for groups and individuals, with women and men, in all settings and levels of care, by all clinicians, for all types of trauma and substance abuse.

Seeking Safety covers 25 topics that address cognitive, behavioral, interpersonal, and case management domains. The topics can be conducted in any order, using as few or as many as are possible within a client's course of treatment. Each topic represents a coping skill relevant to both trauma and substance abuse, such as compassion, taking good care of yourself, healing from anger, coping with triggers, and asking for help. This treatment model builds hope through an emphasis on ideals and simple, emotionally evocative language and quotations. It attends to clinician processes and offers concrete strategies that are thought to be essential for clients dealing with concurrent substance use disorders and histories of trauma.

More than 20 published studies (which include pilot studies, randomized controlled trials, and multisite trials representing various investigators and populations) provide the evidence base for this treatment model. For more information, see SAMHSA's NREPP Web site (http://www.nrepp.samhsa.gov) as well as the "Outcomes" section of the Seeking Safety Web site (http://www.seekingsafety.org/3-03-06/studies.html). Study samples included people with chronic, severe trauma symptoms and substance dependence who were diverse in ethnicity and were treated in a range of settings (e.g., criminal justice, VA centers, adolescent treatment, homelessness services, public sector). Seeking Safety has shown positive outcomes on trauma symptoms, substance abuse, and other domains (e.g., suicidality, HIV risk, social functioning, problem-solving, sense of meaning); consistently outperformed treatment as usual; and achieved high satisfaction ratings from both clients and clinicians. It has been translated into seven languages, and a version for blind and/or dyslexic individuals is available.

The five key elements of Seeking Safety are:

1. Safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions).
2. Integrated treatment (working on trauma and substance abuse at the same time).
3. A focus on ideals to counteract the loss of ideals in both trauma and substance abuse.
4. Four content areas: cognitive, behavioral, interpersonal, and case management.
5. Attention to clinician processes (addressing countertransference, self-care, and other issues).

Substance Dependence PTSD Therapy

Substance Dependence PTSD Therapy (Triffleman, 2000) was designed to help clients of both sexes cope with a broad range of traumas. It combines existing treatments for PTSD and substance abuse into a structured, 40-session (5-month, twice-weekly) individual therapy that occurs in two phases. Phase I is "Trauma-Informed, Addictions-Focused Treatment" and focuses on coping skills and cognitive interventions as well as creating a safe environment. Phase I draws on CBT models, anger management, relaxation training, HIV risk reduction, and motivational enhancement techniques. Phase II, "Trauma-Focused, Addictions-Informed Treatment," begins with psychoeducation about PTSD followed by "Anti-Avoidance I," in which a modified version of stress inoculation training is taught in two to four sessions. Following this is "Anti-Avoidance II," lasting 6 to 10 sessions, in which in vivo exposure is used.

Trauma Affect Regulation: Guide for Education and Therapy

Trauma Affect Regulation: Guide for Education and Therapy (TARGET; Ford & Russo, 2006; Frisman, Ford, Lin, Mallon, & Chang, 2008) uses emotion and information processing in a present-focused, strengths-based approach to education and skills training for trauma survivors with severe mental, substance use, and co-occurring disorders across diverse populations. TARGET helps trauma survivors understand how trauma changes the brain's

TARGET: The Seven-Step FREEDOM Approach

Focus: Being focused helps a person pay attention and think about what's happening right now instead of just reacting based on alarm signals tied to past trauma. This step teaches participants to use the SOS skill (Slow down, Orient, Self-check) to pay attention to body signals and the immediate environment and to use a simple scale to measure stress and control levels.

Recognize triggers: Recognizing trauma triggers enables a person to anticipate and reset alarm signals as he or she learns to distinguish between a real threat and a reminder. This step helps participants identify personal triggers, take control, and short-circuit their alarm reactions.

Emotion self-check: The goal of this skill is to identify two types of emotions. The first are "alarm" or reactive emotions such as terror, rage, shame, hopelessness, and guilt. Because these emotions are the most noticeable after trauma, they are the alarm system's way of keeping a person primed and ready to fend off further danger. The second type of emotion, "main" emotions, include positive feelings (e.g., happiness, love, comfort, compassion) and feelings that represent positive strivings (e.g., hope, interest, confidence). By balancing both kinds of emotions, a person can reflect and draw on his or her own values and hopes even when the alarm is activated.

Evaluate thoughts: When the brain is in alarm mode, thinking tends to be rigid, global, and catastrophic. Evaluating thoughts, as with identifying emotions, is about achieving a healthier balance of positive as well as negative thinking. Through a two-part process, participants learn to evaluate the situation and their options with a focus on how they choose to act—moving from reactive thoughts to "main" thoughts. This is a fundamental change from the PTSD pattern, which causes problems by taking a person straight from alarm signals to automatic survival reactions.

Define goals: Reactive goals tend to be limited to just making it through the immediate situation or away from the source of danger. These reactive goals are necessary in true emergencies but don't reflect a person's "main" goals of doing worthwhile things and ultimately achieving a good and meaningful life. This step teaches one how to create "main" goals that reflect his or her deeper hopes and values.

Options: The only options that are available when the brain's alarm is turned on and won't turn off are automatic "flight/fight" or "freeze/submit" reactive behaviors that are necessary in emergencies but often unhelpful in ordinary living. This step helps identify positive intentions often hidden by the more extreme reactive options generated by the alarm system. This opens the possibility for a greater range of options that take into consideration one's own needs and goals as well as those of others.

Make a contribution: When the brain's alarm is turned on and reacting to ordinary stressors as if they were emergencies, it is very difficult for a person to come away from experiences with a feeling that they have made a positive difference. This can lead to feelings of alienation, worthlessness, or spiritual distress. The ultimate goal of TARGET is to empower adults and young people to think clearly enough to feel in control of their alarm reactions and, as a result, to be able to recognize the contribution they are making not only to their own lives, but to others' lives as well.

Source: Advanced Trauma Solutions, 2012.

normal stress response into an extreme survival-based alarm response that can lead to PTSD, and it teaches them a seven-step approach to making the PTSD alarm response less distressing and more adaptive (summarized by the acronym FREEDOM: Focus, Recognize triggers, Emotion self-check, Evaluate thoughts, Define goals, Options, and Make a contribution).

TARGET can be presented in individual therapy or gender-specific psychoeducational groups, and it has been adapted for individuals who are deaf; it has also been translated into Spanish and Dutch. TARGET is a resilience-building and recovery program not limited to individual or group psychotherapy; it is also designed to provide an educational curriculum and milieu intervention that affects all areas of practice in school, therapeutic, or correctional programs. TARGET is listed in SAMHSA's NREPP (http://www.nrepp.samhsa.gov).

Trauma Recovery and Empowerment Model

The trauma recovery and empowerment model (TREM) of therapy (Fallot & Harris, 2002; Harris & Community Connections Trauma Work Group, 1998) is a manualized group intervention designed for female trauma survivors with severe mental disorders. TREM addresses the complexity of long-term adaptation to trauma and attends to a range of difficulties common among survivors of sexual and physical abuse. TREM focuses mainly on developing specific recovery skills and current functioning and uses techniques that are effective in trauma recovery services. The model's content and structure, which cover 33 topics, are informed by the role of gender in women's experience of and coping with trauma.

TREM can be adapted for shorter-term residential settings and outpatient substance abuse treatment settings, among others. Adaptations of the model for men and adolescents are available. The model was used in SAMHSA's Women, Co-Occurring Disorders and Violence Study for three of the nine study sites and in SAMHSA's Homeless Families program, and it is listed in SAMHSA's NREPP. This model has been used with clients in substance abuse treatment; research by Toussaint, VanDeMark, Bornemann, and Graeber (2007) shows that women in a residential substance abuse treatment program showed significantly better trauma treatment outcomes using TREM than they did in treatment as usual, but no difference in substance use.

TREM Program Format

Each session includes an experiential exercise to promote group cohesiveness. The 33 sessions are divided into the following general topic areas:

- **Part I–empowerment** introduces gender identity concepts, interpersonal boundaries, and self-esteem.
- **Part II–trauma recovery** concentrates on sexual, physical, and emotional abuse and their relationship to psychiatric symptoms, substance abuse, and relational patterns and issues.
- **Part III–advanced trauma recovery issues** addresses additional trauma issues, such as blame and the role of forgiveness.
- **Part IV–closing rituals** allows participants to assess their progress and encourages them to plan for their continued healing, either on their own or as part of a community of other survivors.
- **Part V–modifications or supplements for special populations** provides modifications for subgroups such as women with serious mental illness, incarcerated women, women who are parents, women who abuse substances, and male survivors.

Source: Mental Health America Centers for Technical Assistance, 2012.

Triad Women's Project

The Triad Project was developed as a part of SAMHSA's Women, Co-Occurring Disorders and Violence Study. It is a comprehensive, trauma-informed, consumer-responsive integrated model designed for female trauma survivors with co-occurring substance use and mental disorders who live in semirural areas. Triad integrates motivational enhancement for substance use disorders, DBT, and intensive case management techniques for co-occurring mental disorders. This program is a 16-week group intervention for women that uses integrated case management services, a curriculum-based treatment group, and a peer support group (Clark & Fearday, 2003).

Emerging Interventions

New interventions are emerging to address traumatic stress symptoms and disorders. The following sections summarize a few interventions not highlighted in prior chapters; this is not an exhaustive list. In addition to specific interventions, technology is beginning to shape the delivery of care and to increase accessibility to tools that complement trauma-specific treatments. Numerous applications are available and evolving. For more information on the role of technology in the delivery of care, see the planned TIP, *Using Technology-Based Therapeutic Tools in Behavioral Health Services* (SAMHSA, planned g).

Couple and Family Therapy

Trauma and traumatic stress affects significant relationships, including the survivor's family. Although minimal research has targeted the effectiveness of family therapy with trauma survivors, it is important to consider the needs of the individual in the context of their relationships. Family and couples therapy may be key to recovery. Family members may experience secondary traumatization silently, lack understanding of traumatic stress symptoms or treatment, and/or have their own histories of trauma that influence their willingness to support the client in the family or to talk about anything related to trauma and its effects. Family members can engage in similar patterns of avoidance and have their own triggers related to the trauma being addressed at the time. A range of couple and family therapies have addressed traumatic stress and PTSD, but few studies exist that support or refute their value. Current couple or family therapies that have some science-based evidence include behavioral family therapy, behavioral marital therapy, cognitive–behavioral couples treatment, and lifestyle management courses (Riggs, Monson, Glynn, & Canterino, 2009).

Mindfulness Interventions

Mindfulness is a process of learning to be present in the moment and observing internal experience (e.g., thoughts, bodily sensations) and external experience (e.g., interactions with others) in a nonjudgmental way. Mindfulness challenges limiting beliefs that arise from trauma, quells anxiety about future events, and simply helps one stay grounded in the present. It plays a significant role in helping individuals who have been traumatized observe their experiences, increase awareness, and tolerate uncomfortable emotions and cognitions.

To date, mindfulness-based interventions appear to be valuable as an adjunct to trauma-specific interventions and in decreasing arousal (Baer, 2003). It may also help individuals tolerate discomfort during exposure-oriented and trauma processing interventions. Overall, mindfulness practices can help clients in managing traumatic stress, coping, and resilience. In a study of firefighters, mindfulness was associated with fewer PTSD symptoms, depressive symptoms, physical symptoms, and alcohol problems when controlling for other variables (Smith et al., 2011).

Becoming an Observer and Learning To Tolerate Discomfort: The Leaf and Stream Metaphor

The following exercise, "leaves floating on a stream," is a classic. Many clinicians and authors provide renditions of this mindfulness practice. The main objectives are to stand back and observe thoughts rather than get caught up in them. Simply stated, thoughts are just thoughts. Thoughts come and go like water flowing down a stream. We don't need to react to the thoughts; instead, we can just notice them.

Conduct the mindfulness exercise for about 10 minutes, then process afterward. Take time to allow participants to visualize each sense as they imagine themselves sitting next to the stream. For example, what does it look like? What do they hear as they sit next to the stream? Don't rush the exercise. As you slowly make the statements detailed in the following two paragraphs, take time in between each statement for participants to be in the exercise without interruption; simply offer gentle guidance.

Begin to sit quietly, bringing your attention to your breath. If you feel comfortable, close your eyes. As you focus on breathing in and out, imagine that you are sitting next to a stream. In your imagination, you may clearly see and hear the stream, or you may have difficulty visualizing the stream. Follow along with the guided exercise; either way, it will work just as well.

Now begin to notice the thoughts that come into your mind. Some thoughts rush by, while others linger. Just allow yourself to notice your thoughts. As you begin to notice each thought, imagine putting those words onto a leaf as it floats by on the stream. Just let the thoughts come, watching them drift by on the leaves. If your thoughts briefly stop, continue to watch the water flow down the stream. Eventually, your thoughts will come again. Just let them come, and as they do, place them onto a leaf. Your attention may wander. Painful feelings may arise. You may feel uncomfortable or start to think that the exercise is "stupid." You may hook onto a thought—rehashing it repeatedly. That's okay; it's what our minds do. As soon as you notice your mind wandering or getting stuck, just gently bring your focus back to your thoughts, and place them onto the leaves. Now, bring your attention back to your breath for a moment, then open your eyes and become more aware of your environment.

Facilitated Questions:

- What was it like for you to observe your thoughts?
- Did you get distracted? Stuck?
- Were you able to bring yourself back to the exercise after getting distracted?
- In what ways was the exercise uncomfortable?
- In what ways was the exercise comforting?

For clients and practitioners who want to develop a greater capacity for mindfulness, see Kabat-Zinn's books *Wherever You Go, There You Are: Mindfulness Meditation In Everyday Life* (1994) and *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness* (1990). For clinical applications of mindfulness, see *Mindfulness-Based Cognitive Therapy for Depression: A New Approach to Preventing Relapse* (Segal et al., 2002) and *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors* (Marlatt & Donovan, 2005).

Pharmacological Therapy

Pharmacotherapy for people with mental, substance use, and traumatic stress disorders needs to be carefully managed by physicians who are well versed in the treatment of each condition. Medications can help manage and control symptoms; however, they are only a part of a comprehensive treatment plan. There

are no specific "antitrauma" drugs; rather, certain drugs target specific trauma symptoms. Clients receiving pharmacotherapy need careful assessment. Some clients with preexisting mental disorders may need further adjustment in medications due to the physiological effects of traumatic stress. In addition, sudden withdrawal from a pattern of self-administered substances can not only lead to dangerous levels of physical distress, but also exacerbate the emergence of more severe PTSD symptoms. Distress after trauma often lessens over time, which can sometimes make the use of medications unnecessary for some individuals. Some trauma survivors do not develop long-term psychological problems from their experiences that require medication; others may simply refuse the initiation of pharmacotherapy or the use of additional medications.

Concluding Note

Behavioral health counselors can best serve clients who have experienced trauma by providing integrated treatment that combines therapeutic models to target presenting symptoms and disorders. Doing so acknowledges that the disorders interact with each other. Some models have integrated curricula; others that address trauma alone can be combined with behavioral health techniques with which the counselor is already familiar.

In part, the choice of a treatment model or general approach will depend on the level of evidence for the model, the counselor's training, identified problems, the potential for prevention, and the client's goals and readiness for treatment. Are improved relationships with family members a goal? Will the client be satisfied if sleep problems decrease, or is the goal resolution of broader issues? Are there substance use or substance-related disorders? Is the goal abstinence? Collaborating with clients to decide on goals, eliciting what they would like from treatment, and determining what they expect to happen can provide some clues as to what treatment models or techniques might be successful in keeping clients engaged in recovery.

Part 2: An Implementation Guide for Behavioral Health Program Administrators

1 Trauma-Informed Organizations

IN THIS CHAPTER

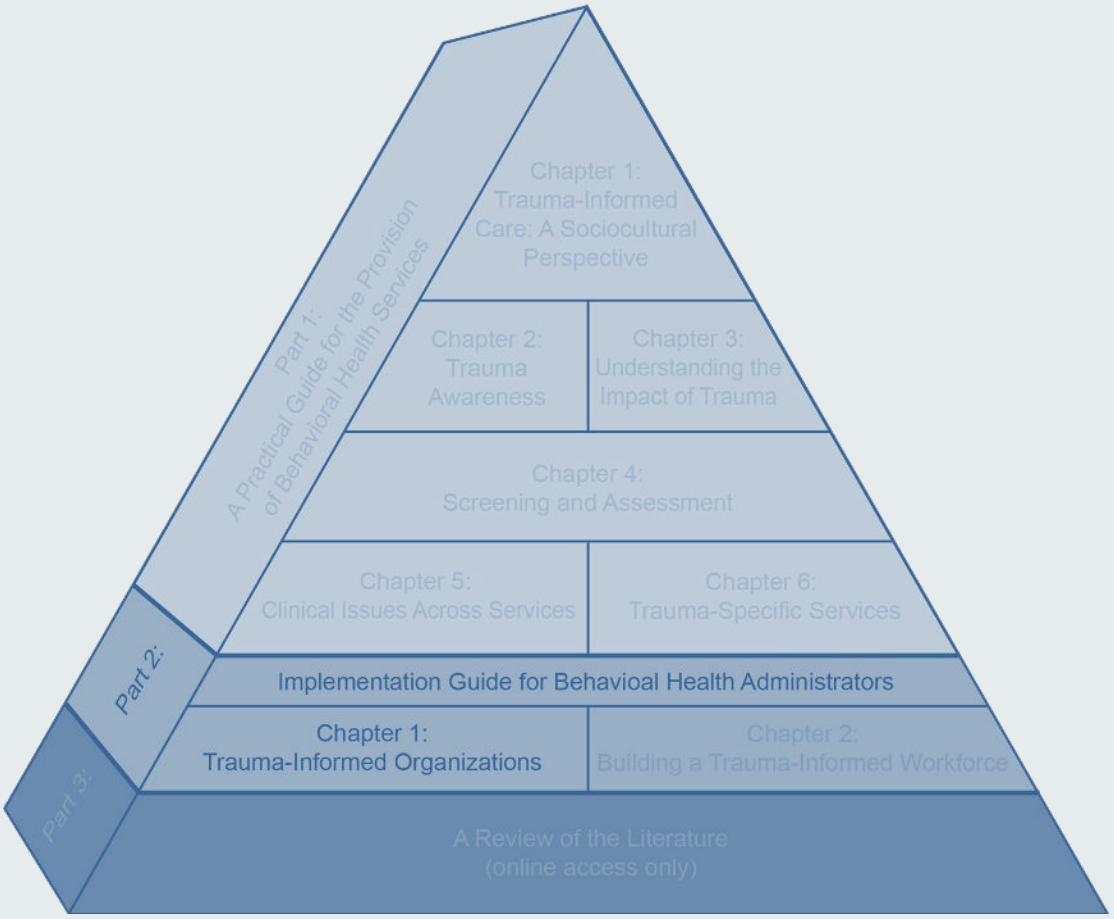
- Show Organizational and Administrative Commitment to TIC
- Use Trauma Informed Principles in Strategic Planning
- Review and Update Vision, Mission, and Value Statements
- Assign a Key Staff Member To Facilitate Change
- Create a Trauma Informed Oversight Committee
- Conduct an Organizational Self Assessment of Trauma Informed Services
- Develop an Implementation Plan
- Develop Policies and Procedures To Ensure Trauma Informed Practices and To Prevent Retraumatization
- Develop a Disaster Plan
- Incorporate Universal Routine Screenings
- Apply Culturally Responsive Principles
- Use Science Based Knowledge
- Create a Peer Support Environment
- Obtain Ongoing Feedback and Evaluations
- Change the Environment To Increase Safety
- Develop Trauma Informed Collaborations

Part 2 provides a broad overview of how to create and implement an institutional framework for trauma-informed services in program delivery and staff development, policies and procedures, administrative practices, and organizational infrastructure in behavioral health services. Chapter 1, "Trauma-Informed Organizations," focuses on specific organizational strategies that will help develop a trauma-informed culture in behavioral health settings. Numerous strategies are presented, including organizational commitment to trauma-informed care (TIC), trauma-informed organizational assessment, implementation of universal screening for trauma, and creation of a peer support environment.

Chapter 2, "Building a Trauma-Informed Workforce," focuses on organizational activities that foster the development of a trauma-informed workforce, including recruiting, hiring, and retaining trauma-informed staff; providing training on evidence-based and emerging trauma-informed best practices; developing competencies specific to TIC; addressing ethical considerations; providing trauma-informed supervision; and preventing and treating secondary trauma in behavioral health service providers.

The strategies described in the following sections can help supervisors and other administrative staff members create a trauma-informed behavioral health environment. As a starting point, the administration should identify key personnel and consumers to guide the organizational change process and the organizational assessment. Administrators and supervisors need to plan for and demonstrate an ongoing commitment to these strategies, or staff may perceive development activities as comprising yet another idea or demand from the agency that is short-lived beyond the initial thrust of training.

TIC Framework in Behavioral Health Services—Trauma-Informed Organizations



Creating a trauma-informed organization is a fluid, ongoing process; it has no completion date. Consumer demographics change across time, exposure to specific types of trauma may become more prevalent, and knowledge of best and evidence-based practices (EBPs) will continue to advance. A trauma-informed organization continues to demonstrate a commitment to compassionate and effective practices and organizational reassessments, and it changes to meet the needs of consumers with histories of trauma. It is encouraging that recent Substance Abuse and Mental Health Services Administration (SAMHSA) data indicates that the majority of over 10,000 programs they surveyed state that they provide trauma-related care (Capezza & Najavits, 2012). However, there remains a major need to make TIC consistently high-quality, routine, and pervasive across treatment systems.

The following stages form the basis of creating a trauma-informed organization:

1. Commit to creating a trauma-informed agency.
2. Create an initial infrastructure to initiate, support, and guide changes.
3. Involve key stakeholders, including consumers who have histories of trauma.
4. Assess whether and to what extent the organization's current policies, procedures, and operations either support TIC or interfere with the development of a trauma-informed approach.
5. Develop an organizational plan to implement and support the delivery of TIC within the agency.

Trauma-Informed Services and Service Systems

"A trauma-informed service system and/or organization is one in which all components of the system have been reconsidered and evaluated in the light of a basic understanding of the role that violence and trauma play in the lives of people seeking mental health and addiction services. A 'trauma-informed' organizational environment is capable of supporting and sustaining 'trauma-specific' services as they develop. A trauma-informed system recognizes that trauma results in multiple vulnerabilities and affects many aspects of a survivor's life over the lifespan, and therefore coordinates and integrates trauma-related activities and training with other systems of care serving trauma survivors. A basic understanding of trauma and trauma dynamics…should be held by all staff and should be used to design systems of services in a manner that accommodates the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid retraumatization and facilitate consumer participation in treatment. A trauma-informed service system is knowledgeable and competent to recognize and respond effectively to adults and children traumatically impacted by any of a range of overwhelming adverse experiences, both interpersonal in nature and caused by natural events and disasters. There should be written plans and procedures to develop a trauma-informed service system and/or trauma-informed organizations and facilities with methods to identify and monitor progress. Training programs for this purpose should be implemented."

Source: Jennings, 2009, pp. 111–112.

6. Create collaborations between providers and consumers and among service providers and various community agencies.
7. Put the organizational plan into action.
8. Reassess the implementation of the plan and its ability to meet the needs of consumers and to provide consistent TIC on an ongoing basis.
9. Implement quality improvement measures as needs and problem areas are identified.
10. Institute practices that support sustainability, such as ongoing training, clinical supervision, consumer participation and feedback, and resource allocation.

Strategy #1: Show Organizational and Administrative Commitment to TIC

Foremost, administrators need to understand the impact that trauma can have on people's lives. The consistent delivery of TIC is only as effective as the organization's commitment, which must extend to administrative practices with staff members, program policies and procedures, program design, staffing patterns, use of peer support, staff and peer training and supervision, organizational assessment and consumer feedback, and resources to uphold trauma-informed principles and practices. Even short-term change is not sustainable without the agency's continual commitment.

Typically, desirable organizational change doesn't occur by accident. It comes from steadfast leadership, a convincing message that change is necessary and beneficial for staff and consumers, and resources that support change. Many people naturally resist change; thus, an organization's commitment includes a willingness to discuss with staff members the impact and role of trauma in their service setting, patience in planning and implementation, and

Seminal Resource for Administrators

As you investigate how best to implement or improve trauma informed services within your organization or across systems, review the influential work, *Using Trauma Theory to Design Service Systems: New Directions for Mental Health Services.*

(Harris & Fallot, 2001c)

Advice to Administrators: Managing Staff Reactions to Implementation of New Processes or Ideas

A common hurdle for administrators after introducing a new process or idea is the staff assumption that it will require more work. Frontline staff members are often inundated with many responsibilities beyond face-to-face time with clients. In addition, a common misperception is that if you begin to address trauma, you will have difficulty containing it.

In addition to administrative buy-in, administrators must promote rather than simply announce the implementation of trauma-informed services. Promotion includes educating staff about the rationale for trauma-informed services, offering opportunities for discussion and input from staff and consumers, providing training focused on trauma-informed skills, and so forth. For example, the San Diego Trauma-Informed Guide Team (2012) created a promotional brochure on how TIC can make staff jobs easier:

- Focuses on root problem
- Is preventative
- Increases support system
- Facilitates collaboration
- Shares workload
- Empowers client
- Provides consistency in agencies/systems
- Uses evidence-based best practices

TIC may be cost-effective, lead to less intensive services and less use of services, prevent undue stress for staff members and clients, and prevent client crises caused by old policies that could retraumatize trauma survivors.

the ability to tolerate the uncertainty that naturally accompanies transitions.

Strategy #2: Use Trauma-Informed Principles in Strategic Planning

Strategic planning provides an opportunity to explore and develop short- and long-term goals. The planning process often begins with reevaluating the organizations' values, mission, and vision, yet agencies cannot adequately develop a trauma-informed strategic plan without obtaining specific information about internal (staff, resources, processes) and external environmental (referral constellation, changes in health care, funding sources, State and Federal standards, community needs, consumer demographics, etc.) factors and influences. Data gathered through staff, consumer, organizational, and community assessments shapes the direction of the plan, including projected demands, challenges, obstacles, strengths, weaknesses, and resources. At the conclusion of this planning process, the organization will have specific goals, objectives, and tasks to meet the needs of their stakeholders and to address any anticipated challenges. Ideally, strategic planning should define key steps in developing or refining trauma-informed services within the organization.

Strategy #3: Review and Update Vision, Mission, and Value Statements

Vision, mission, and value statements provide a conceptual framework for TIC development and delivery. They should not be created in isolation; they should reflect voices from the community, populations, and other stakeholders that the organization serves. These statements develop through input, discussion, and assessment. They are not static; they evolve as needs, populations, or environments change.

Statement Example

As behavioral health service providers, we strive to be trauma aware—to understand the dynamics and impact of trauma on the lives of individuals, families, and communities. We strive to create a trauma-sensitive culture by demonstrating, through consumer empowerment, program design, and direct care, an understanding of the relationships among trauma, substance abuse, and mental illness.

Advice to Administrators: How To Create Vision, Value, and Mission Statements

Define the organization's vision, values, and mission to be compatible with TIC. Emphasize the organizational culture needed to provide TIC. An outgrowth of that cultural shift may include an enhanced working environment for employees and consumers that is noncoercive and reduces conflicts, restraint, and seclusion. Even if the current mission statement is appropriate, change it anyway to symbolize intended change within the organization. To define or redefine the vision, values, and mission:

- Involve consumers, all levels of staff, and leadership, including the director/CEO.
- Review:
  - Organizational priorities to identify and manage conflicting priorities.
  - Resources to assess whether reallocation is necessary for change (e.g., to hire peer support specialists, to furnish comfort rooms).
- Operationalize the vision, values, and mission at the level of individual departments
- Evaluate progress at regular staff meetings to ensure that changing the culture of care stays on the agenda.

Source: New Logic Organizational Learning, 2011.

Strategy #4: Assign a Key Staff Member To Facilitate Change

Prior to the development of an oversight committee, a senior staff member with the authority to initiate and implement changes should be assigned to oversee the developmental process. By assigning a trauma-aware senior staff member who is committed to trauma-informed services, it is more likely that the organization's and committee's goals, objectives, and plans will remain in focus. This senior staff member is responsible for ongoing development and facilitation of the oversight committee; management of the initial organizational assessment, reassessments, and other evaluative and feedback processes; and facilitation and oversight of the implementation plan and subsequent changes, including policies and procedures to ensure delivery of TIC.

Strategy #5: Create a Trauma-Informed Oversight Committee

The role of the oversight committee includes providing ongoing input and direction in the initial organizational assessment, strategic plan, plan implementation, reevaluation and development of trauma-informed policies and procedures, and future reassessments. The committee monitors progress and uses real-time data to forge a clear pathway to new processes that support TIC. The committee should involve stakeholders from the community, consumers, specialists, staff members, and administrators. Leadership involvement is necessary. Stakeholders may be alumni, family members, community-based organizations, and other institutions that interact with the agency or would benefit from trauma-informed services.

Initially, the agency must educate the committee on the organization's mission, values, and vision as well as the task at hand—developing trauma-informed services. To ease potential conflicts or confusion about the organization's structure, the guidelines, expectations, and roles of the committee need to be communicated directly to committee members as well as the organization as a whole, including board members, support and professional staff, supervisors, and so forth. The committee also needs to know the extent of their power and the necessary lines of communication before, during, and after evaluating and implementing changes in the organization.

Including consumers and/or those who have lived through trauma is vital. They have unique knowledge, experiences, and perspectives on the impact of treatment design, delivery, policies, and procedures. They offer firsthand information on practices that can potentially retraumatize clients in behavioral health settings and can suggest preventive, alternative practices and solutions. Consumer committee members keep staff and administrators aware of the goal of achieving TIC.

Strategy #6: Conduct an Organizational Self-Assessment of Trauma-Informed Services

An organizational self-assessment evaluates the presence and/or the effectiveness of current trauma-informed practices across each service and level of the organization. This assessment allows an organization to see how it functions within the context of trauma-informed principles and provides feedback to inform the development or revision of the implementation plan for TIC. In essence, this assessment process can serve as a blueprint for change and as a benchmark of compliance with and progress in implementing trauma-informed practices across time. Overall, it is a process of identifying organizational strengths, weaknesses, opportunities, and threats related to the implementation and maintenance of TIC. Refer to Appendix F for sample organizational assessment tools for the organization and the consumer.

The self-assessment should obtain feedback from key stakeholders, particularly consumers, family members, referral sources, community organizations, and all levels of the organization's staff, including nonclinical and clinical staff, supervisors, and administrative personnel. Similar to the universal screening process, an organizational self-assessment is only as effective as the steps taken after data are gathered and analyzed. From this assessment, an implementation plan should be established that highlights the goals, objectives, steps, timeframe, and personnel responsible in overseeing the specific objective. Assessment shouldn't be a once-and-done project. Timely and regularly scheduled organizational assessments should follow to assist in quality improvement. For an explanation of more detailed steps to take in conducting an organizational self-assessment, see Chapter 4 of the planned Treatment Improvement Protocol (TIP), *Improving Cultural Competence* (SAMHSA, planned c).

Advice to Administrators: Ten Steps to Quality Improvement

1. Identify new goals or problems.
2. Gather input from each level of the organization, including consumers and other key stakeholders.
3. Analyze the feedback.
4. Explore improvement options and the potential barriers associated with each.
5. Select the overall approach and specific strategies to address barriers (anticipate barriers, and try to address them before they occur).
6. Develop an implementation plan, and then present the plan to staff members and other key stakeholders not directly involved in the quality improvement process.
7. Implement the plan.
8. Reassess the new plan.
9. Evaluate the results and determine if new goals or additional problems or issues need to be addressed.
10. Repeat the first nine steps.

Strategy #7: Develop an Implementation Plan

Implementation plans should evolve from consumer participation, demographic profiles

Advice to Administrators: Implementation Plan Content

1. **Introduction and overview:** This includes the organization's history, the demographics that characterize its client base, the rationale for the implementation plan, and the incorporation of TIC. Focus on identification of strengths, weaknesses, opportunities, and threats. Provide an overview of goals and objectives.
2. **Specific goals and objectives:** Goals and objectives should address:
   - Workforce development strategies for recruiting, hiring, retaining, training, supervising, and promoting wellness of clinical and nonclinical staff members to support TIC.
   - Consumer participation and peer support development and implementation strategies.
   - Policies, procedures, and practices to support TIC and culturally responsive services, to promote safety, and to prevent retraumatization.
   - Specific evidence-based or best practice adoptions to support TIC.
   - Strategies to amend facility design or environment (plant) operations to reinforce safety.
   - Fiscal planning to ensure sustainability of the steps initiated in the organization.
3. **Guidelines for implementation:** Guidelines should highlight the specific steps, roles, responsibilities, and timeframes for each activity to meet TIC objectives.

of populations served, data from organizational self-assessment, and research on promising and evidence-based trauma-informed practices. Using the framework proposed in this TIP, the oversight committee is responsible for designing a plan that outlines the purpose, goals, objectives, timeframes, and personnel responsible for each objective (Exhibit 2.1-1).

Exhibit 2.1-1: TIC Planning Guidelines

The following publications provide samples of organizational guidelines for implementing TIC.

- Fallot, R. D. & Harris, M. (2009). *Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol.* Washington, DC: Community Connections, 2009.
- Guarino, K., Soares, P., Konnath, K., Clervil, R., & Bassuk, E. (2009). *Trauma-informed organizational toolkit.* Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; the Daniels Fund; the National Child Traumatic Stress Network; and the W. K. Kellogg Foundation.
- Huckshorn, K. (2009). Transforming cultures of care toward recovery oriented services: Guidelines toward creating a trauma informed system of care. In *Trauma informed care (TIC) planning guidelines for use in developing an organizational action plan.* Alexandria, VA: National Association of State Mental Health Program Directors.
- Jennings, A. (2009). *Criteria for building a trauma-informed mental health service system.* Retrieved on May 21, 2013, from http://www.theannainstitute.org/CBTIMHSS.pdf
- Ohio Legal Rights Service (2007). *Trauma-informed treatment in behavioral health settings.* Columbus, OH: Ohio Legal Rights Service.
- Prescott, L., Soares, P., Konnath, K., & Bassuk, E. (2008). *A long journey home: A guide for creating trauma-informed services for mothers and children experiencing homelessness* [draft]. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; the Daniels Fund; the National Child Traumatic Stress Network; and the W.K. Kellogg Foundation.

The following resource is a systemwide set of guidelines for implementing TIC.

- U.S. Department of Health and Human Services, Health Resources and Services Administration (2006). *Model trauma system: Planning and evaluation.* Rockville, MD: Health Resources and Services Administration.

Strategy #8: Develop Policies and Procedures To Ensure Trauma-Informed Practices and To Prevent Retraumatization

In the early stage of evaluating current services and planning for TIC, the committee needs to assess practices, procedures, and policies that may have been or could be retraumatizing to any individual, at any level of the organization, from consumers to administrators. Programs that are not trauma informed are as likely to be unaware of the impact of trauma on staff as they are to be unaware of its influence on consumers. In the initial review, careful scrutiny should be used to eliminate any practice that is potentially harmful, including seclusion and restraint practices, therapeutic activities that are shaming, treatment planning without collaboration, any medical inquiry without privacy, and so forth.

Policies and procedures are the building blocks of each agency. They guide the service process and, if followed, they provide an opportunity for the agency to deliver consistent responses and care. Policies and procedures must incorporate trauma-informed practices across all domains and standards, such as admissions, plant/environmental standards, screening and assessment processes, referrals (to other services, including hospitalization, or for further evaluations), treatment planning, confidentiality, discharge, and more. They also need to be updated periodically to incorporate new science and to meet the changing needs of consumers. By regularly reviewing and adapting administrative and clinical policies and procedures in response to ever-changing needs and evidence, the agency can provide staff members with good guidelines for providing trauma-informed services that are consistent yet flexible.

Program Curriculum: Roadmap to Seclusion-Free and Restraint-Free Mental Health Services

This curriculum, written from consumer perspectives, provides behavioral health staff with education, strategies, and hands-on tools to prevent and ultimately eliminate the use of seclusion and restraint. It includes many handouts for participants and consumers. This training package, available online (http://store.samhsa.gov/product/Roadmap-to-Seclusion-and-Restraint-Free-Mental-Health-Services-CD-/SMA06-4055), is divided into seven modules plus a resources section:

- Module 1: The Personal Experience of Seclusion and Restraint
- Module 2: Understanding the Impact of Trauma
- Module 3: Creating Cultural Change
- Module 4: Understanding Resilience and Recovery from the Consumer Perspective
- Module 5: Strategies to Prevent Seclusion and Restraint
- Module 6: Sustaining Change Through Consumer and Staff Involvement
- Module 7: Review and Action Plan
- Resource Section

Source: Center for Mental Health Services (CMHS), SAMHSA, 2005.

Strategy #9: Develop a Disaster Plan

Facilities are often required to develop disaster plans, but specific requirements vary from State to State. From the outset, developing a disaster plan in behavioral health services is essential. Many clients in behavioral health services have lived with trauma, so proactive steps that reduce the impact of a new trauma may prevent worsening of symptoms and decrease the risk for more pervasive effects. (See also Technical Assistance Publication 34, *Disaster Planning Handbook for Behavioral Health Treatment Programs* [SAMHSA, 2013].)

Most disaster events cannot be accurately anticipated. Even so, behavioral health organizations can take steps to reduce the impact of a disaster event on program functioning and on the lives of clients. Each service or program should develop a disaster response committee that meets regularly to develop, maintain, and adapt policies and procedures to respond to disasters affecting the program. Committee planning efforts may include:

1. Creating a disaster response team of program staff members tasked with coordinating program administration and services in a disaster event.
2. Establishing a communication process for informing staff and clients of the status of program functioning and for coordinating staff assignments during and shortly after the disaster event.
3. Outlining a process to inform clients and their families of available services, their location, and contact information for accessing services to meet clients' critical needs.
4. Developing plans for service provision during a disaster event and service implementation after the event.
5. Creating special plans for high-risk or special needs clients who need services during and shortly after the disaster. Examples of this are clients who are homeless, in detoxification services or methadone programs, on prescribed psychopharmaceuticals, or at risk for suicide.
6. Making plans for maintaining the security of client records, program records, and facilities during and shortly after the event.
7. Coordinating ahead with other community resources and services to ensure that clients at high risk or with special needs get the services they require as soon as possible.
8. Prioritizing how services will start back up after a disaster event.
9. Providing special services after the event to clients at high risk for trauma reactions and symptoms.
10. Establishing a postdisaster debriefing process to review disaster responses, services, and outcomes.

Some specific disaster events, such as hurricanes, may sometimes offer opportunities for planning and preparation in advance of the disaster event. This preparation time is usually just a few days, but it allows programs to make advance preparations and take advance action to establish lines of communication, stockpile resources, prepare for evacuation of clients, and protect client and program records.

Strategy #10: Incorporate Universal Routine Screenings

A key element of trauma-informed services is the institution of universal routine screening across all services, regardless of the individual's path in accessing services (e.g., primary care, hospitalization, outpatient). Considering the prevalence of trauma among individuals who seek services for mental and substance use disorders, the implementation of screening is paramount. Without screening, clients are not identified as trauma survivors. Subsequently, they miss recovery opportunities and treatment services that would be more likely to meet their needs, while also running a higher risk of being retraumatized by unexamined organizational policies, procedures, and practices. For more information on the rationale, processes, and instruments of universal screening for trauma, refer to Part 1, Chapter 4.

Strategy #11: Apply Culturally Responsive Principles

Providers must be culturally competent when incorporating evidence-based and best practices as well as trauma-informed treatment

models within the organization. Clients' views of behavioral health differ according to race, ethnicity, and culture (refer to the planned Treatment Improvement Protocol [TIP], *Improving Cultural Competence* [SAMHSA, planned c]). Likewise, cultures attach different meanings to trauma, and responses to trauma will vary considerable across cultures (see Part 3, the online literature review, for more information). For example, trauma survivors who come from a collective society or culture, in which the goals of the group take precedence over the goals of the individual, may be more focused on the well-being of their family or the family's response to the trauma survivors' experience. Often, this view runs in opposition to the individualistic perspective of many behavioral health services. Subsequently, treatment providers who are not culturally competent may interpret collective values as a sign of resistance or avoidance in dealing with traumatic stress. CMHS (2003) outlines principles of cultural competence in disaster work applicable across all forms of trauma:

1. ***Recognize the importance of culture and respect diversity.*** Those who value culture and diversity understand their own cultures, attitudes, values, and beliefs, and they work to understand the cultures of others. This includes being able to communicate effectively with those from other cultures, respecting others' feelings about personal space, knowing about others' social organization, understanding how time is viewed, and being aware of others' beliefs about the effects of their behaviors.
2. ***Maintain a current profile of the cultural composition of the community.*** This includes describing the community's population in terms of race and ethnicity, age, gender, religion, refugee and immigrant status, housing status, income levels, rural/urban balance, unemployment, languages spoken, literacy, schools, and businesses.
3. ***Recruit workers who are representative of the community or service area.*** If the workers who are available do not match the community, they should have the personal attributes, knowledge, and skills to develop cultural competence.
4. ***Provide ongoing cultural competence training to staff.*** Topics should include cultural values and traditions, family values, linguistics and literacy, immigration experiences and status, help-seeking behaviors, techniques and strategies for cross-cultural outreach, and the avoidance of stereotypes and labels (DeWolfe & Nordboe, 2000b).
5. ***Ensure that services are accessible, appropriate, and equitable.*** In planning disaster work or TIC, community associations and organizations are invaluable. Gaining their acceptance requires time and energy.
6. ***Recognize the role of help-seeking behaviors, traditions, and natural support networks.*** Culture includes traditions that dictate whom, or which groups, to seek in times of need; how to handle suffering and loss; and how healing takes place. These customs and traditions are respected by a culturally responsive disaster relief program.
7. ***Involve community leaders and organizations representing diverse cultural groups as "cultural brokers."*** Collaborating with community leaders is an effective means of learning about the community, establishing program credibility, and ensuring that services are culturally responsive.
8. ***Ensure that services and information are culturally and linguistically responsive.*** Communication with individuals who do not speak English, who are illiterate in all languages or have limited literacy, and who are deaf or hard of hearing is essential to service provision. Local radio stations, television outlets, and newspapers that are multicultural are an excellent venue for educational information after a disaster.

Using survivors' friends or relatives as interpreters is not recommended, as survivors may be uncomfortable discussing personal matters with family members or friends. Asking children to interpret can place too heavy a responsibility on them and reverses parents' and children's roles.

9. ***Assess and evaluate the program's level of cultural responsiveness.*** Self-assessment and process evaluation can help keep a program on track. A variety of strategies can be used for collecting data and communicating findings to stakeholders.

Strategy #12: Use Science-Based Knowledge

Along with culturally responsive services, trauma-informed organizations must use science-based knowledge to guide program development and the implementation of services, policies, procedures, and practices. This includes the adoption of EBPs (see Part 1, Chapter 6, and Part 3, Section 1, to review definition, treatments, and resources for EBPs). TIC research is quite new; interpret these limited studies and information cautiously. Chambless and Hollon's (1998) criteria, which are still the benchmark for EBPs, are valuable resources for administrators. Look closely at who was included—and excluded—from treatment studies. Often, the types of severe, chronic, and unstable cases seen in community settings are excluded from treatment studies. Evidence-based interventions should be a primary consideration in selecting appropriate treatment models for people with mental illness, substance use disorders, and co-occurring psychological trauma. Nonetheless, other variables must also be contemplated before adopting EBPs in an organization, including the cultural appropriateness of the practice; the strength of its clinical focus on strengths-based strategies; training and competence of clinical staff; the cost of training, materials, and implementation; and the ease of maintaining EBP fidelity amidst staff turnover.

For more detailed information on EBPs, visit the National Registry of Evidence Based Programs and Practices (NREPP) Web site (http://nrepp.samhsa.gov). For more specific research oriented information on trauma and trauma specific treatments, refer to the literature review in Part 3 of this TIP, available online.

Strategy #13: Create a Peer-Support Environment

The main purpose of peer support services is to provide consumer mentoring, support, and care coordination for clients with histories of mental illness or substance abuse. The goals are to help others deal with personal and environmental barriers that impede recovery and achieve wellness. Peer support accomplishes this through many activities, including advocacy, support during crises and recovery activities, modeling, education, and assistance in accessing available resources. Peer support programs send a powerful message to staff members, consumers, and the community—that recovery is possible through support, collaboration, and empowerment. These programs reinforce the trauma-informed premise that organizations need to reflect the populations that they serve and involve consumers in planning, implementing, monitoring, and delivering recovery services.

For an introduction to peer support services, see *What Are Peer Recovery Support Services?* (Center for Substance Abuse Treatment, 2009e).

Notably, peer support services have the potential to be considerably flexible to meet client needs at each stage of recovery. Specifically, peer support services can be incorporated

across the continuum of care, starting with outreach services and extending into long-term recovery services. Peer support specialists can enhance consumer motivation to change, to initiate services, and/or to engage in recovery activities. They can play powerful liaison roles by supporting clients entering treatment and explaining what to expect from services. They can ease the transition into treatment, from one service to the next, from one modality to another (e.g., inpatient group to outpatient group), and beyond formal treatment. Moreover, peer support services create an atmosphere focused on mutuality rather than pathology. They provide living models of resilience and promote hope—that recovery is possible and attainable.

Administrators should familiarize themselves with how other organizations have implemented peer support programs, current curricula, certifications and training processes, competencies and ethics, and peer support service State standards or recommendations, if applicable. The Carter Center's Summit in 2009, The Pillars of Peer Support Services, supported in part by SAMHSA and CMHS, highlighted the numerous elements necessary to develop a strong, vital peer workforce (Daniels et al., 2010). These elements include:

- Clear job and service descriptions.
- Job-related competencies and competence-based testing processes.
- Peer support certifications.
- Ongoing continuing education.
- Media and technology access for peer specialists.
- Sustainable funding.
- Research and evaluation components.
- Code of ethics and conduct.
- Competence-based training for supervisors.
- Multilevel support and program support teams.

> "Peer recovery support services are evidence based and have been demonstrated to promote positive health outcomes and control the cost of healthcare. These services are offered by a trained individual with lived experience and recovery from a mental illness, substance use and/or chronic health conditions. Peer recovery support services minimally include chronic illness self management, whole health and wellness promotion and engagement, relapse prevention, life skill coaching, and insurance and health systems navigation."
>
> (Daniels et al., 2012, p. 22)

Advice to Administrators: Sample Peer Support Staff Tasks

- Use active listening skills help peers identify areas of dissatisfaction and benefits of changing beliefs, thoughts, and behavior.
- Use problem-solving skills to help peers identify barriers to recovery and develop plans to meet peer-determined goals.
- Facilitate recovery support groups.
- Link clients with community resources.
- Work with the treatment team to advocate for clients and to remove recovery barriers.
- Participate in consumer panels to educate staff about the consumer perspective and about peer support.
- Participate in hospital-wide committees and workgroups

Source: New Logic Organizational Learning, 2011.

Strategy #14: Obtain Ongoing Feedback and Evaluations

Obtain feedback on and evaluations of organizational performance on a regular basis. Give consumers a clear avenue for offering feedback at any time, and make evaluations assessing the organization's progress toward providing trauma-informed services standard practice. Without feedback and further evaluation, organizations cannot assess whether they are

meeting trauma-informed objectives. A routine monitoring process for TIC implementation gives the organization additional information necessary to combat new obstacles and threats and to understand what works. Regular monitoring equips organizations with the ability to formulate different strategies to meet objectives as well as to respond to the changing needs of the population. Ongoing evaluation and consumer feedback are essential in improving the quality of services.

Strategy #15: Change the Environment To Increase Safety

Practices that generate emotional and physical safety are necessary. Another aspect of creating safety is reevaluating the physical facilities and environment to enhance safety and to circumvent preventable retraumatization. Think how traumatizing it would be if you were a female rape survivor and a night counselor was conducting a room check at 2:00 a.m., or a male security guard was walking the women's residential wing. What would it be like if you were sitting with your back to the door in a small office during an intake interview, if your history included a physical assault and robbery? For most, it would at least increase anxiety; for others it would be retraumatizing. Trauma-informed providers must carefully assess environmental safety. Although you are likely to identify some facility issues that could erode safety for trauma survivors, a safe environment will only be established if regular feedback is obtained from consumers about their experiences with the program.

Strategy #16: Develop Trauma-Informed Collaborations

TIC is about collaboration with consumers, staff members, key stakeholders, and other agencies. Collaborative relationships provide opportunities for consumers to access the most appropriate services as needs arise. Rather than waiting for a crisis or a dire need for a service to investigate available resources, it is far more efficient and compassionate to establish relationships within the agency and with other community resources before these needs arise. No agency can meet the needs of every client; referral agreements and/or collaborative arrangements that integrate the delivery of TIC, including support services (e.g., housing, legal, medical), are important.

Creating Sanctuary

The sanctuary model is a trauma-based therapeutic approach that has been used in inpatient, residential, therapeutic community, and outpatient settings with children, adolescents, and adults. It provides a template for changing social service delivery systems so that they are better equipped to respond to the complex needs of trauma survivors. Sanctuary is informed by four knowledge areas: "the psychobiology of trauma, the active creation of nonviolent environments, principles of social learning, and an understanding of the ways in which complex adaptive systems grow, change, and alter their course" (Bloom et al., 2003, p. 174).

The sanctuary model describes a stage-based approach to healing that is referred to as SAGE: safety, affect modulation, grieving, and emancipation. This model is nonlinear; an individual does not necessarily move from one stage to another in a straight path, but progress in one area does affect progress in other areas (Bloom, 1997; Bloom et al., 2003). SAGE is a cognitive–behavioral translation of the sanctuary model (Bills, 2003). Early in treatment, the focuses are typically on safety and affect management. Safety encompasses four domains: physical, psychological, social, and moral (Bloom, 1997; see http://www.sanctuaryweb.com for further details and a curriculum).

2 Building a Trauma-Informed Workforce

IN THIS CHAPTER

- Introduction
- Workforce Recruitment, Hiring, and Retention
- Training in TIC
- Trauma Informed Counselor Competencies
- Counselor Responsibilities and Ethics
- Clinical Supervision and Consultation
- Secondary Traumatization
- Counselor Self Care

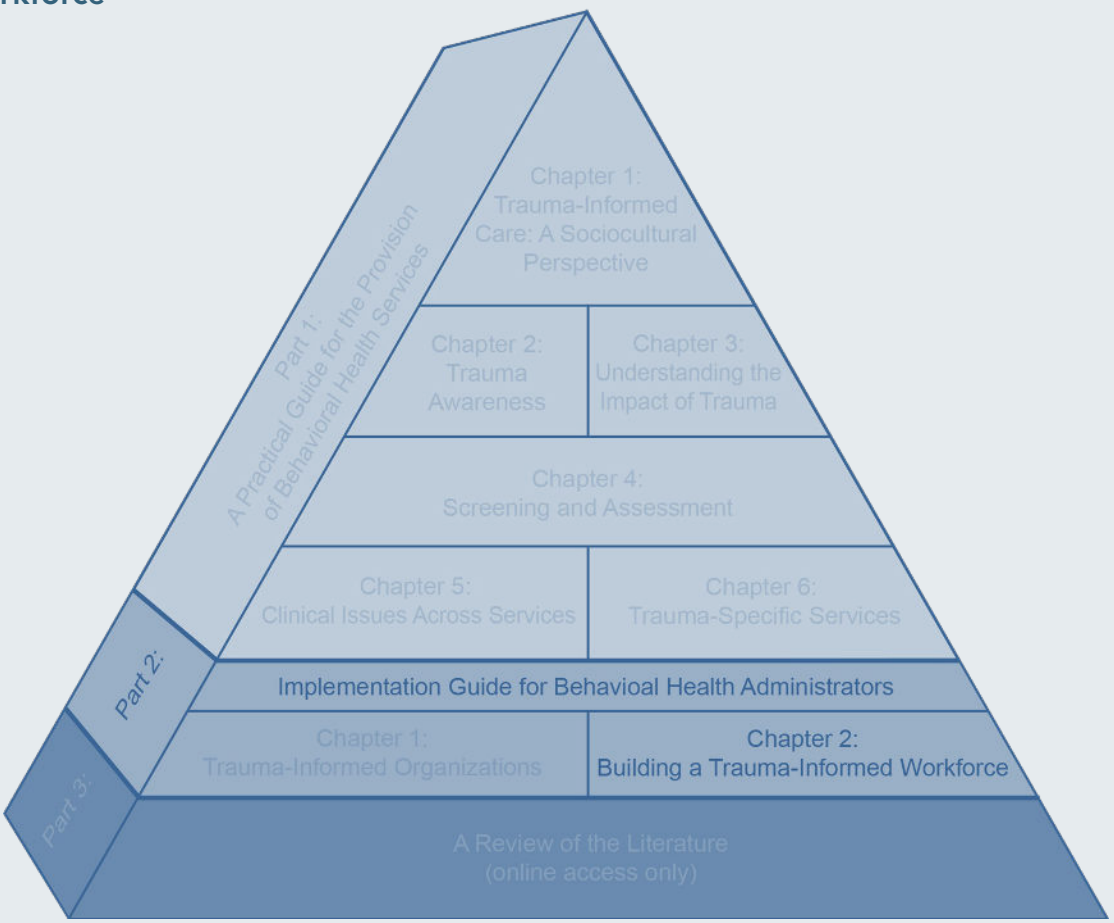
Introduction

For an organization to embrace a trauma-informed care (TIC) model fully, it must adopt a trauma-informed organizational mission and commit resources to support it. This entails implementing an agency-wide strategy for workforce development that is in alignment with the values and principles of TIC and the organization's mission statement. Without a fully trained staff, an organization will not be able to implement the TIC model. However, simply training behavioral health professionals in TIC is not enough. Counselors will not be able to sustain the kind of focus required to adopt and implement a trauma-informed philosophy and services without the ongoing support of administrators and clinical supervisors.

An organizational environment of care for the health, well-being, and safety of, as well as respect for, its staff will enhance the ability of counselors to provide the best possible trauma-informed behavioral health services to clients. This culture of care must permeate the organization from top to bottom. Behavioral health program administrators should aim to strengthen their workforce; doing so "requires creating environments that support the health and well-being, not only of persons with mental and substance use conditions, but of the workforce as well" (Hoge, 2007, p. 58). An organizational culture of care, safety, and respect demands activities that foster the development of trauma-informed counselors. This chapter focuses on key workforce development activities, such as:

- Recruiting, hiring, and retaining trauma-informed staff.
- Training behavioral health service providers on the principles of, and evidence-based and emerging best practices relevant to, TIC.
- Developing and promoting a set of counselor competencies specific to TIC.

TIC Framework in Behavioral Health Services—Building a Trauma-Informed Workforce



- Delineating the responsibilities of counselors and addressing ethical considerations specifically relevant to promoting TIC.
- Providing trauma-informed clinical supervision.
- Committing to prevention and treatment of secondary trauma of behavioral health professionals within the organization.

Addressing each of these areas is essential to building a trauma-informed workforce and an organizational culture that supports TIC.

Workforce Recruitment, Hiring, and Retention

An Action Plan for Behavioral Health Workforce Development (Hoge et al., 2007) emphasizes the importance of organization-wide support and active involvement in workforce recruitment, hiring, and retention in behavioral health systems. One of the key findings of this report is that the work environment itself in many behavioral health settings can be toxic to the workforce and may hinder the delivery of individualized, respectful, collaborative, and client-centered care to service recipients. Factors such as the downward pressure on organizations for higher productivity of counselors increase caseloads and decrease wages of behavioral health staff members and may create a high-stress environment that contributes to low morale and worker dissatisfaction. Other factors that often contribute to low retention of qualified counselors in behavioral health settings include the lack of professional career

ladders, fragile job security, the lack of clinical supervision, and an inability to influence the organization in which they are working (Hoge et al., 2007).

Added to this mix is the intensity of working with people with the co-occurring conditions of trauma-related mental and substance use disorders and the risk of secondary traumatization of counselors. In creating and sustaining a trauma-informed workforce, organizations need to foster a work environment that parallels the treatment philosophy of a trauma-informed system of care. Doing so allows counselors to count on a work environment that values safety, endorses collaboration in the making of decisions at all levels, and promotes counselor well-being.

Recruitment and Hiring in a Trauma-Informed System of Care

In a 2007 technical report (Jennings, 2007b), the National Center for Trauma-Informed Care identified several priorities for organizations with regard to recruitment and hiring trauma-informed staff, including:

- Active recruitment of and outreach to prospective employees who are trauma-informed or have formal education in providing trauma-informed or trauma-specific services in settings such as universities, professional organizations, professional training and conference sites, peer support groups, and consumer advocacy groups.
- Hiring counselors and peer support staff members with educational backgrounds and training in trauma-informed and/or trauma-specific services and/or lived experience of trauma and recovery.
- Providing incentives, bonuses, and promotions for staff members during recruitment and hiring that take into consideration prospective employees' trauma-related education, training, and job responsibilities.

In addition to hiring behavioral health professionals with formal professional education and training, organizations should also "routinely survey the demographics and other characteristics of the population served and recruit a workforce of similar composition" (Hoge et al., 2007, p. 297). Essentially, this means actively engaging in outreach to consumer advocacy groups, recovery-oriented programs, community and faith-based organizations, and former clients/consumers with the intention of recruiting potential employees whose knowledge and expertise comes from their lived experience of trauma, resilience, and recovery. Support staff members, peer support workers, counselors in training, and apprentices can be recruited from this population and offered incentives, such as tuition reimbursement, training stipends, and professional mentoring with the goal of developing a trauma-informed workforce from within the demographic served. Jennings (2007b) calls these staff members "trauma champions" who can provide needed expertise in a trauma-informed organization to promote trauma-informed policies, staff development, and trauma-based services consistent with the mission of the organization (p. 135).

Who Is a Trauma Champion?

"A champion understands the impact of violence and victimization on the lives of people seeking mental health or addiction services and is a front-line worker who thinks 'trauma first.' When trying to understand a person's behavior, the champion will ask, 'is this related to abuse and violence?' A champion will also think about whether his or her own behavior is hurtful or insensitive to the needs of a trauma survivor. The champion is there to do an identified job—he is a case manager or a counselor or a residential specialist—but in addition to his or her job, a champion is there to shine the spotlight on trauma issues."

Source: Harris & Fallot, 2001a, p. 8.

As with hiring behavioral health professionals who are in recovery from substance use disorders, the organization should be transparent and explicit in its recruitment and hiring practices of trauma survivors in recovery. The organization can be transparent by advertising the mission statement of the organization as part of the recruitment process and inviting applicants who are in recovery from trauma to apply. The needs of behavioral health staff members who are in recovery from both substance use and trauma-related conditions and working in a trauma-informed system of care should be addressed in the organization's ongoing training, clinical supervision, and staff development policies and practices.

Workforce Retention

Staff turnover is rampant in behavioral health settings. It is costly to the organization, and as a result, it is costly to clients. A strong therapeutic relationship with a counselor is one of the largest factors in an individual's ability to recover from the overwhelming effects of trauma. When behavioral health professionals leave an organization prematurely or in crisis as a result of chronic levels of high stress or secondary traumatization, clients must deal with disruptions in their relationships with counselors. Some of the organizational factors that contribute to chronic levels of high stress and often lead to high staff turnover include expecting counselors to maintain high caseloads of clients who have experienced trauma; not providing trauma-informed clinical supervision and training to counselors; and failing to provide adequate vacation, health insurance, and other reasonable benefits that support counselors' well-being. Other factors that may have a more profound impact on staff retention include failing to acknowledge the reality of secondary traumatization, promoting the view that counselors' stress reactions are a personal failure instead of a normal response to engaging with clients' traumatic material, and not supporting personal psychotherapy for counselors (Saakvitne, Pearlman, & Traumatic Stress Institute/Center for Adult & Adolescent Psychotherapy, 1996).

Research on promoting counselor retention in behavioral health settings demonstrates that

Advice to Administrators: Preventing Turnover and Increasing Workforce Retention

To prevent behavioral health staff turnover and increase retention of qualified, satisfied, and highly committed trauma-informed counselors, consider:

- Offering competitive wages, benefits, and performance incentives that take into account education, training, and levels of responsibility in providing trauma-informed or trauma-specific services.
- Creating a safe working environment that includes both the physical plant and policies and procedures to prevent harassment, stalking, and/or violence in the workplace and to promote respectful interactions amongst staff at all levels of the organization.
- Establishing an organizational policy that normalizes secondary trauma as an accepted part of working in behavioral health settings and views the problem as systemic—not the result of individual pathology or a deficit on the part of the counselor.
- Instituting reasonable, manageable caseloads that mix clients with and without trauma-related concerns.
- Letting staff offer input into clinical and administrative policies that directly affect their work experience.
- Providing vacation, health insurance (which includes coverage for psychotherapy/personal counseling), and other benefits that promote the well-being of the staff.
- Implementing regular, consistent clinical supervision for all clinical staff members.
- Providing ongoing training in trauma-informed services offered by the organization.

behavioral health staff members are interested in the same kind of work environment and benefits as employees in many other fields. They include a "living wage with healthcare benefits; opportunities to grow and advance; clarity in a job role; some autonomy and input into decisions; manageable workloads; administrative support without crushing administrative burden; basic orientation and training for assigned responsibilities; a decent and safe physical work environment; a competent and cohesive team of coworkers; the support of a supervisor; and rewards for exceptional performance" (Hoge et al., 2007, p. 18).

When an organization's administration values its staff by providing competitive salaries and benefits, a safe working environment, a reasonable and manageable workload, input into the making of clinical and administrative policy decisions, and performance incentives, it helps behavioral health workers feel connected to the mission of the organization and become dedicated to its sustainability and growth. This type of work environment demonstrates both a level of respect for counselors (similar to the level of respect a trauma-informed organization displays toward clients) and an appreciation for the complexity of their job responsibilities and the stress they face when working with people who have experienced trauma in their lives. To retain behavioral health professionals working in a trauma-informed setting, wages and performance incentives should be tied not only to education, training, and work experience, but also to levels of responsibility in working with clients who have experienced trauma.

Training in TIC

Training for all staff members is essential in creating a trauma-informed organization. It may seem that training should simply focus on new counselors or on enhancing the skill level of those who have no prior experience in working with trauma, but training should, in fact, be more systematic across the organization to develop fully sustainable trauma-informed services. All employees, including administrative staff members, should receive an orientation and basic education about the prevalence of trauma and its impact on the organization's clients. To ensure safety and reduction of harm, training should cover dynamics of retraumatization and how practice can mimic original sexual and physical abuse experiences, trigger trauma responses, and cause further harm to the person. Training for all employees must also educate them "about the impacts of culture, race, ethnicity, gender, age, sexual orientation, disability, and socioeconomic status on individuals' experiences of trauma" (Jennings, 2007a, p. 5).

All clinical and direct service staff members, regardless of level of experience, should receive more indepth training in screening and assessment of substance use and trauma-related disorders; the relationships among trauma, substance use disorders, and mental disorders; how to understand difficult client behaviors through a trauma-informed lens; how to avoid retraumatizing clients in a clinical setting; the development of personal and professional boundaries unique to clinical work with traumatized clients; how to identify the signs of secondary traumatization in themselves; and how to develop a comprehensive personal and professional self-care plan to prevent and/or ameliorate the effects of secondary traumatization in the workplace. All clinical staff members who work with traumatized clients should receive additional training in evidence-based and promising practices for the treatment of trauma (for information on locating training, see Appendix B.) This might include training done within the agency by experts in the field or training received by attending advanced trauma trainings. Administrators

should provide the time and financial resources to clinical staff members for this professional development activity. Jennings (2007a) suggests that, whenever possible, "trainings should be multi-system, inclusive of staff in mental health and substance abuse, health care, educational, criminal justice, social services systems and agencies, and promoting systems integration and coordination" (p. 5).

Moreover, criminal justice settings, schools, military/veteran programs, and other places in which behavioral health services are provided may benefit from approaches that are sensitive to the special circumstances and cultures of these environments. For example, in exploring trauma-informed correctional care, Miller and Najavits (2012, p. 1) observe:

> Prisons are challenging settings for trauma-informed care. Prisons are designed to house perpetrators, not victims. Inmates arrive shackled and are crammed into overcrowded housing units; lights are on all night, loud speakers blare without warning and privacy is severely limited. Security staff is focused on maintaining order and must assume each inmate is potentially violent. The correctional environment is full of unavoidable triggers, such as pat downs and strip searches, frequent discipline from authority figures, and restricted movement….This is likely to increase trauma-related behaviors and symptoms that can be difficult for prison staff to manage….Yet, if trauma-informed principles are introduced, all staff can play a major role in minimizing triggers, stabilizing offenders, reducing critical incidents, deescalating situations, and avoiding restraint, seclusion or other measures that may repeat aspects of past abuse.

The Need for Training

Behavioral health service providers working with clients who have mental, substance use, and trauma-related disorders need to have the best knowledge, skills, and abilities. Substance abuse counselors, in particular, require additional training and skill development to be able to extend trauma-informed services (within the

Case Illustration: Larry

Larry is a 28-year-old clinical social worker who just finished his master's program in social work and is working in a trauma-informed outpatient program for people with substance use disorders. He is recovering from alcohol use disorder and previously worked in a residential rehabilitation program as a recovery support counselor. There, his primary responsibilities were to take residents to Alcoholics Anonymous (AA) meetings, monitor their participation, and confront them about their substance use issues and noncompliance with the program's requirement of attendance at 12-Step meetings.

In Larry's new position as a counselor, he confronts a client in his group regarding her discomfort with attending AA meetings. The client reports that she feels uncomfortable with the idea that she has to admit that she is powerless over alcohol to be accepted by the group of mostly men. She was sexually abused by her stepfather when she was a child and began drinking heavily and smoking pot when she was 11 years old. The client reacts angrily to Larry's intervention.

In supervision, Larry discusses his concerns regarding the client's resistance to AA and the feedback that he provided to her in group. Beyond focusing supervision on Larry's new role as a counselor in a trauma-informed program, the clinical supervisor recommends that Larry take an interactive, multisession, computer-assisted training on the 12-Step facilitation (TSF) model. The TSF model introduces clients to and assists them with engaging in 12-Step recovery support groups. The agency has the computer-based training available in the office, and Larry agrees to use follow-up coaching sessions with his supervisor to work on implementation of the approach. The supervisor recognizes that Larry is falling back on his own recovery experience and the strategies he relied on in his previous counseling role. He will benefit from further training and coaching in an evidence-based practice that provides a nonaggressive, focused, and structured way to facilitate participation in recovery support groups with clients who have trauma histories.

limits of their professional licensure and scope of practice) to clients who have co-occurring substance use, trauma-related, or mental disorders. Many clinical practice issues in traditional substance abuse treatment are inconsistent with trauma-informed practice, which needs to be addressed with further training. Similarly, mental health clinicians often need training in substance abuse treatment, as they typically do not have backgrounds or experience in that domain. Moreover, several surveys indicate that clinicians consistently perceive the combination of trauma and substance abuse as harder to treat than either one alone (Najavits, Norman, Kivlahan, & Kosten, 2010). It is thus key to emphasize cross-training as part of TIC. Exhibit 2.2-1 addresses these issues and offers suggestions for additional training.

Exhibit 2.2-1: Clinical Practice Issues Relevant to Counselor Training in Trauma-Informed Treatment Settings

- Some substance abuse counseling strategies commonly used to work through clients' denial and minimization of their substance use issues may be inappropriate when working with trauma survivors (e.g., highly confrontational models can remind trauma survivors of emotional abuse).

  Training: The Stages of Change model of addiction treatment can help counselors shift from the traditional confrontation of denial to conceptualizing clients' ambivalence about changing substance use patterns as a normal part of the precontemplation stage of change. This method is a respectful cognitive–behavioral approach that helps counselors match counseling strategies to their assessment of where each client is in each stage of change, with the ultimate goal of helping clients make changes to health risk behaviors. (Connors, Donovan, & DiClemente, 2001).

- The 12-Step concept of powerlessness (Step 1) may seem unhelpful to trauma survivors for whom the emotional reaction to powerlessness is a major part of their trauma (particularly for victims of repetitive trauma, such as child abuse or intimate partner violence). It can be confusing and counterproductive to dwell on this concept of powerlessness regarding trauma when the therapeutic objective for trauma-informed counseling methods should be to help clients empower themselves. For people in recovery, powerlessness is a paradox, sometimes misunderstood by both counselors and clients, in that the acknowledgment of powerlessness often creates a sense of empowerment. Most clients, with support and respectful guidance from a counselor, will come to understand that powerlessness (as used in 12-Step programs) is not an inability to stand up for oneself or express a need, and it does not mean for one to be powerless in the face of abuse. With this understanding, clients may become more open to participating in 12-Step groups as a resource for their recovery from substance use disorders. When clients continue to struggle with this concept and decline to participate in 12-Step recovery efforts, they may benefit from referral to other forms of mutual-help programs or recovery support groups in which the concept of powerlessness over the substance of abuse is not such a significant issue.

  Training: The TSF model can help counselors develop a more supportive and understanding approach to facilitating clients' involvement in 12-Step recovery groups (if this is a client-generated recovery goal). "Although based on standard counseling models, TSF differs from them in several ways. These differences include TSF's strong emphasis on therapist support, discouragement of aggressive 'confrontation of denial' and therapist self-disclosure, and highly focused and structured format" (Sholomskas & Carroll, 2006, p. 939).

  Another well-intentioned, but often misguided, approach by counselors who have not had formal or extensive training is "digging" for trauma memories without a clear therapeutic rationale or understanding of client readiness. In doing so, the counselor may unintentionally retraumatize the client or produce other harmful effects. In early intervention, it is sufficient simply to acknowledge and validate the pain and suffering of the client without uncovering or exploring specific trauma memories. The counselor who is insufficiently trained in trauma-informed clinical

(Continued on the next page.)

Exhibit 2.2-1: Clinical Practice Issues Relevant to Counselor Training in Trauma-Informed Treatment Settings (continued)

practice may also press agendas that are ultimately unhelpful, such as insisting that the client forgive an abuser, pursue a legal case against a perpetrator, or engage in trauma treatment, even when the client may not be ready for such steps. These efforts are particularly inappropriate for clients in early recovery from substance use disorders. The first goal in treatment is stabilization

Training: The Seeking Safety model of treating substance abuse and posttraumatic stress disorder (PTSD) can help counselors focus on the primary goal of stabilization and safety in TIC. This model emphasizes safety as the target goal, humanistic themes such as honesty and compassion, and making cognitive–behavioral therapy accessible and interesting to clients who may otherwise be difficult to engage (Najavits, 2002a).

- Treatment should be client-centered; it should acknowledge the client's right to refuse counseling for trauma-related issues. It is important to discuss the advantages and disadvantages of exploring trauma-related concerns, and then, following an open discussion, to allow clients the right to choose their path. This discussion should be part of the informed consent process at the start of treatment. Clients also have the right to change their minds.

  Training: Motivational interviewing, a client-centered, nonpathologizing counseling method, can aid clients in resolving ambivalence about and committing to changing health risk behaviors including substance use, eating disorders, self-injury, avoidant and aggressive behaviors associated with PTSD, suicidality, and medication compliance (Arkowitz, Miller, Westra, & Rollnick, 2008; Kress & Hoffman, 2008). Training in MI can help counselors remain focused on the client's agenda for change, discuss the pros and cons of treatment options, and emphasize the personal choice and autonomy of clients.

In addition to the training needs of substance abuse counselors, all direct care workers in mental health settings, community-based programs, crisis intervention settings, and criminal justice environments should receive training in TIC. Guidelines for training in assisting trauma-exposed populations are presented in Exhibit 2.2-2.

Continuing Education

Research on the effectiveness of single-session didactic and/or skill-building workshops

Exhibit 2.2-2: Guidelines for Training in Mental Health Interventions for Trauma-Exposed Populations

After a year of collaboration in 2002, the Task Force on International Trauma Training of the International Society for Traumatic Stress Studies published a consensus-based set of recommendations for training. Core curricular elements of the recommended training include:

- Competence in listening.
- Recognition of psychosocial and mental problems to promote appropriate assessment.
- Familiarity with established interventions in the client population.
- Full understanding of the local context, including help-seeking expectations, duration of treatment, attitudes toward intervention, cost-effectiveness of intervention, and family attitudes and involvement.
- Strategies for solving problems on the individual, family, and community levels.
- Treatment approaches for medically unexplained somatic pain.
- Collaboration with existing local resources and change agents (e.g., clergy, traditional healers, informal leaders).
- Self-care components.

Source: Weine et al., 2002.

Advice to Administrators: Trauma-Informed Staff Training

- Establish training standards for the evidence-based and promising trauma-informed practice models (such as Seeking Safety) adopted by your organization.
- Bring expert trainers with well-developed curricula in TIC and trauma-specific practices into your organization.
- Select a core group of clinical supervisors and senior counselors to attend multisession training or certification programs. These clinicians can then train the rest of the staff.
- Use sequenced, longitudinal training experiences instead of single-session seminars or workshops.
- Emphasize interactive and experiential learning activities over purely didactic training.
- Provide ongoing mentoring/coaching to behavioral health professionals in addition to regular clinical supervision to enhance compliance with the principles and practices of TIC and to foster counselor mastery of trauma-specific practice models.
- Build organization-wide support for the ongoing integration of new attitudes and counselor skills to sustain constructive, TIC-consistent changes in practice patterns.
- Provide adequate and ongoing training for clinical supervisors in the theory and practice of clinical supervision and the principles and practices of TIC.
- Include information and interactive exercises on how counselors can identify, prevent, and ameliorate secondary traumatic stress (STS) reactions in staff trainings.
- Offer cross-training opportunities to enhance knowledge of trauma-informed processes throughout the system.

demonstrates that immediate gains in counselor knowledge and skills diminish quickly after the training event (Martino, Canning-Ball, Carroll, & Rounsaville, 2011). Consequently, organizations may be spending their scarce financial resources on sending counselors to this kind of training but may not be reaping adequate returns with regard to long-lasting changes in counselor skills and the development of trauma-informed and trauma-specific counselor competencies. Hoge et al. (2007) suggest the implementation of training strategies for behavioral health professionals that have proven to be effective in improving counselor skills, attitudes, and practice approaches. These strategies include: "interactive approaches; sequenced, longitudinal learning experiences; outreach visits, known as academic detailing; auditing of practice with feedback to the learner; reminders; the use of opinion leaders to influence practice; and patient-mediated interventions, such as providing information on treatment options to persons in recovery, which in turn influences the practice patterns of their providers" (p. 124).

Trauma-Informed Counselor Competencies

Hoge et al. (2007) identified a number of counselor competencies in behavioral health practices that are consistent with the skills needed to be effective in a trauma-informed system of care. They include person-centered planning, culturally competent care, development of therapeutic alliances, shared responsibility for decisions, collaboratively developed recovery plans, evidence-based practices, recovery- and resilience-oriented care, interdisciplinary- and team-based practice, and consumer/client advocacy. In addition, counselor competencies critical to the effective delivery of services to clients with trauma-related disorders include:

- Screening for and assessment of trauma history and trauma-related disorders, such as mood and anxiety disorders.
- Awareness of differences between trauma-informed and trauma-specific services.

- Understanding the bidirectional relationships among substance use and mental disorders and trauma.
- Engagement in person-centered counseling.
- Competence in delivering trauma-informed and trauma-specific evidence-based interventions that lessen the symptoms associated with trauma and improve quality of life for clients.
- Awareness of and commitment to counselor self-care practices that prevent or lessen the impact of secondary traumatization on behavioral health workers.

Exhibit 2.2-3 provides a checklist of competencies for counselors working in trauma-informed behavioral health settings. Administrators and clinical supervisors can use this checklist to assess behavioral health professionals' understanding of trauma awareness and counseling skills and determine the need for additional training and clinical supervision.

Counselor Responsibilities and Ethics

Treating all clients in an ethical manner is an expectation of all healthcare providers. It is of special importance when working with clients who have trauma-related disorders, as their trust in others may have been severely shaken. Counselors who work with traumatized individuals on a regular basis have special responsibilities to their clients because of the nature of this work. Administrators and clinical supervisors in trauma-informed organizations should develop policies that clearly define the counselors' job and should provide education about the role of counselors in the organization and their responsibilities to clients.

General Principles Regarding Counselor Responsibilities

The following are some general principles governing the responsibilities of counselors who provide behavioral health services for clients with histories of trauma:

- Counselors are responsible for routinely screening clients for traumatic experiences and trauma-related symptoms (Ouimette & Brown, 2003; see also Treatment Improvement Protocol [TIP] 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders*, Center for Substance Abuse Treatment [CSAT], 2005c).
- Counselors should offer clients with substance use and trauma-related disorders continuing mental health services if it is within their professional license and scope of practice to do so.
- Counselors are responsible for referring clients with substance use disorders and co-occurring trauma-related disorders to treatment that addresses both disorders when the treatment falls outside of the counselor's professional license and scope of practice (Ouimette & Brown, 2003).
- Counselors should refer clients with substance use disorders and co-occurring trauma-related disorders to concurrent participation in mutual-help groups if appropriate (Ouimette & Brown, 2003).
- Counselors have a responsibility to practice the principles of confidentiality in all interactions with clients and to respect clients' wishes not to give up their right to privileged communication.
- Counselors are responsible for educating clients about the limits of confidentiality and what happens to protected health information, along with the client's privilege, when the client signs a release of information or agrees to assign insurance benefits to the provider.
- Counselors must inform clients that treatment for trauma-related disorders is always voluntary.
- Counselors are responsible for being aware of their own secondary trauma and

Exhibit 2.2-3: Trauma-Informed Counselor Competencies Checklist

Trauma Awareness

___ Understands the difference between trauma-informed and trauma-specific services

___ Understands the differences among various kinds of abuse and trauma, including: physical, emotional, and sexual abuse; domestic violence; experiences of war for both combat veterans and survivors of war; natural disasters; and community violence

___ Understands the different effects that various kinds of trauma have on human development and the development of psychological and substance use issues

___ Understands how protective factors, such as strong emotional connections to safe and nonjudgmental people and individual resilience, can prevent and ameliorate the negative impact trauma has on both human development and the development of psychological and substance use issues

___ Understands the importance of ensuring the physical and emotional safety of clients

___ Understands the importance of not engaging in behaviors, such as confrontation of substance use or other seemingly unhealthy client behaviors, that might activate trauma symptoms or acute stress reactions

___ Demonstrates knowledge of how trauma affects diverse people throughout their lifespans and with different mental health problems, cognitive and physical disabilities, and substance use issues

___ Demonstrates knowledge of the impact of trauma on diverse cultures with regard to the meanings various cultures attach to trauma and the attitudes they have regarding behavioral health treatment

___ Demonstrates knowledge of the variety of ways clients express stress reactions both behaviorally (e.g., avoidance, aggression, passivity) and psychologically/emotionally (e.g., hyperarousal, avoidance, intrusive memories)

Counseling Skills

___ Expedites client-directed choice and demonstrates a willingness to work within a mutually empowering (as opposed to a hierarchical) power structure in the therapeutic relationship

___ Maintains clarity of roles and boundaries in the therapeutic relationship

___ Demonstrates competence in screening and assessment of trauma history (within the bounds of his or her licensing and scope of practice), including knowledge of and practice with specific screening tools

___ Shows competence in screening and assessment of substance use disorders (within the bounds of his or her licensing and scope of practice), including knowledge of and practice with specific screening tools

___ Demonstrates an ability to identify clients' strengths, coping resources, and resilience

___ Facilitates collaborative treatment and recovery planning with an emphasis on personal choice and a focus on clients' goals and knowledge of what has previously worked for them

___ Respects clients' ways of managing stress reactions while supporting and facilitating taking risks to acquire different coping skills that are consistent with clients' values and preferred identity and way of being in the world

___ Demonstrates knowledge and skill in general trauma-informed counseling strategies, including, but not limited to, grounding techniques that manage dissociative experiences, cognitive–behavioral tools that focus on both anxiety reduction and distress tolerance, and stress management and relaxation tools that reduce hyperarousal

(Continued on the next page.)

Exhibit 2.2-3: Trauma-Informed Counselor Competencies Checklist (continued)

___ Identifies signs of STS reactions and takes steps to engage in appropriate self-care activities that lessen the impact of these reactions on clinical work with clients

___ Recognizes when the needs of clients are beyond his or her scope of practice and/or when clients' trauma material activates persistent secondary trauma or countertransference reactions that cannot be resolved in clinical supervision; makes appropriate referrals to other behavioral health professionals

Source: Abrahams et al., 2010.

countertransference reactions and seeking appropriate help in responding to these reactions so that they do not interfere with the best possible treatment for clients.

TIC organizations have responsibilities to clients in their care, including:

- Protecting client confidentiality, particularly in relation to clients' trauma histories. Organizations should comply with the State and Federal laws that protect the confidentiality of clients being treated for mental and substance use disorders.
- Providing clients with an easy-to-read statement of their rights as consumers of mental health and substance abuse services, including the right to confidentiality (Exhibit 2.2-4).
- Providing quality clinical supervision to all counselors and direct-service workers, with an emphasis on TIC. Organizations should, at minimum, comply with State licensing requirements for the provision of clinical supervision to behavioral health workers.
- Establishing and maintaining appropriate guidelines and boundaries for client and counselor behavior in the program setting.
- Creating and maintaining a trauma-informed treatment environment that respects the clients' right to self-determination and need to be treated with dignity and respect.
- Maintaining a work environment that reinforces and supports counselor self-care.

All behavioral health professionals are responsible for abiding by professional standards of care that protect the client. Breaches of confidentiality, inappropriate conduct, and other violations of trust can do further harm to clients who already have histories of trauma. Many treatment facilities have a Client Bill of Rights (or a similar document) that describes the rights and responsibilities of both the counselors and the participants; it often is part of the orientation and informed consent process when a client enters treatment. However, simply reading and acknowledging the receipt of a piece of paper is not a substitute for the dialog that needs to happen in a collaborative therapeutic partnership. Administrators are responsible for providing clients with easy-to-read information describing counselor responsibilities and client rights. Clinical supervisors are responsible for helping counselors engage in a respectful dialog with clients about those rights and responsibilities as part of a comprehensive informed consent process.

Exhibit 2.2-4 is an excerpt from a Client Bill of Rights that outlines clients' right to confidentiality in plain language that is readable and easily understood.

Exhibit 2.2-4: Sample Statement of the Client's Right to Confidentiality From a Client Bill of Rights

Tri-County Mental Health Services is a trauma-informed mental health and substance abuse treatment agency in Maine. Below is a statement regarding clients' right to confidentiality and staff responsibility to protect that privilege; this statement is provided in a brochure outlining consumer rights that is easily accessible to service recipients at the agency and online.

Confidentiality

We will not give out information about you to anyone without your knowledge and permission. This includes written information from your record and verbal information from your providers. Additionally, we will not request any information about you without your knowledge and permission. A Release of Information Form allows you to say what information can be shared and with whom. You determine the length of time this is valid, up to one year.

Tri-County policies prevent any employee of the agency who does not have a direct need to know from having access to any information about you. The penalty for violation can include immediate dismissal.

Exceptions to this rule of confidentiality include times when a client is at immediate risk of harm to self or others, or when ordered by the court. We will make every effort to notify you in these instances.

Source: Tri-County Mental Health Services, 2008, pp. 6-7.

Ethics in Treating Traumatized Clients

All behavioral health professionals must conform to the ethical guidelines established by their profession's State licensing boards and/or certifying organizations. State licensing boards for substance abuse counseling, psychiatry, social work, psychology, professional counseling, and other behavioral health professions provide regulatory standards for ethical practice in these professions. These boards also have specific procedures for responding to complaints regarding the actions of professional caregivers. Additionally, national professional societies have standards for ethical practices. Members of these organizations are expected to practice within the boundaries and scope of these standards. Some of these standards are quite explicit, whereas others are more general; most approach professional ethics not as a rigid set of rules, but rather, as a process of making ethical decisions.

Clinical supervisors are responsible for informing counselors of their ethical responsibilities with regard to their own organization's policies and procedures, monitoring supervisees' reading and understanding the codes of ethics of professional organizations and State licensing boards, and promoting counselor understanding of ethics and how to make decisions ethically as a regular part of clinical supervision, team meetings, and counselor training. Administrators can support high ethical standards by creating an organization-wide ethics task group consisting of counselors, supervisors, and administrators who meet regularly to review and revise clinical policies in line with State and Federal law and professional codes of ethics. Administrators may also act as a support mechanism for counselors who need additional consultation regarding potential ethical dilemmas with clients. The Green Cross Academy of Traumatology provides ethical guidelines for the treatment of clients who have experienced trauma; these guidelines are adapted in Exhibit 2.2-5.

Exhibit 2.2-5: Green Cross Academy of Traumatology Ethical Guidelines for the Treatment of Clients Who Have Been Traumatized

Respect for the dignity of clients

- Recognize and value the personal, social, spiritual, and cultural diversity present in society, without judgment. As a primary ethical commitment, make every effort to provide interventions with respect for the dignity of those served.

Responsible caring

- Take the utmost care to ensure that interventions do no harm.
- Have a commitment to the care of those served until the need for care ends or the responsibility for care is accepted by another qualified service provider.
- Support colleagues in their work and respond promptly to their requests for help.
- Recognize that service to survivors of trauma can exact a toll in stress on providers. Maintain vigilance for signs in self and colleagues of such stress effects, and accept that dedication to the service of others imposes an obligation to sufficient self-care to prevent impaired functioning.
- Engage in continuing education in the appropriate areas of trauma response. Remain current in the field and ensure that interventions meet current standards of care.

Integrity in relationships

- Clearly and accurately represent your training, competence, and credentials. Limit your practice to methods and problems for which you are appropriately trained and qualified. Readily refer to or consult with colleagues who have appropriate expertise; support requests for such referrals or consultations from clients.
- Maintain a commitment to confidentiality, ensuring that the rights of confidentiality and privacy are maintained for all clients.
- Do not provide professional services to people with whom you already have either emotional ties or extraneous relationships of responsibility. The one exception is in the event of an emergency in which no other qualified person is available.
- Refrain from entering other relationships with present or former clients, especially sexual relationships or relationships that normally entail accountability.
- Within agencies, ensure that confidentiality is consistent with organizational policies; explicitly inform individuals of the legal limits of confidentiality.

Responsibility to society

- Be committed to responding to the needs generated by traumatic events, not only at the individual level, but also at the level of community and community organizations in ways that are consistent with your qualifications, training, and competence.
- Recognize that professions exist by virtue of societal charters in expectation of their functioning as socially valuable resources. Seek to educate government agencies and consumer groups about your expertise, services, and standards; support efforts by these agencies and groups to ensure social benefit and consumer protection.
- If you become aware of activities of colleagues that may indicate ethical violations or impairment of functioning, seek first to resolve the matter through direct expression of concern and offers of help to those colleagues. Failing a satisfactory resolution in this manner, bring the matter to the attention of the officers of professional societies and of governments with jurisdiction over professional misconduct.

Clients' universal rights

All clients have the right to:

- Not be judged for any behaviors they used to cope, either at the time of the trauma or after the trauma.
- Be treated at all times with respect, dignity, and concern for their well-being.
- Refuse treatment, unless failure to receive treatment places them at risk of harm to self or others.

(Continued on the next page.)

Exhibit 2.2-5: Academy of Traumatology Ethical Guidelines for the Treatment of Clients Who Have Been Traumatized (continued)

- Be regarded as collaborators in their own treatment plans.
- Provide their informed consent before receiving any treatment.
- Not be discriminated against based on race, culture, sex, religion, sexual orientation, socioeconomic status, disability, or age.
- Have promises kept, particularly regarding issues related to the treatment contract, role of counselor, and program rules and expectations.

Procedures for introducing clients to treatment

Obtain informed consent, providing clients with information on what they can expect while receiving professional services. In addition to general information provided to all new clients, clients presenting for treatment who have histories of trauma should also receive information on:

- The possible short-term and long-term effects of trauma treatment on the client and the client's relationships with others.
- The amount of distress typically experienced with any particular trauma treatment.
- Possible negative effects of a particular trauma treatment.
- The possibility of lapses and relapses when doing trauma work, and the fact that these are a normal and expected part of healing.

Reaching counseling goals through consensus

Collaborate with clients in the design of a clearly defined contract that articulates a specific goal in a specific time period or a contract that allows for a more open-ended process with periodic evaluations of progress and goals.

Informing clients about the healing process

- Clearly explain to clients the nature of the healing process, making sure clients understand.
- Encourage clients to ask questions about any and all aspects of treatment and the therapeutic relationship. Provide clients with answers in a manner they can understand.
- Encourage clients to inform you if the material discussed becomes overwhelming or intolerable.
- Inform clients of the necessity of contacting you or emergency services if they feel suicidal or homicidal, are at risk of self-injury, or have a sense of being out of touch with reality.
- Give clients written contact information about available crisis or emergency services.
- Inform clients about what constitutes growth and recovery and about the fact that some trauma symptoms may not be fully treatable.
- Address unrealistic expectations clients may have about counseling and/or the recovery process.

Level of functioning

- Inform clients that they may not be able to function at the highest level of their ability—or even at their usual level—when working with traumatic material.
- Prepare clients to experience trauma-related symptoms, such as intrusive memories, dissociative reactions, reexperiencing, avoidance behaviors, hypervigilance, or unusual emotional reactivity.

Source: Green Cross Academy of Traumatology, 2007. Adapted with permission.

Boundaries in therapeutic relationships

Maintaining appropriate therapeutic boundaries is a primary ethical concern for behavioral health professionals. Counselors working with clients who have substance use, trauma-related, and other mental disorders may feel challenged at times to maintain boundaries that create a safe therapeutic container. Some clients, especially those with longstanding disorders, bring a history of client–counselor relationships to counseling. Clients who have been traumatized may need help understanding the roles and responsibilities of both the counselor and the client. Clients with trauma-related conditions may also have special needs

Advice to Clinical Supervisors: Recognizing Boundary Confusion

Clinical supervisors should be aware of the following counselor behaviors that can indicate boundary confusion with clients:

- The counselor feels reluctant or embarrassed to discuss specific interactions with a client or details of the client's treatment in supervision or team meetings.
- The counselor feels possessive of the client, advocates with unusual and excessive vehemence for the client, or expresses an unreasonable sense of overresponsibility for the client.
- The counselor becomes defensive and closed to hearing ideas from the supervisor or the treatment team members about approaches to working with a client and/or exploring his or her own emotional reactions to a client.
- The clinician begins or increases personal self-disclosure to the client and is not able to identify legitimate clinical reasons for the self-disclosure.

in establishing appropriate boundaries in the counseling setting; they may be particularly vulnerable and not understand or appreciate the need for professional boundaries, including not engaging in dual relationships. For example, some clients might experience a counselor's boundary around not giving the client his or her personal phone number for emergency calls as a rejection or abandonment. Cultural considerations also influence therapeutic boundaries.

Administrators, in collaboration with clinical supervisors, are responsible for creating policies regarding counselor and client boundaries for various issues (e.g., giving and receiving gifts, counselor personal disclosure, and counselor roles and responsibilities when attending the same 12-Step meetings as clients); policies should be specific to their organization and conform to State and Federal law and behavioral health professional codes of ethics. Clinical supervisors are responsible for training counselors in the informed consent process and effective ways to discuss boundaries with clients when they enter treatment.

Guidelines for establishing and maintaining boundaries in therapeutic relationships, adapted from the Green Cross Academy of Traumatology, are given in Exhibit 2.2-6.

Clients with trauma histories may be especially vulnerable to counselor behaviors that are inconsistent or that are experienced by the client as boundary violations. Examples of such behavior include: being late for appointments, ending counseling sessions early, repeatedly and excessively extending the session time, canceling or "forgetting" appointments multiple times, spending time in the session talking about their own needs and life experiences, exploring opportunities for contact outside the therapeutic relationship (including making arrangements to meet at AA or other 12-Step recovery group meetings), and enforcing rules differently for one client than for another.

Due to the complex dynamics that can arise in the treatment of clients with trauma histories, regularly scheduled clinical supervision, where issues of ethics and boundaries can be discussed, is recommended for counselors. For more information on how clinical supervision can be effectively used, see TIP 52, *Clinical Supervision and the Professional Development of the Substance Abuse Counselor* (CSAT, 2009b).

Boundary crossing and boundary violation

Although guidelines and codes of ethics are useful tools in helping clinical supervisors and counselors understand the boundaries between counselors and clients, they are open to interpretation and are context-bound. Given these limitations, it is crucial to educate counselors

Exhibit 2.2-6: Boundaries in Therapeutic Relationships

Procedures for Establishing Safety

Roles and boundaries
Counselor roles and boundaries should be established at the start of the counseling relationship and reinforced periodically, particularly at times when the client is experiencing high stress.

Ongoing Relationships and the Issue of Boundaries

Dual relationships
Dual relationships and inappropriate interactions with clients are to be avoided. It is important to tell clients at the beginning of counseling that contact between the counselor and the client can only occur within the boundaries of the professional relationship. This information is part of the informed consent process. Relationships outside these boundaries include sexual or romantic relationships, a counselor also serving as a client's sponsor in 12-Step programs, and any kind of relationship in which the counselor exploits the client for financial gain.

Sexual contact
- Never engage in any form of sexual contact with clients.
- Do not reward sexualized behaviors with attention or reactivity.
- Directly clarify the boundaries of the therapeutic relationship, and address the underlying motivations of persisting sexualized behavior.
- Set limits on a client's inappropriate behaviors while maintaining an ethos of care. Maintain respect for the dignity and worth of the client at all times.
- Understand that a client's attempt to sexualize a therapeutic relationship may reflect an early history of abuse, difficulty understanding social norms, or a variety of psychological problems.
- Readdress the absolute inappropriateness of sexual and/or romantic behavior in a nonlecturing, nonpunitive manner.
- If sexual behavior between clients occurs in a treatment program, counselors should consult with a clinical supervisor. Document the nature of the contact and how the issue is addressed.
- If a counselor has sexual contact with a client, he or she should take responsibility by ceasing counseling practice, referring clients to other treatment providers, and notifying legal and professional authorities. If a counselor is at risk for engaging with a client sexually but has not acted on it, the counselor should immediately consult with a supervisor, colleague, or psychotherapist.

Boundaries
Counselors should use care with self-disclosure or any behaviors that may be experienced as intrusive by the client, including:
- Personal disclosures made for the counselor's own gratification.
- Sexualized behavior with the client.
- Excessively intrusive questions or statements.
- Interrupting the client frequently.
- Violating the client's personal space.
- Interpersonal touch, which might activate intrusive memories or dissociative reactions or be experienced as a boundary violation by the client.
- Being consistently late for appointments or allowing outside influences (such as telephone calls) to interrupt the client's time in a counseling session.

Source: Green Cross Academy of Traumatology, 2007. Adapted with permission.

in TIC settings regarding the boundary issues that may arise for clients who have been traumatized and to give counselors a conceptual framework for understanding the contextual nature of boundaries. For example, it would be useful for clinical supervisors to discuss with

counselors the distinction between boundary crossings and boundary violations in clinical practice. Gutheil and Brodsky (2008) define boundary crossing as a departure from the customary norms of counseling practice in relation to psychological, physical, or social space "that are harmless, are nonexploitative, and may even support or advance the therapy" (p. 20). Examples of boundary crossings include taking phone calls from a client between sessions if the client is in crisis or telling a client a story about the counselor's recovery from trauma (without offering specific personal information or graphic/detailed description of the trauma) with the intention of offering hope that it is possible to recover.

Gutheil and Brodsky (2008) define boundary violations as boundary crossings that are unwanted and dangerous and which exploit the client, stating that "some boundary crossings are inadvisable because of their intent (i.e., they are not done in the service of the patient's well-being and growth, involve extra therapeutic gratification for the therapist) and/or their effect (i.e., they are not likely to benefit the patient and entail a significant risk of harming the patient)" (pp. 20–21). An example of a boundary violation would be when a counselor invites a client to attend the same AA meetings the counselor attends or shares drinking and drugging "war stories" for the counselor's own gratification. Two key elements in understanding when a boundary crossing becomes a boundary violation are the intent of the counselor and the damaging effect on the client. Maintaining a standard of practice of nonexploitation of the client is the primary focus for clinical supervisors and counselors in determining when boundary crossings become boundary violations.

Context is also an important consideration in determining the acceptability of boundary crossings. For example, it may be acceptable for a counselor in a partial hospitalization program for serious mental illness to have a cup of coffee at the kitchen table with a resident, whereas for a counselor in an outpatient mental health program, having a cup of coffee with a client at the local coffee shop would be a much more questionable boundary crossing.

Case Illustration: Denise

Denise is a 40-year-old licensed professional counselor working in an inpatient eating disorder program. She has had extensive training in trauma and eating disorder counseling approaches and has been working as a clinician in mental health settings for 15 years. Denise is usually open to suggestions from her supervisor and other treatment team members about specific strategies to use with clients who have trauma histories and eating disorders. However, in the past week, her supervisor has noticed that she has become defensive in team meetings and individual supervision when discussing a recently admitted young adult who was beaten and raped by her boyfriend; subsequently, the client was diagnosed with PTSD and anorexia. When the clinical supervisor makes note of the change in Denise's attitude and behavior in team meetings since this young woman was admitted, initially Denise becomes defensive, saying that the team just doesn't understand this young woman and that the client has repeatedly told Denise, "You're the only counselor I trust."

The clinical supervisor recognizes that Denise may be experiencing secondary traumatization and boundary confusion due to working with this young woman and to the recent increase in the number of clients with co-occurring trauma-related disorders on her caseload. After further exploration, Denise reveals that her own daughter was raped at the same age as the young woman and that hearing her story has activated an STS reaction in Denise. Her way of coping has been to become overly responsible for and overprotective of the young woman. With the nonjudgmental support of her supervisor, Denise is able to gain perspective, recognize that this young woman is not her daughter, and reestablish boundaries with her that are appropriate to the inpatient treatment setting.

Clinical Supervision and Consultation

Organizational change toward a TIC model doesn't happen in isolation. Ongoing support, supervision, and consultation are key ingredients that reinforce behavioral health professionals' training in trauma-informed and trauma-specific counseling methods and ensure compliance with practice standards and consistency over time. Often, considerable energy and resources are spent on the transition to new clinical and programmatic approaches, but without long-range planning to support those changes over time. The new treatment approach fades quickly, making it hard to recognize and lessening its reliability.

Advice to Clinical Supervisors and Administrators: Adopting an Evidence-Based Model of Clinical Supervision and Training

Just as adopting evidence-based clinical practices in a trauma-informed organization is important in providing cost-effective and outcome-relevant services to clients, adopting an evidence-based model of clinical supervision and training clinical supervisors in that model can enhance the quality and effectiveness of clinical supervision for counselors. This will ultimately enhance client care.

One of the most commonly used and researched integrative models of supervision is the discrimination model, originally published by Janine Bernard in 1979 and since updated (Bernard & Goodyear, 2009). This model is considered a competence-based and social role model of supervision; it includes three areas of focus on counselor competencies (intervention, conceptualization, and personalization) and three possible supervisor roles (teacher, counselor, and consultant).

Counselor competencies:

- Intervention: The supervisor focuses on the supervisee's intervention skills and counseling strategies used with a particular client in a given session.
- Conceptualization: The supervisor focuses on how the supervisee understands what is happening in a session with the client.
- Personalization: The supervisor focuses on the personal style of the counselor and countertransference responses (i.e., personal reactions) of the counselor to the client.

Supervisor roles:

- Teacher: The supervisor teaches the supervisee specific counseling theory and skills and guides the supervisee in the use of specific counseling strategies in sessions with clients. The supervisor as teacher is generally task-oriented. The supervisor is more likely to act as a teacher with beginning counselors.
- Counselor: The supervisor does not act as the counselor's therapist, but helps the counselor reflect on his or her counseling style and personal reactions to specific clients. The supervisor as counselor is interpersonally sensitive and focuses on the process and relational aspects of counseling.
- Consultant: The supervisor is more of a guide, offering the supervisee advice on specific clinical situations. The supervisor as consultant invites the counselor to identify topics and set the agenda for the supervision. The supervisor is more likely to act as a consultant with more advanced counselors.

This model of supervision may be particularly useful in working with counselors in TIC settings, because the supervisor's response to the supervisee is flexible and specific to the supervisee's needs. In essence, it is a counselor-centered model of supervision in which the supervisor can meet the most relevant needs of the supervisee in any given moment.

For a review of other theories and methods of clinical supervision, refer to TIP 52, *Clinical Supervision and Professional Development of the Substance Abuse Counselor* (CSAT, 2009b).

Ongoing supervision and consultation supports the organizational message that TIC is the standard of practice. It normalizes secondary traumatization as a systemic issue (not the individual pathology of the counselor) and reinforces the need for counselor self-care to prevent and lessen the impact of secondary traumatization. Quality clinical supervision for direct care staff demonstrates the organization's commitment to implementing a fully integrated, trauma-informed system of care.

Supervision and Consultation

Historically, there was an administrative belief that counselors who had extensive clinical experience and training would naturally be the best clinical supervisors. However, research does not support this idea (Falender & Shafranske, 2004). Although a competent clinical supervisor needs to have an extensive clinical background in the treatment of substance use, trauma-related, and other mental disorders, it is also essential for any counselor moving into a supervisory role to have extensive training in the theory and practice of clinical supervision before taking on this role. In particular, clinical supervisors in trauma-informed behavioral health settings should be educated in how to perform clinical supervision (not just administrative supervision) of direct service staff and in the importance of providing continuous clinical supervision and support for staff members working with individuals affected by trauma. Clinical

Case Illustration: Arlene

Arlene is a 50-year-old licensed substance abuse counselor who has a personal history of trauma, and she is actively engaged in her own recovery from trauma. She is an experienced counselor who has several years of training in trauma-informed and trauma-specific counseling practices. Her clinical supervisor, acting in the role of consultant, begins the supervision session by inviting her to set the agenda. Arlene brings up a clinical situation in which she feels stuck with a client who is acting out in her Seeking Safety group (for more information on Seeking Safety, see Najavits, 2002a).

Arlene reports that her client gets up suddenly and storms out of the group room two or three times during the session. The supervisor, acting in the role of the counselor and focusing on personalization, asks Arlene to reflect on the client's behavior and what feelings are activated in her in response to the client's anger. Arlene is able to identify her own experience of hyperarousal and then paralysis as a stress reaction related to her prior experience of domestic violence in her first marriage. The supervisor, acting in the role of teacher and focusing on conceptualization, reminds Arlene that her client is experiencing a "fight-or-flight" response to some experience in the group that reminds her of her own trauma experience. The supervisor then suggests to Arlene that her own reactions are normal responses to her previous history of trauma, and that when her client is angry, Arlene is not reexperiencing her own trauma but is being activated by the client's traumatic stress reaction to being in group. In this way, the supervisor highlights the parallel process of the client–counselor's stress reactions to a perceived threat based on prior trauma experiences.

The supervisor, acting again as a consultant and focusing on personalization this time, invites Arlene to reflect on the internal and external resources she might be able to bring to this situation that will help remind her to ground herself so she can lessen the impact of her stress reactions on her counseling strategy with this client. Arlene states that she can create a list of safe people in her life and place this list in her pocket before group. She can use this list as a touchstone to remind her that she is safe and has learned many recovery skills that can help her stay grounded, maintain her boundaries, and deal with her client's behavior. The clinical supervisor, acting as a consultant and now focusing on intervention, asks Arlene if she has some specific ideas about how she can address the client's behavior in group. Arlene and the clinical supervisor spend the remainder of the session discussing different options for addressing the client's behavior and helping her feel safer in group.

supervision in a TIC organization should focus on the following priorities:

- General case consultation
- Specialized consultation in specific and unusual cases
- Opportunities to process clients' traumatic material
- Boundaries in the therapeutic and supervisory relationship
- Assessment of secondary traumatization
- Counselor self-care and stress management
- Personal growth and professional development of the counselor

Supervision of counselors working with traumatized clients should be regularly scheduled, with identified goals and with a supervisor who is trained and experienced in working with trauma survivors. The styles and types of supervision and consultation may vary according to the kind of trauma work and its context. For instance, trauma counseling in a major natural disaster would require a different approach to supervision and consultation than would counseling adults who experienced childhood developmental trauma or counseling clients in an intensive early recovery treatment program using a manualized trauma-specific counseling protocol.

Competence-based clinical supervision is recommended for trauma-informed organizations. Competence-based clinical supervision models identify the knowledge and clinical skills each counselor needs to master, and they use targeted learning strategies and evaluation procedures, such as direct observation of counselor sessions with clients, individualized coaching, and performance-based feedback. Studies on competence-based supervision approaches have demonstrated that these models improve counselor treatment skills and proficiency (Martino et al., 2011).

Whichever model of clinical supervision an organization adopts, the key to successful trauma-informed clinical supervision is the recognition that interactions between the supervisor and the counselor may parallel those between the counselor and the client. Clinical supervisors need to recognize counselors' trauma reactions (whether they are primary or secondary to the work with survivors of trauma) and understand that a confrontational or punitive approach will be ineffective and likely retraumatize counselors.

Clinical supervisors should adopt a respectful and collaborative working relationship with counselors in which role expectations are clearly defined in an informed consent process similar to that used in the beginning of the counselor–client relationship and in which exploring the nature of boundaries in both client–counselor and counselor–supervisor relationships is standard practice. Clear role boundaries, performance expectations, open dialog, and supervisor transparency can go a long way toward creating a safe and respectful relationship container for the supervisor and supervisee and set the stage for a mutually enhancing, collaborative relationship. This respectful, collaborative supervisory relationship is the main source of training and professional growth for the counselor and for the provision of quality care to people with behavioral health disorders.

Secondary Traumatization

The demands of caregiving exact a price from behavioral health professionals that cannot be ignored; otherwise, they may become ineffective in their jobs or, worse, emotionally or psychologically impaired. In a study of Master's level licensed social workers, 15.2 percent of respondents to a survey reported STS as a result of indirect exposure to trauma material at a level that meets the diagnostic criteria for PTSD. This rate is almost twice the rate of PTSD in the general population. The author

STS is a trauma related stress reaction and set of symptoms resulting from exposure to another individual's traumatic experiences rather than from exposure directly to a traumatic event.

concluded that behavioral health professionals' experience of STS is a contributing factor in staff turnover and one reason why many behavioral health service professionals leave the field (Bride, 2007). Secondary traumatization of behavioral health workers is a significant organizational issue for clinical supervisors and administrators in substance abuse and mental health treatment programs to address.

To prevent or lessen the impact of secondary traumatization on behavioral health professionals, clinical supervisors and administrators need to understand secondary trauma from the ecological perspective described in Part 1, Chapter 1 of this TIP. The organization itself creates a social context with risk factors that can increase the likelihood of counselors experiencing STS reactions, but it also contains protective factors that can lessen the risk and impact of STS reactions on staff members. Organizations can lessen the impact of the risk factors associated with working in trauma-informed organizations by mixing caseloads to contain clients both with and without trauma-related issues, supporting ongoing counselor training, providing regular clinical supervision, recognizing counselors' efforts, and offering an empowering work environment in which counselors share in the responsibility of making decisions and can offer input into clinical and program policies that affect their work lives.

When organizations support their counselors in their work with clients who are traumatized, counselors can be more effective, more productive, and feel greater personal and professional satisfaction. In addition, counselors develop a sense of allegiance toward the organization, thus decreasing staff turnover. If organizations do not provide this support, counselors can become demoralized and have fewer emotional and psychological resources to manage the impact of clients' traumatic material and outward behavioral expressions of trauma on their own well-being. Providing counselors with the resources to help them build resilience and prevent feeling overwhelmed should be a high priority for administrators and clinical supervisors in TIC organizations.

Risk and Protective Factors Associated With Secondary Traumatization

Clinical and research literature on trauma describes a number of factors related to the development of secondary trauma reactions and psychological distress in behavioral health professionals across a wide range of practice settings, as well as individual and organizational factors that can prevent or lessen the impact of STS on staff. The risk and protective factors model of understanding secondary trauma is based on the ecological perspective

Advice to Clinical Supervisors: Recognizing Secondary Traumatization

Some counselor behaviors that demonstrate inconsistency to clients may be outward manifestations of secondary traumatization, and they should be discussed with counselors through a trauma-informed lens. It is imperative that clinical supervisors provide a nonjudgmental, safe context in which counselors can discuss these behaviors without fear of reprisal or reprimand. Clinical supervisors should work collaboratively with supervisees to help them understand their behavior and engage in self-care activities that lessen the stress that may be contributing to these behaviors.

outlined in Part 1, Chapter 1 of this TIP. The terms "compassion fatigue," "vicarious traumatization," "secondary traumatization," and "burnout" are used in the literature, sometimes interchangeably and sometimes as distinct constructs. As stated in the terminology portion of the "How This TIP Is Organized" section that precedes Part 1, Chapter 1, of this TIP, the term "secondary traumatization" refers to traumatic stress reactions and psychological distress from exposure to another individual's traumatic experiences; this term will be used throughout this section, although the studies cited may use other terms.

Risk factors

Individual risk factors that may contribute to the development of STS in behavioral health professionals include preexisting anxiety or mood disorders; a prior history of personal trauma; high caseloads of clients with trauma-related disorders; being younger in age and new to the field with little clinical experience or training in treating trauma-related conditions; unhealthy coping styles, including distancing and detachment from clients and co-workers; and a lack of tolerance for strong emotions (Newall & MacNeil, 2010). Other negative coping strategies include substance abuse, other addictive behaviors, a lack of recreational activities not related to work, and a lack of engagement with social support. A recent study of trauma nurses found that low use of support systems, use of substances, and a lack of hobbies were among the coping strategies that differed between nurses with and without STS (Von Rueden et al., 2010). Other researchers found that clinicians who engaged in negative coping strategies, such as alcohol and illicit drug use, were more likely to experience intrusive trauma symptoms (Way, Van Deusen, Martin, Applegate, & Janle, 2004).

Numerous organizational factors can contribute to the development of STS in counselors who work with clients with trauma-related disorders. These risk factors include organizational constraints, such as lack of resources for clients, lack of clinical supervision for counselors, lack of support from colleagues, and lack of acknowledgment by the organizational culture that secondary traumatization exists and is a normal reaction of counselors to client trauma (Newall & MacNeil, 2010). In a study of 259 individuals providing mental health counseling services, counselors who spent more time in session with clients with trauma-related disorders reported higher levels of traumatic stress symptoms (Bober & Regehr, 2006). Counselors may be more at risk for developing secondary traumatization if the organization does not allow for balancing the distribution of trauma and nontrauma cases amongst staff members.

Protective factors

Much of the clinical and research literature focuses on individual factors that may lessen the impact of STS on behavioral health professionals, including male gender, being older, having more years of professional experience,

Advice to Clinical Supervisors: Recognizing STS in Counselors Who Are In Recovery

For counselors who are in recovery from a substance use or mental disorder, the development of STS may be a potential relapse concern. As Burke, Carruth, and Prichard (2006) point out, "a return to drinking or illicit drug use as a strategy for dealing with secondary trauma reactions would have a profoundly detrimental effect on the recovering counselor" (p. 292). So too, secondary trauma may ignite the reappearance of depressive or anxiety symptoms associated with a previous mental disorder. Clinical supervisors can address these risk factors with counselors and support them in engaging with their own recovery support network (which might include a peer support group or an individual counselor) to develop a relapse prevention plan.

having specialized training in trauma-informed and trauma-specific counseling practices, lacking a personal trauma history, exhibiting personal autonomy in the workplace, using positive personal coping styles, and possessing resilience or the ability to find meaning in stressful life events and to rebound from adversity (Sprang, Clark, & Whitt-Woosley, 2007). Some of these factors, like positive personal coping styles and the ability to find meaning in adversity, can be developed and enhanced through personal growth work, psychotherapy, engagement with spiritual practices and involvement in the spiritual community, and stress reduction strategies like mindfulness meditation. A recent multimethod study of an 8-week workplace mindfulness training group for social workers and other social service workers found that mindfulness meditation increased coping strategies, reduced stress, and enhanced self-care of the participants; findings suggested that workers were more likely to practice stress management techniques like mindfulness at their place of work than at home (McGarrigle & Walsh, 2011). Organizations can support counselors' individual efforts to enhance positive personal coping styles, find meaning in adversity, and reduce stress by providing time for workers during the workday for personal self-care activities, like mindfulness meditation and other stress reduction practices.

One of the organizational protective factors identified in the literature that may lessen the negative impact of secondary traumatization on behavioral health professionals is providing adequate training in trauma-specific counseling strategies, which increases providers' sense of efficacy in helping clients with trauma-related disorders and reduces the sense of hopelessness that is often a part of the work (Bober & Regehr 2006). One study found that specialized trauma training enhanced job satisfaction and reduced levels of compassion fatigue, suggesting that "knowledge and training might provide some protection against the deleterious effects of trauma exposure" (Sprang et al., 2007, p. 272). Another protective factor that may lessen the chances of developing secondary traumatization is having a diverse caseload of clients. Organizations "must determine ways of distributing workload in order to limit the traumatic exposure of any one worker. This may not only serve to reduce the impact of immediate symptoms but may also address the potential longitudinal effects" (Bober & Regehr, 2006, p. 8).

Emotional support from professional colleagues can be a protective factor. A study of substance abuse counselors working with clients who were HIV positive found that workplace support from colleagues and supervisors most effectively prevented burnout (Shoptaw, Stein, & Rawson, 2000). This support was associated with less emotional fatigue and depersonalization, along with a sense of greater personal accomplishment. In a study of domestic violence advocates, workers who received more support from professional peers were less likely to experience secondary traumatization (Slattery & Goodman, 2009).

In addition, counselor engagement in relationally based clinical supervision with a trauma-informed supervisor acts as a protective agent. Slattery and Goodman (2009) note that "for the trauma worker, good supervision can normalize the feelings and experiences, provide support and information about the nature and course of the traumatic reaction, help in the identification of transference and countertransference issues, and reveal feelings or symptoms associated with the trauma" (p. 1362). Workers who reported "engaging, authentic, and empowering relationships with their supervisors" were less likely to experience STS (p. 1369). Thus, it is not simply the frequency and regularity of clinical supervision,

but also the quality of the supervision and the quality of the supervisor–counselor relationship that can lessen the impact of STS on behavioral health professionals.

Engagement with a personal practice of spirituality that provides a sense of connection to a larger perspective and meaning in life is another protective factor that can lessen the impact of STS on counselors (Trippany, Kress, & Wilcoxon, 2004). Although recovering counselors may look to support groups for connection to a spiritual community, other behavioral health professionals might find support for enhancing spiritual meaning and connection in church, a meditation group, creative endeavors, or even volunteer work. The key is for counselors to develop their own unique resources and practices to enhance a sense of meaningful spirituality in their lives. Clinical supervisors should be aware of spiritual engagement as a protective factor in preventing and lessening the impact of STS and should support clinicians in including it in their self-care plans, but they should take care not to promote or reject any particular religious belief system or spiritual practice.

Another protective factor that may lessen the impact of workers' STS is a culture of empowerment in the organization that offers counselors a sense of autonomy, a greater ability to participate in making decisions about clinical and organizational policies, and obtaining support and resources that further their professional development. Slattery & Goodman (2009) surveyed 148 domestic violence advocates working in a range of settings. The authors found that those workers "who reported a high level of shared power were less likely to report posttraumatic stress symptoms, despite their own personal abuse history or degree of exposure to trauma" (p. 1370). To the degree that organizations can provide a cultural context within which behavioral health professionals have autonomy and feel empowered, they will be able to lessen the impact of STS on their professional and personal lives. Self-efficacy and empowerment are antidotes to the experience of powerlessness that often accompanies trauma.

Strategies for Preventing Secondary Traumatization

The key to prevention of secondary traumatization for behavioral health professionals in a trauma-informed organization is to reduce risk and enhance protective factors. Organizational strategies to prevent secondary traumatization include:

- Normalize STS throughout all levels of the organization as a way to help counselors feel safe and respected, enhancing the likelihood that they will talk openly about their experiences in team meetings, peer supervision, and clinical supervision.
- Implement clinical workload policies and practices that maintain reasonable standards for direct-care hours and emphasize balancing trauma-related and nontrauma-related counselor caseloads.
- Increase the availability of opportunities for supportive professional relationships by promoting activities such as team meetings, peer supervision groups, staff retreats, and counselor training that focuses on understanding secondary traumatization and self-care. Administrators and clinical supervisors should provide time at work for counselors to engage in these activities.
- Provide regular trauma-informed clinical supervision that is relationally based. Supervisors should be experienced and trained in trauma-informed and trauma-specific practices and provide a competence-based model of clinical supervision that promotes counselors' professional and personal development. Supervision limited to case consultation or case management is insufficient to

reduce the risk for secondary traumatization and promote counselor resilience.

- Provide opportunities for behavioral health professionals to enhance their sense of autonomy and feel empowered within the organization. Some of these activities include soliciting input from counselors on clinical and administrative policies that affect their work lives, including how to best balance caseloads of clients with and without histories of trauma; inviting representatives of the counseling staff to attend selected agency board of directors and/or management team meetings to offer input on workforce development; and inviting counselors to participate in organizational task forces that develop trauma-informed services, plan staff retreats, or create mechanisms to discuss self-care in team meetings. Administrators and clinical supervisors should assess the organization's unique culture and develop avenues for counselor participation in activities that will enhance their sense of empowerment and efficacy within the organization.

Exhibit 2.2-7 highlights some specific strategies that individual counselors can engage in to prevent secondary traumatization.

Assessment of Secondary Traumatization

Counselors with unacknowledged STS can harm clients, self, and family and friends by becoming unable to focus on and attend to their needs or those of others. They may feel helpless or cynical and withdraw from support systems. Exhibit 2.2-8 describes some emotional, cognitive, and behavioral signs that may indicate that a counselor is experiencing secondary traumatization. Clinical supervisors should be familiar with the manifestations of STS in their counselors and should address signs of STS immediately.

Stamm (2009–2012) has developed and revised a self-assessment tool, the Professional Quality of Life Scale (ProQOL), that measures indicators of counselor compassion fatigue and compassion satisfaction. Compassion fatigue "is best defined as a syndrome consisting of a combination of the symptoms

Exhibit 2.2-7: Counselor Strategies To Prevent Secondary Traumatization

Strategies that counselors can use (with the support and encouragement of supervisors and administrators) to prevent secondary traumatization include:

- ***Peer support*:** Maintaining adequate social support, both personally and professionally, helps prevent isolation and helps counselors share the emotional distress of working with traumatized individuals.
- ***Supervision and consultation*:** Professional consultation will help counselors understand secondary traumatization, their own personal risks, the protective factors that can help them prevent or lessen its impact, and their countertransference reactions to specific clients.
- ***Training*:** Ongoing professional training can improve counselors' understanding of trauma and enhance a sense of mastery and self-efficacy in their work.
- ***Personal psychotherapy or counseling*:** Being in counseling can help counselors become more self-aware and assist them in managing the psychological and emotional distress that often accompanies working with clients who have trauma histories in a number of behavioral health settings.
- ***Maintaining balance in one's life*:** Balancing work and personal life, developing positive coping styles, and maintaining a healthy lifestyle can enhance resilience and the ability to manage stress.
- ***Engaging in spiritual activities that provide meaning and perspective*:** Connection to a spiritual community and spiritual practices (such as meditation) can help counselors gain a larger perspective on trauma and enhance resilience.

Exhibit 2.2-8: Secondary Traumatization Signs

The following are some indicators that counselors may be experiencing secondary traumatization.

Psychological distress
- Distressing emotions: grief, depression, anxiety, dread, fear, rage, shame
- Intrusive imagery of client's traumatic material: nightmares, flooding, flashbacks of client disclosures
- Numbing or avoidance: avoidance of working with client's traumatic material
- Somatic issues: sleep disturbances, headaches, gastrointestinal distress, heart palpitations, chronic physiological arousal
- Addictive/compulsive behaviors: substance abuse, compulsive eating, compulsive working
- Impaired functioning: missed or canceled appointments, decreased use of supervision, decreased ability to engage in self-care, isolation and alienation

Cognitive shifts
- Chronic suspicion about others
- Heightened sense of vulnerability
- Extreme sense of helplessness or exaggerated sense of control over others or situations
- Loss of personal control or freedom
- Bitterness or cynicism
- Blaming the victim or seeing everyone as a victim
- Witness or clinician guilt if client reexperiences trauma or reenacts trauma in counseling
- Feeling victimized by client

Relational disturbances
- Decreased intimacy and trust in personal/professional relationships
- Distancing or detachment from client, which may include labeling clients, pathologizing them, judging them, canceling appointments, or avoiding exploring traumatic material
- Overidentification with the client, which may include a sense of being paralyzed by one's own responses to the client's traumatic material or becoming overly responsible for the client's life

Frame of reference
- Disconnection from one's sense of identity
- Dramatic change in fundamental beliefs about the world
- Loss or distortion of values or principles
- A previous sense of spirituality as comfort or resource decreases or becomes nonexistent
- Loss of faith in something greater
- Existential despair and loneliness

Sources: Figley, 1995; Newall & MacNeil, 2010; Saakvitne et al., 1996.

of secondary traumatic stress and professional burnout" (Newall & MacNeil, 2010, p. 61). Although secondary traumatization as a reaction to exposure to clients' trauma material is similar to PTSD, burnout is a more general type of psychological distress related to the pressures of working in high-stress environments over time. Burnout may be a result of secondary traumatization and/or a contributing factor in the development of secondary traumatization. The ProQOL includes STS and burnout scales that have been validated in research studies (Adams, Figley, & Boscarino, 2008; Newall & MacNeil, 2010).

This tool can be used in individual and group clinical supervision, trainings on self-care, and team meetings as a way for counselors to check in with themselves on their levels of stress and potential signs of secondary traumatization.

Case Illustration: Gui

Gui is a 48-year-old licensed substance abuse counselor who has worked in a methadone maintenance clinic for 12 years. He originally decided to get his degree and become a counselor because he wanted to help people and make a difference in the world. Over the past 6 months, he has felt fatigued a great deal, gets annoyed easily with both clients and coworkers, and has developed a cynical attitude about the world and the people who come to the clinic for help. During this time, the clinic has been forced to lay off a number of counselors due to funding cutbacks. As a result, Gui and the remaining counselors have had a 20 percent increase in the number of weekly client contact hours required as part of their job duties. In addition, the level and severity of clients' trauma-related and other co-occurring disorders, poverty, joblessness, and homelessness has increased.

Gui is a valued employee, and when Gui discusses his thoughts that he might want to leave the clinic with his clinical supervisor, the supervisor listens to Gui's concerns and explores the possibility of having him fill out the ProQOL to get a pulse on his stress level. Gui agrees and is willing to discuss the results with his supervisor. He is not surprised to see that he scores above average on the burnout scale of the instrument but is very surprised to see that he scores below average on the secondary traumatic stress scale and above average on the compassion satisfaction scale. He begins to feel more hopeful that he still finds satisfaction in his job and sees that he is resilient in many ways that he did not acknowledge before.

Gui and the clinical supervisor discuss ways that the supervisor and the organization can lessen the impact of the stress of the work environment on Gui and support the development of a self-care plan that emphasizes his own ability to rebound from adversity and take charge of his self-care.

The compassion satisfaction scale allows counselors to reflect on their resilience and reminds them of why they choose to work with people with substance use and trauma-related disorders, despite the fact that this work can lead to secondary traumatization. The compassion satisfaction subscale reminds counselors that they are compassionate, that one of the reasons they are in a helping profession is that they value service to others, and that helping brings meaning and fulfillment to their lives. Exhibits 2.2-9 through 2.2-11 present the most recent version of the ProQOL.

Addressing Secondary Traumatization

If a counselor is experiencing STS, the organization should address it immediately. Clinical supervisors can collaborate with counselors to devise an individualized plan that is accessible, acceptable, and appropriate for each counselor and that addresses the secondary stress reactions the counselor is experiencing, providing specific self-care strategies to counteract the stress. Decisions about strategies for addressing secondary traumatization should be based on the personal preferences of the counselor, the opportunity for an immediate intervention following a critical incident, and the counselor's level of awareness regarding his or her experience of STS. Counselors may need to talk about what they are experiencing, feeling, and thinking. These experiences can be processed in teams, in consultations with colleagues, and in debriefing meetings to integrate them effectively (Myers & Wee, 2002).

If a critical incident evokes secondary traumatization among staff—such as a client suicide, a violent assault in the treatment program, or another serious event—crisis intervention should be available for workers who would like to participate. Any intervention should be voluntary and tailored to each worker's individual needs (e.g., peer, group, or individual sessions); if possible, these services should be offered continuously instead of just one time.

Exhibit 2.2-9: PRoQOL Scale

COMPASSION SATISFACTION AND COMPASSION FATIGUE (PRoQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *past 30 days*.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

___ 1. I am happy.
___ 2. I am preoccupied with more than one person I *[help]*.
___ 3. I get satisfaction from being able to *[help]* people.
___ 4. I feel connected to others.
___ 5. I jump or am startled by unexpected sounds.
___ 6. I feel invigorated after working with those I *[help]*.
___ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
___ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
___ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
___ 10. I feel trapped by my job as a *[helper]*.
___ 11. Because of my *[helping]*, I have felt "on edge" about various things.
___ 12. I like my work as a *[helper]*.
___ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
___ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
___ 15. I have beliefs that sustain me.
___ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
___ 17. I am the person I always wanted to be.
___ 18. My work makes me feel satisfied.
___ 19. I feel worn out because of my work as a *[helper]*.
___ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
___ 21. I feel overwhelmed because my case [work] load seems endless.
___ 22. I believe I can make a difference through my work.
___ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
___ 24. I am proud of what I can do to *[help]*.
___ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
___ 26. I feel "bogged down" by the system.
___ 27. I have thoughts that I am a "success" as a *[helper]*.
___ 28. I can't recall important parts of my work with trauma victims.
___ 29. I am a very caring person.
___ 30. I am happy that I chose to do this work.

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Source: Stamm, 2012. Used with permission.

Exhibit 2.2-10: Your Scores on the ProQOL: Professional Quality of Life Screening

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental healthcare professional.

Compassion Satisfaction _____
Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout_____
Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress_____
The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a healthcare professional.

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Source: Stamm, 2012. Used with permission.

Exhibit 2.2-11: What Is My Score and What Does It Mean?

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section,** total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

*You Wrote	Change to
1	5
2	4
3	3
4	2
5	1

3. ____
6. ____
12. ____
16. ____
18. ____
20. ____
22. ____
24. ____
27. ____
30. ____
Total : _____

The sum of my Compassion Satisfaction questions is	So my score equals	And my Compassion Satisfaction level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are *not* happy so you reverse the score.

*1. ____ = ____
*4. ____ = ____
8. ____
10. ____
*15. ____ = ____
*17. ____ = ____
19. ____
21. ____
26. ____
*29. ____ = ____
Total : _____

The sum of my Burnout questions is	So my score equals	And my Burnout level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Secondary Traumatic Stress Scale

Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add the[m] up. When you have added them up you can find your score on the table to the right.

2. ____
5. ____
7. ____
9. ____
11. ____
13. ____
14. ____
23. ____
25. ____
28. ____
Total : _____

The sum of my Secondary Trauma questions is	So my score equals	And my Secondary Traumatic Stress level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

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The objective of debriefing a critical incident that evokes STS reactions in counselors is to help them dissipate the hyperarousal associated with traumatic stress and prevent long-term aftereffects that might eventually lead to counselor impairment. Because clinical supervisors may also be experiencing secondary traumatization, it is advisable for administrators to invite an outside trauma consultant into the organization to provide a safe space for all staff members (including clinical supervisors) to address and process the critical stress incident. For noncrisis situations, secondary traumatization should be addressed in clinical supervision. Clinical supervisors and counselors should work collaboratively to incorporate regular screening and self-assessment of STS into supervision sessions.

Advice to Clinical Supervisors: Advantages and Disadvantages of Using Psychometric Measures

Using a psychometric measure such as the ProQOL has advantages and disadvantages. It is important to understand that all tests measure averages and ranges but do not account for individual circumstances.

If you use the ProQOL in clinical supervision, present it as a self-assessment tool. Let counselors opt out of sharing their specific results with you and/or your team if it is administered in a group. If counselors choose to share scores on specific items or scales with you, work collaboratively and respectfully with them to explore their own understanding of and meanings attached to their scores. If this tool is not presented to supervisees in a nonjudgmental, mindful way, counselors may feel as if they have failed if their scores on the secondary traumatization scale are above average or if their scores on the compassion satisfaction scale are below average. High scores on the compassion fatigue and burnout scales do not mean that counselors don't care about their clients or that they aren't competent clinicians. The scores are simply one way for you and your supervisees to get a sense of whether they might be at risk for secondary traumatization, what they can do to prevent it, how to address it, and how you can support them.

The potential benefits of using a self-assessment tool like the ProQOL in clinical supervision are that it can help counselors:

- Reflect on their emotional reactions and behaviors and identify possible triggers for secondary traumatization.
- Assess their risk levels.
- Examine alternative coping strategies that may prevent secondary traumatization.
- Understand their own perceptions of themselves and their job satisfaction, affirming what they already know about their risk of secondary traumatization and their compassion satisfaction.
- Reflect on different factors that might contribute to unexpected low or high scores, such as the day of the week, the intensity of the workload, whether they have just come back from the weekend or a vacation, and so forth.
- Increase self-awareness and self-knowledge, because scores on specific items or scales bring to consciousness what is often outside of awareness.
- Realize how resilient they are emotionally, mentally, physically, and spiritually.
- Become aware of and open up conversations about self-care and self-care activities and resources, such as supportive coworkers, team members, and social networks outside of work.

If used regularly, self-assessment tools can help counselors and clinical supervisors monitor STS levels, indicate significant positive and negative changes, and suggest action toward self-care in specific areas. Clinical supervisors should fill out the ProQOL and review results with their own supervisors, a peer supervisor, or a colleague before administering it to supervisees. Doing so enables supervisors to gauge their own reactions to the self-assessment and anticipate potential reactions from supervisees.

Advice to Clinical Supervisors: Is it Supervision or Psychotherapy?

Although there are some aspects of clinical supervision that can be therapeutic and parallel the therapeutic and emotional support that occurs between the counselor and the client, clinical supervision is not therapy. As a result, it is important for clinical supervisors to maintain appropriate boundaries with supervisees when addressing their STS reactions at work.

When does the process in supervision cross over into the realm of practicing therapy with a supervisee? One clear indicator is if the supervisor begins to explore the personal history of the counselor and reflects directly on that history instead of bringing it back to how the counselor's history influences his or her work with a particular client or with clients with trauma histories in general. Clinical supervisors should focus only on counselor issues that may be directly affecting their clinical functioning with clients. If personal issues arise in clinical supervision, counselors should be encouraged to address them in their own counseling or psychotherapy.

Exhibit 2.2-12: Clinical Supervisor Guidelines for Addressing Secondary Traumatization

1. Engage counselors in regular screening/self-assessment of counselors' experience of STS.
2. Address signs of STS with counselors in clinical supervision.
3. Work collaboratively with counselors to develop a comprehensive self-care plan and evaluate its effectiveness on a regular basis.
4. Provide counselors a safe and nonjudgmental environment within which to process STS in individual and group supervision or team meetings.
5. Provide counselors with a safe and nonjudgmental place within which to debrief critical stress incidents at work; bring in an outside consultant if needed.
6. Support and encourage counselors to engage in individual counseling or psychotherapy, when needed, to explore personal issues that may be contributing to secondary traumatization at work.

When STS issues arise, the clinical supervisor should work with counselors to review and revise their self-care plans to determine what strategies are working and whether additional support, like individual psychotherapy or counseling, may be warranted.

Exhibit 2.2-12 outlines some guidelines for clinical supervisors in addressing secondary trauma in behavioral health professionals working with clients who have substance use, mental, and trauma-related disorders.

Counselor Self-Care

In light of the intensity of therapeutic work with clients with co-occurring substance use, mental, and trauma-related disorders and the vulnerability of counselors to secondary traumatization, a comprehensive, individualized self-care plan is highly recommended. Balance is the key to the development of a self-care plan—a balance between home and work, a balance between focusing on self and others, and a balance between rest and activity (Saakvitne, Perlman, & Traumatic Stress Institute/ Center for Adult & Adolescent Psychotherapy 1996). Counselor self-care is also about balancing vulnerability, which allows counselors to be present and available when clients address intensely painful content, with reasonable efforts to preserve their sense of integrity in situations that may threaten the counselors' faith or worldview (Burke et al., 2006). A comprehensive self-care plan should include activities that nourish the physical, psychological/mental, emotional/relational, and spiritual aspects of counselors' lives.

The literature on counselor self-care advocates for individual, team, and organizational strategies that support behavioral health professionals working with clients who have

Case Illustration: Carla

Carla is a 38-year-old case manager working in an integrated mental health and substance abuse agency. She provides in-home case management services to home-bound clients with chronic health and/or severe mental health and substance abuse problems. Many of her clients have PTSD and chronic, debilitating pain.

Both her parents had alcohol use disorders, and as a result, Carla became the caretaker in her family. She loves her job; however, she often works 50 to 60 hours per week and has difficulty leaving her work at work. She often dreams about her clients and wakes up early, feeling anxious. She sometimes has traumatic nightmares, even though she was never physically or sexually abused, and she has never experienced the trauma of violence or a natural disaster. She drinks five cups of coffee and three to four diet sodas every day and grabs burgers and sweets for snacks while she drives from one client to the next. She has gained 20 pounds in the past year and has few friends outside of her coworkers. She has not taken a vacation in more than 2 years. She belongs to the Catholic church down the street, but she has stopped going because she says she is too busy and exhausted by the time Sunday rolls around.

The agency brings in a trainer who meets with the case management department and guides the staff through a self-assessment of their current self-care practices and the development of a comprehensive self-care plan. During the training, Carla acknowledges that she has let her work take over the rest of her life and needs to make some changes to bring her back into balance. She writes out her self-care plan, which includes cutting back on the caffeine, calling a friend she knows from church to go to a movie, going to Mass on Sunday, dusting off her treadmill, and planning a short vacation to the beach. She also decides that she will discuss her plan with her supervisor and begin to ask around for a counselor for herself to talk about her anxiety and her nightmares. In the next supervision session, Carla's supervisor reviews her self-care plan with her and helps Carla evaluate the effectiveness of her self-care strategies. Her supervisor also begins to make plans for how to cover Carla's cases when she takes her vacation.

substance use and trauma-related disorders. Counselors are responsible for developing comprehensive self-care plans and committing to their plans, but clinical supervisors and administrators are responsible for promoting counselor self-care, supporting implementation of counselor self-care plans, and modeling self-care. Counselor self-care is an ethical imperative; just as the entire trauma-informed organization must commit to other ethical issues with regard to the delivery of services to clients with substance use, mental, and trauma-related disorders, it must also commit to the self-care of staff members who are at risk for secondary traumatization as an ethical concern. Saakvitne and colleagues (1996) suggest that when administrators support counselor-self-care, it is not only cost-effective in that it reduces the negative effects of secondary traumatization on counselors (and their clients), but also promotes "hope-sustaining behaviors" in counselors, making them more motivated and open to learning, and thereby improving job performance and client care.

A Comprehensive Self-Care Plan

A self-care plan should include a self-assessment of current coping skills and strategies and the development of a holistic, comprehensive self-care plan that addresses the following four domains:

1. Physical self-care
2. Psychological self-care (includes cognitive/mental aspects)
3. Emotional self-care (includes relational aspects)
4. Spiritual self-care

Activities that may help behavioral health workers find balance and cope with the stress

Advice to Clinical Supervisors: Spirituality

The word "spiritual" in this context is used broadly to denote finding a sense of meaning and purpose in life and/or a connection to something greater than the self. Spiritual meanings and faith experiences are highly individual and can be found within and outside of specific religious contexts.

Engaging in spiritual practices, creative endeavors, and group/community activities can foster a sense of meaning and connection that can counteract the harmful effects of loss of meaning, loss of faith in life, and cognitive shifts in worldview that can be part of secondary traumatization. Counselors whose clients have trauma-related disorders experience fewer disturbances in cognitive schemas regarding worldview and less hopelessness when they engage in spiritually oriented activities, such as meditation, mindfulness practices, being in nature, journaling, volunteer work, attending church, and finding a spiritual community (Burke et al., 2006). Clinical supervisors can encourage counselors to explore their own spirituality and spiritual resources by staying open and attuned to the multidimensional nature of spiritual meaning of supervisees and refraining from imposing any particular set of religious or spiritual beliefs on them. A strong sense of spiritual connection can enhance counselors' resilience and ability to cope with the sometimes overwhelming effects of clients' trauma material and trauma-related behavior (including suicidality) on counselors' faith in life and sense of meaning and purpose.

Modeling Self-Care

"Implementing interventions was not always easy, and one of the more difficult coping strategies to apply had to do with staff working long hours. Many of the staff working at the support center also had full-time jobs working for the Army. In addition, many staff chose to volunteer at the Family Assistance Center and worked 16- to 18-hour days. When we spoke with them about the importance of their own self-care, many barriers emerged: guilt over not working, worries about others being disappointed in them, fear of failure with respect to being unable to provide what the families might need, and a 'strong need to be there.' Talking with people about taking a break or time off proved problematic in that many of them insisted that time off was not needed, despite signs of fatigue, difficulty concentrating, and decreased productivity. Additionally, time off was not modeled. Management, not wanting to fail the families, continued to work long hours, despite our requests to do otherwise. Generally, individuals could see and understand the reasoning behind such endeavors. Actually making the commitment to do so, however, appeared to be an entirely different matter. In fact, our own team, although we kept reasonable hours (8 to 10 per day), did not take a day off in 27 days. Requiring time off as part of membership of a Disaster Response Team might be one way to solve this problem."

—Member of a Disaster Response Team at the Pentagon after September 11

Source: Walser, 2004, pp. 4–5.

of working with clients with trauma-related disorders include talking with colleagues about difficult clinical situations, attending workshops, participating in social activities with family and friends, exercising, limiting client sessions, balancing caseloads to include clients with and without trauma histories, making sure to take vacations, taking breaks during the workday, listening to music, walking in nature, and seeking emotional support in both their personal and professional lives (Saakvitne et al., 1996). In addition, regular clinical supervision and personal psychotherapy or counseling can be positive coping strategies for lessening the impact of STS on counselors. Still, each counselor is unique, and a self-care approach that is helpful to one counselor may not be helpful to another. Exhibits 2.2-13 and 2.2-14 offer tools for self-reflection to help counselors discover which specific self-care activities might best suit them. The worksheet can be used privately by counselors or by clinical supervisors as an exercise in individual supervision, group supervision, team meetings, or trainings on counselor self-care.

Exhibit 2.2-13: Comprehensive Self-Care Plan Worksheet

Name: Date:	Personal	Professional/Workspace
Physical		
Psychological/Mental		
Emotional/Relational		
Spiritual		

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Review the questions in Exhibit 2.2-14, and then write down specific self-care strategies in the form (given in Exhibit 2.2-13) that you're confident you will practice in both personal and professional realms.

The *Comprehensive Self-Care Worksheet* is a tool to help counselors (and clinical supervisors) develop awareness of their current coping strategies and where in the four domains they need to increase their engagement in self-care activities. Once completed, clinical supervisors should periodically review the plan with their supervisees for effectiveness in preventing and/or ameliorating secondary traumatization and then make adjustments as needed.

Essential Components of Self-Care

Saakvitne and colleagues (1996) describe three essential components, the "ABCs," of self-care that effectively address the negative impact of secondary traumatization on counselors:

1. **Awareness** of one's needs, limits, feelings, and internal/external resources. Awareness involves mindful/nonjudgmental attention to one's physical, psychological, emotional, and spiritual needs. Such attention requires quiet time and space that supports self-reflection.
2. **Balance** of activities at work, between work and play, between activity and rest, and between focusing on self and focusing on others. Balance provides stability and helps counselors be more grounded when stress levels are high.
3. **Connection** to oneself, to others, and to something greater than the self. Connection decreases isolation, increases hope, diffuses stress, and helps counselors share the burden of responsibility for client care. It provides an anchor that enhances counselors' ability to witness tremendous suffering without getting caught up in it.

Exhibit 2.2-14: Comprehensive Self-Care Plan Worksheet Instructions

Use the following questions to help you engage in a self-reflective process and develop your comprehensive self-care plan. Be specific and include strategies that are accessible, acceptable, and appropriate to your unique circumstances. Remember to evaluate and revise your plan regularly.

Physical
What are non-chemical things that help my body relax?
What supports my body to be healthy?

Psychological/Mental
What helps my mind relax?
What helps me see a bigger perspective?
What helps me break down big tasks into smaller steps?
What helps me counteract negative self-talk?
What helps me challenge negative beliefs?
What helps me build my theoretical understanding of trauma and addictions?
What helps me enhance my counseling/helping skills in working with traumatized clients?
What helps me become more self-reflective?

Emotional/Relational
What helps me feel grounded and able to tolerate strong feelings?
What helps me express my feelings in a healthy way?
Who helps me cope in positive ways and how do they help?
What helps me feel connected to others?
Who are at least three people I feel safe talking with about my reactions/feelings about clients?
How can I connect with those people on a regular basis?

Spiritual
What helps me find meaning in life?
What helps me feel hopeful?
What sustains me during difficult times?
What connects me to something greater?

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Clinical supervisors can help counselors review their self-care plans through the ABCs by reflecting on these questions:

1. Has the counselor accurately identified his or her needs, limits, feelings, and internal and external resources in the four domains (physical, psychological/mental, emotional/relational, spiritual)?
2. Has the counselor described self-care activities that provide a balance between work and leisure, activity and rest, and a focus on self and others?
3. Has the counselor identified self-care activities that enhance connection to self, others, and something greater than self (or a larger perspective on life)?

Supervisors should make their own self-care plans and review them periodically with their clinical supervisors, a peer supervisor, or a colleague.

Commitment to Self-Care

One of the major obstacles to self-care is giving in to the endless demands of others, both at work and at home. It is therefore essential for counselors with the support of clinical supervisors to become "guardians of [their] boundaries and limits" (Saakvitne et al., 1996, p 136). Creating a daily schedule that includes breaks for rest, exercise, connection with coworkers, and other self-care activities can support counselors in recognizing that they are valuable individuals who are worthy of taking the time to nourish and nurture themselves, thus increasing commitment to self-care. Another way to support counselors in committing to self-care is for supervisors and administrators to model self-care in their own professional and personal lives.

Understanding that counselor self-care is not simply a luxury or a selfish activity, but rather, an ethical imperative (Exhibit 2.2-15) can foster counselors' sense of connection to their own values and accountability to the people they serve as competent and compassionate caregivers. Clinical supervisors and administrators can reinforce this sense of accountability while supporting counselors by providing a caring, trauma-informed work environment

Exhibit 2.2-15: The Ethics of Self-Care

The Green Cross Academy of Traumatology was originally established to serve a need in Oklahoma City following the April 19, 1995, bombing of the Alfred P. Murrah Federal Building. Below are adapted examples of the Academy's code of ethics with regard to worker self-care.

Ethical Principles of Self-Care in Practice
These principles declare that it is unethical not to attend to your self-care as a practitioner, because sufficient self-care prevents harming those we serve.

Standards of self-care guidelines:
- Respect for the dignity and worth of self: A violation lowers your integrity and trust.
- Responsibility of self-care: Ultimately it is your responsibility to take care of yourself—and no situation or person can justify neglecting this duty.
- Self-care and duty to perform: There must be a recognition that the duty to perform as a helper cannot be fulfilled if there is not, at the same time, a duty to self-care.

Standards of humane practice of self-care:
- Universal right to wellness: Every helper, regardless of her or his role or employer, has a right to wellness associated with self-care.
- Physical rest and nourishment: Every helper deserves restful sleep and physical separation from work that sustains them in their work role.
- Emotional rest and nourishment: Every helper deserves emotional and spiritual renewal both in and outside the work context.
- Sustenance modulation: Every helper must utilize self-restraint with regard to what and how much they consume (e.g., food, drink, drugs, stimulation) since improper consumption can compromise their competence as a helper.

Commitment to self-care:
- Make a formal, tangible commitment: Written, public, specific, measurable promises of self-care.
- Set deadlines and goals: The self-care plan should set deadlines and goals connected to specific activities of self-care.
- Generate strategies that work and follow them: Such a plan must be attainable and followed with great commitment and monitored by advocates of your self-care.

Source: Green Cross Academy of Traumatology, 2010. Adapted with permission.

that acknowledges and normalizes secondary traumatization and by offering reasonable resources that make it possible for counselors to do their work and take care of themselves at the same time. Preventing secondary traumatization and lessening its impact on counselors once it occurs is not only cost-effective with regard to decreasing staff turnover and potential discontinuity of services to clients; it is also the ethical responsibility of a trauma-informed organization.

Appendices

Appendix A—Bibliography

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Substance Abuse and Mental Health Services Administration. (planned f). *Reintegration-related behavioral health issues in veterans and military families.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration.

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Appendix B—Trauma Resource List

Introduction

As it would be difficult to include every organization focused on trauma, the list of resources in this appendix is not exhaustive; consequently, this list does not include books or other materials concerning the vast nature of this topic, but rather, it concentrates solely on online resources accessible to the public for free or as part of an organization membership. The inclusion of selected resources does not necessarily signify endorsement by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). Following these resources for adults is a list of resources focused on children and adolescents and a list of training opportunities.

Technology and Trauma: Using the Web To Treat PTSD

The role of the Internet in helping those who are experiencing posttraumatic stress disorder (PTSD) has expanded rapidly; there are numerous Web sites with toolkits and research publications for clinicians who treat clients with PTSD, as well as Web sites aimed at providing information and support for these individuals. The U.S. military has contributed to the field in developing these avenues—specifically, with interactive Web applications for use on home computers and smartphones.

- PTSD Coach is a smartphone application from the U.S. Department of Veterans Affairs (VA) to help people experiencing PTSD learn about and manage their symptoms (http://www.ptsd.va.gov/public/pages/ptsdcoach.asp).
- Afterdeployment.org is a Web site developed by the Defense Centers of Excellence project led by the National Center for Telehealth & Technology, with interactive workshops about PTSD, traumatic brain injury (TBI), anxiety, and depression, aimed at returning veterans (http://www.afterdeployment.org).
- T2 Virtual PTSD Experience, also developed by the National Center for Telehealth & Technology, is an application to be used within the popular online game Second Life as an interactive way of simulating how PTSD can be acquired within a combat environment, how PTSD may present itself to the person experiencing it, and how to seek effective treatment (http://www.t2health.org/vwproj).

Resources for Adults

Academy of Cognitive Therapy

http://www.academyofct.org
260 South Broad Street
18th Floor
Philadelphia, PA 19102
Phone: 267-350-7683
Email: info@academyofct.org

The Academy of Cognitive Therapy, a nonprofit organization, supports continuing education and research in cognitive therapy, provides a valuable resource in cognitive therapy for professionals and the public at large,

and actively works toward the identification and certification of clinicians skilled in cognitive therapy. Certification is awarded to those individuals who, based on an objective evaluation, have demonstrated an advanced level of expertise in cognitive therapy. The Academy includes physicians, psychologists, social workers, and other mental health professionals from around the world. The Academy formed a Trauma Task Force after September 11, 2001, to disseminate information (available on their Web site) to help people around the world receive the best help possible following trauma.

Addiction Technology Transfer Center Network

http://www.attcnetwork.org/index.asp
5100 Rockhill Road
Kansas City, MO 64110
Phone: 816-235-6888
Email: networkoffice@attcnetwork.org

The Addiction Technology Transfer Center (ATTC) Network serves as a resource for students and professionals to identify international distance education opportunities for the substance abuse treatment field and as a free marketing venue for ATTC-approved sponsors of distance education courses. The ATTC Web site provides trauma-related resources that include case studies, information on working with returning veterans who have been exposed to trauma, and links to various publications on PTSD and secondary traumatic stress.

Agency for Healthcare Research and Quality

http://www.innovations.ahrq.gov/index.aspx
540 Gaither Road
Suite 2000
Rockville, MD 20850
Phone: 301-427-1104

The Agency for Healthcare Research and Quality (AHRQ) is the research arm of HHS, specializing in patient safety and quality improvement, outcomes and effectiveness of care, clinical practice and technology assessment, and healthcare organization and delivery systems. AHRQ also provides funding and technical assistance to health research and research training programs at many universities and institutions. AHRQ's Web site provides links to research publications on PTSD and to other government publications and toolkits dealing with trauma-informed care.

The American Academy of Experts in Traumatic Stress

http://www.aaets.org
203 Deer Road
Ronkonkoma, NY 11779
Phone: 631-543-2217
Email: info@aaets.org

The American Academy of Experts in Traumatic Stress is a multidisciplinary network of professionals who are committed to the advancement of intervention for survivors of trauma. The Academy aims to identify expertise among professionals and across disciplines and to provide meaningful standards for those who work regularly with survivors. The Academy is committed to fostering a greater appreciation of the effects of common traumatic experiences (e.g., chronic illness, accidents, domestic violence, loss) in addition to large-scale disasters and catastrophes. The group's aim is to help all victims to become survivors and, ultimately, to thrive.

American Red Cross Disaster Services

http://www.redcross.org/what-we-do/disaster-relief
American Red Cross National Headquarters
2025 E Street, NW

Washington, DC 20006
Phone: 202-303-4498

Red Cross disaster relief focuses on meeting people's immediate emergency disaster-caused needs. When a disaster threatens or strikes, the Red Cross provides shelter, food, and health and mental health services to address basic human needs. In addition to these services, the core of Red Cross disaster relief is the assistance given to individuals and families affected by disaster to enable them to resume their normal daily activities independently. Training opportunities are also provided.

Anxiety and Depression Association of America

http://www.adaa.org
8701 Georgia Avenue #412
Silver Spring, MD 20910
Phone: 240-485-1001

The Anxiety and Depression Association of America (ADAA) is the only national, nonprofit membership organization dedicated to informing the public, healthcare professionals, and legislators that anxiety disorders are real, serious, and treatable. ADAA promotes the early diagnosis, treatment, and cure of anxiety disorders and is committed to improving the lives of the people who have them. The ADAA Web site provides information about the symptoms of PTSD and how it can be treated, in addition to offering a PTSD self-screening tool.

Association for Behavioral and Cognitive Therapies

http://www.abct.org
305 7th Avenue
16th Floor
New York, NY 10001
Phone: 212-647-1890
Fax: 212-647-1865

The Association for Behavioral and Cognitive Therapies is a professional, interdisciplinary organization concerned with the application of behavioral and cognitive science to understanding human behavior, developing interventions to enhance the human condition, and promoting the appropriate use of these interventions. The association's Web site includes resources for the public and for professionals on trauma and disaster-related problems, a clinical referral directory, and other resources and training opportunities in behavioral therapy.

Association of Traumatic Stress Specialists

http://www.atss.info
88 Pompton Avenue
Verona, NJ 07044
Phone: 973-559-9200
Email: Admin@atss.info

The Association of Traumatic Stress Specialists is an international membership organization that offers three distinct board certifications to qualified individuals who provide services, intervention, response, and/or treatment in the field of traumatic stress. The Association is dedicated to improving the quality of life of all individuals throughout the world who have been affected by traumatic events. Membership represents those who serve survivors of natural disasters, terrorist attacks, injuries and deaths related to serving in the line of duty or to school and workplace violence; veterans; refugees; victims of crime; Holocaust survivors; those affected and exploited by political persecution; and others who have experienced traumatic stress injuries.

Center for Anxiety and Related Disorders

http://www.bu.edu/card
648 Beacon Street
6th Floor

Boston, MA 02215
Phone: 617-353-9610

The Center for Anxiety and Related Disorders (CARD) at Boston University is a clinical and research center dedicated to advancing knowledge and providing care for anxiety, mood, eating, sleep, and related disorders. CARD's Web site offers information regarding PTSD and research publications on trauma and anxiety, in addition to linking to toolkits from the National Child Traumatic Stress Network's Adolescent Traumatic Stress and Substance Abuse Program.

Center for the Study of Traumatic Stress

http://www.cstsonline.org
Uniformed Services University of the Health Sciences
Department of Psychiatry
4301 Jones Bridge Road
Bethesda, MD 20814-4799
Phone: 301-295-2470
Fax: 301-319-6965

The Center for the Study of Traumatic Stress (CSTS) is a federally funded organization established by the Military Health System in 1987 to address Department of Defense concerns regarding health risks and concerns resulting from the traumatic impact of the use of weapons of mass destruction in combat, acts of terrorism and hostage events, combat and peacekeeping operations, natural disasters, and assaults or accidents occurring in both uniformed and civilian communities. CSTS primarily serves members of the armed forces, along with their children and families.

Center for Culture, Trauma and Mental Health Disparities

http://www.semel.ucla.edu/cctmhd
UCLA Semel Institute of Neuroscience & Biobehavioral Sciences
760 Westwood Plaza
Los Angeles, CA 90024
Phone: 310-794-9929

The Collaborative Center for Trauma and Mental Health Disparities at the University of California Los Angeles is a multiethnic and multidisciplinary group that focuses on conducting research and providing training that pertains to trauma in minority populations.

Council of State Governments Justice Center—Mental Health

http://csgjusticecenter.org/jc/category/mental-health
100 Wall Street
20th Floor
New York, NY 10005
Phone: 212-482-2320
Fax: 212-482-2344
Email: consensusproject@csg.org

The Consensus Project is part of the Council of State Governments Justice Center and partners with other organizations, such as SAMHSA's GAINS Center, working to improve outcomes for people, including juveniles, with mental illnesses involved with the criminal justice system. The Consensus Project offers a webinar on trauma services in the criminal justice system and on child trauma and juvenile justice, as well as a local programs database.

Dart Center for Journalism and Trauma

http://www.dartcenter.org
Columbia University
Graduate School of Journalism
2950 Broadway
New York, NY 10027
Phone: 212-854-8056

The Dart Center is dedicated to improving media coverage of trauma, conflict, and

tragedy. The Center also addresses the consequences of such coverage for those working in journalism and provides training and education via seminars, newsroom briefings and consultation on trauma issues, in addition to training for journalism educators and other trainers. The Dart Center Web site offers fact sheets, publications, and DVDs on request for use by journalists, educators, and clinicians.

David Baldwin's Trauma Information Pages

http://www.trauma-pages.com
Phone: 541-686-2598
Email: dvb@trauma-pages.com

This Web site focuses primarily on emotional trauma and traumatic stress, including PTSD and dissociation, whether following individual traumatic experience(s) or a large-scale disaster. The site's purpose is to provide information for clinicians and researchers in the traumatic stress field. Specifically, the focus is on both clinical and research aspects of trauma responses and their resolution.

Disaster Technical Assistance Center

http://www.samhsa.gov/dtac
9300 Lee Highway
Fairfax, VA 22031
Phone: 800-308-3515
Fax: 703-225-2338

SAMHSA has created the Disaster Technical Assistance Center (DTAC) to help States prepare for and respond to a wide range of potential catastrophes—both natural and human-caused disasters. DTAC primarily serves individuals and communities who are recovering from natural and human-caused disasters. It works in conjunction with the Federal Emergency Management Agency (FEMA) and SAMHSA's Emergency Mental Health and Traumatic Stress Services Branch, using strengths-based, outreach-oriented principles conducted in nontraditional settings, as a supplement to programs already in place on a local level.

EMDR Institute, Inc.

http://www.emdr.com
P.O. Box 750
Watsonville, CA 9507
Phone: 831-761-1040
Fax: 831-761-1204
Email: inst@emdr.com

Eye Movement Desensitization and Reprocessing (EMDR) is an information-processing therapy that uses an eight-phase approach. (See the description in Part 1, Chapter 6.) The Web site presents background and descriptive information about this approach to treatment and lists training opportunities, references, and networking groups.

The Federal Emergency Management Agency

http://www.fema.gov
500 C Street SW
Washington, DC 20472
Phone: 202-646-2500

The Federal Emergency Management Agency, a formerly independent agency that became part of the Department of Homeland Security in March 2003, is tasked with responding to, planning for, recovering from, and mitigating against disasters. FEMA can trace its beginnings to the Congressional Act of 1803. This Act, generally considered the first piece of disaster legislation, provided assistance to a New Hampshire town following an extensive fire. In the century that followed, ad hoc legislation was passed more than 100 times in response to hurricanes, earthquakes, floods, and other natural disasters.

The International Critical Incident Stress Foundation, Inc.

http://www.icisf.org
3290 Pine Orchard Lane
Suite 106
Ellicott City, MD 21042
Phone: 410-750-9600
Fax: 410-750-9601
Email: info@icisf.org

The International Critical Incident Stress Foundation, Inc., is a nonprofit, open-membership foundation dedicated to the prevention and mitigation of disabling stress through the provision of education, training, and support services for all emergency services professions; continuing education and training in emergency mental health services for psychologists, psychiatrists, social workers, and licensed professional counselors; and consultation in the establishment of crisis and disaster response programs for varied organizations and communities worldwide.

International Society for the Study of Trauma and Dissociation

http://www.issd.org
8400 Westpark Drive
Second Floor
McLean, VA 22102
Phone: 703-610-9037
Fax: 703-610-0234
Email: info@isst-d.org

The Society is a nonprofit professional association organized for the purposes of information sharing and international networking of clinicians and researchers; providing professional and public education; promoting research and theory about dissociation; and promoting research and training in the identification, treatment, and prevention of dissociative disorders. The Society offers courses in its Dissociative Disorders Psychotherapy Training Program.

The International Society for Traumatic Stress Studies

http://www.istss.org
111 Deer Lake Road
Suite 100
Deerfield, IL 60015
Phone: 847-480-9028
Fax: 847-480-9282

The International Society for Traumatic Stress Studies (ISTSS) was founded in 1985 for professionals to share information about the effects of trauma. ISTSS is dedicated to the discovery and dissemination of knowledge about policy, program, and service initiatives that seek to reduce traumatic stressors and their immediate and long-term consequences. ISTSS provides a forum for the sharing of research, clinical strategies, public policy concerns, and theoretical formulations on trauma in the United States and around the world.

National Alliance on Mental Illness

http://www.nami.org
3803 N. Fairfax Dr.
Suite 100
Arlington, VA 22203
Phone: 703-524-7600
Fax: 703-524-9094

The National Alliance on Mental Illness (NAMI) is a nonprofit advocacy group founded in 1979 to raise awareness and provide essential and free education, advocacy, and support group programs for people living with mental illness and their loved ones. NAMI operates at the local, State, and national levels, with each level of the organizations providing education, information, support, and advocacy for those with mental illness and their support system. NAMI has developed a Trauma Toolkit and includes a series of lectures for mental health professionals about trauma.

National Association of State Alcohol and Drug Abuse Directors, Inc.

http://www.nasadad.org
1025 Connecticut Ave NW
Suite 605
Washington, DC 20036
Phone: 202-293-0090
Fax: 202-293-1250
Email: dcoffice@nasadad.org

The National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD) is a private, not-for-profit educational, scientific, and informational organization. NASADAD's basic purpose is to foster and support the development of effective alcohol and drug abuse prevention and treatment programs throughout every State. NASADAD offers a policy brief with regards to trauma and substance use/abuse in the wake of natural or human-made disasters.

National Association of State Mental Health Program Directors

http://www.nasmhpd.org
66 Canal Center Plaza
Suite 302
Alexandria, VA 22314
Phone: 703-739-9333
Fax: 703-548-9517

The National Association of State Mental Health Program Directors (NASMHPD; pronounced "NASH-pid") is a nonprofit organization dedicated to serving the needs of the Nation's public mental health system through policy development, information dissemination, and technical assistance. NASMHPD represents the $23 billion public mental health service delivery system. As a private, not-for-profit 501(c)(3) membership organization, NASMHPD helps set the agenda and determine the direction of State mental health agency interests across the country, historically including State mental health planning, service delivery, and evaluation. The principal programs operated, funded, and/or regulated by NASMHPD members serve people who have serious mental illnesses, developmental disabilities, and/or substance use disorders. NASMPHD has launched a Technical Assistance Coordinating Center in response to the Alternatives to Restraint and Seclusion State Infrastructure Grant Project, an initiative of SAMHSA's Center for Mental Health Services, designed to promote the implementation and evaluation of best practice approaches to preventing and reducing the use of seclusion and restraint in mental health settings.

National Center for Injury Prevention and Control

http://www.cdc.gov/injury
1600 Clifton Road
Atlanta, GA 30333
Phone: 800-232-4636
Email: cdcinfo@cdc.gov

The National Center for Injury Prevention and Control (NCIPC) was established by the Centers for Disease Control and Prevention in 1992. Through research, surveillance, implementation of evidence-based strategies, capacity building, and communication activities, NCIPC works to reduce morbidity, disability, mortality, and costs associated with injuries and violence. NCIPC is the lead U.S. Federal agency for nonoccupational injury prevention.

National Center for PTSD

http://www.ptsd.va.gov
810 Vermont Avenue NW
Washington, DC 20420
Phone: 802-296-6300
Email: ncptsd@va.gov

The National Center for PTSD (NCPTSD) was created within the Department of

Veterans Affairs in 1989 in response to a Congressional mandate to address the needs of veterans with military-related PTSD. Its mission is to advance the clinical care and social welfare of America's veterans through research, education, and training in the science, diagnosis, and treatment of PTSD and stress-related disorders. Its Web site is provided as an educational resource concerning PTSD and other enduring consequences of traumatic stress. The NCPTSD Web site has information about instruments to measure trauma exposure, risk and resilience factors for PTSD, self-report instruments, and interview schedules. Training opportunities are listed at http://www.ptsd.va.gov/about/training/training-programs.asp.

National Center for Telehealth and Technology

http://www.t2health.org
9933C West Hayes Street
Joint Base Lewis-McChord, WA 98431
Phone: 253-968-1914
Fax: 253-968-4192
Email: AskUs@t2health.org

The National Center for Telehealth and Technology is a Federal agency founded by the Department of Defense as part of the Military Health System. It primarily serves veterans and active-duty military personnel who are experiencing adverse health effects due to TBI and PTSD, as well as military children who are coping with their parents' deployment, through the use of technology (e.g., mobile phone applications, deployable telehealth centers).

National Center for Trauma-Informed Care

http://www.samhsa.gov/nctic
66 Canal Center Plaza
Suite 302
Alexandria, VA 22314
Phone: 866-254-4819
Fax: 703-548-9517
Email: NCTIC@NASMHPD.org

The National Center for Trauma-Informed Care (NCTIC) is a Federal center established by SAMHSA in 2005 to offer consultation, technical assistance, education, outreach, and resources to support trauma-informed care in publicly-funded systems and programs. NCTIC primarily serves those who are already receiving services from the behavioral health system and is focused on helping behavioral health services and programs to become more aware of the impact of trauma among consumers, to adapt services to incorporate trauma-informed practices, and to help raise awareness of practices or processes that are more likely to retraumatize consumers.

National Center for Victims of Crime

http://www.victimsofcrime.org
2000 M Street NW
Suite 480
Washington, DC 20036
Phone: 202-467-8700
Fax: 202-467-8701
Email: webmaster@ncvc.org

The National Center for Victims of Crime (NCVC) is a nonprofit organization funded partially by Federal grants from the Department of Justice. It was founded in 1985 and originally known as the Sunny Von Bulow National Victim Advocacy Center. NCVC is a resource center for those affected by violent crimes and also provides training and education for behavioral health service providers.

National Center on Domestic Violence, Trauma & Mental Health

http://www.nationalcenterdvtraumamh.org/
Phone: 312-726-7020
Fax: 312-726-7022

The National Center on Domestic Violence, Trauma & Mental Health was established in 2005 through a grant from the Family Violence Prevention and Services Program, HHS. The Center's mission is to promote accessible, culturally relevant, and trauma-informed responses to domestic violence and other lifetime trauma so that survivors and their children can access the resources that are essential to their safety and well-being; this is achieved by providing training and online resources to mental health and substance abuse treatment providers and developing policies to improve system responses to domestic violence survivors and their children.

National Center on Elder Abuse

http://www.ncea.aoa.gov
University of California–Irvine
Program in Geriatric Medicine
101 The City Drive South, 200 Building
Orange, CA 92868
Phone: 855-500-3537
Email: ncea-info@aoa.hhs.gov

The National Center on Elder Abuse (NCEA), part of the U.S. Administration on Aging, serves as a national resource center dedicated to the prevention of elder mistreatment. NCEA provides information to both mental health professionals and the general public and also provides technical assistance and training to States and community-based organizations.

National Center on Family Homelessness

http://www.familyhomelessness.org
200 Reservoir Street
Suite 200
Needham, MA 02494
Phone: 617-964-3834
Fax: 617-244-1758
Email: info@familyhomelessness.org

The National Center on Family Homelessness (NCFH) was founded in 1988 and is a nonprofit organization that conducts research and creates public awareness about the special needs of families experiencing homelessness. NCFH primarily serves veterans who are homeless and their families and young mothers who are homeless with their children. NCFH has developed a Trauma-Informed Organizational Toolkit for Homeless Services.

National Coalition Against Domestic Violence

http://www.ncadv.org
1 Broadway
Suite B210
Denver, CO 80203
Phone: 303-839-1852
Fax: 303-831-9251
Email: mainoffice@ncadv.org

The National Coalition Against Domestic Violence (NCADV) is an advocacy group founded in 1978 and acts as a national information and referral center for the general public, media, survivors of domestic violence and their children, and allied and member agencies and organizations. NCADV also works to influence legislation that would provide protection for survivors of domestic violence and their families and provide funding to shelters, healthcare centers, and other organizations.

National Council for Behavioral Health

http://www.thenationalcouncil.org
1701 K Street NW
Suite 400
Washington, DC 20006
Phone: 202-684-7457
Email: communications@thenationalcouncil.org

The National Council for Behavioral Health is a national community behavioral health

advocacy organization, formed in 1970, to conduct Federal advocacy activities, representing the industry on Capitol Hill and before Federal agencies. It also offers a national consulting service program, various publications, and an annual training conference. The National Council Magazine, 2011, Issue 2, focuses on trauma-informed behavioral health services. The National Council has offered a Learning Community for Adoption of Trauma-Informed Practices, funded by SAMHSA.

National Institute on Drug Abuse

http://drugabuse.gov
National Institute on Drug Abuse
National Institutes of Health
6001 Executive Boulevard
Room 5213, MSC 9561
Bethesda, MD 20892-9561
Phone: 301-443-1124
Email: information@nida.nih.gov

The National Institute on Drug Abuse's (NIDA) mission is to lead the Nation in bringing the power of science to bear on drug abuse and addiction. NIDA's goal is to ensure that science, not ideology or anecdote, forms the foundation for all of the Nation's drug abuse reduction efforts. NIDA was established in 1974, and in October 1992 it became part of the National Institutes of Health (NIH), HHS. The Institute is organized into divisions and offices, each of which plays an important role in programs of drug abuse research. NIDA has an ongoing research program on women's health and sex/gender differences, including the gathering of information on trauma and substance abuse.

National Institute of Mental Health

http://www.nimh.nih.gov
National Institute of Mental Health
Science Writing, Press, and Dissemination Branch
6001 Executive Boulevard
Room 8184, MSC 9663
Bethesda, MD 20892-9663
Phone: 301-443-4513
Fax: 301-443-4279
Email: nimhinfo@mail.nih.gov

The National Institute of Mental Health (NIMH) is one of the 27 component institutes of NIH, the Federal Government's principal biomedical and behavioral research agency that is part of HHS. NIMH's mission is to reduce the burden of mental illness and behavioral disorders through research on mind, brain, and behavior. This public health mandate demands that NIMH use science to achieve better understanding, treatment, and eventually, prevention of these disabling conditions that affect millions of Americans. NIMH offers publications and podcasts related to traumatic events and PTSD.

National Registry for Evidence-Based Programs and Practices

http://www.nrepp.samhsa.gov
Phone: 866-436-7377
Email: nrepp@samhsa.hhs.gov

SAMHSA's National Registry for Evidence-Based Programs and Practices (NREPP) is a searchable online registry of more than 300 interventions supporting mental health promotion, substance abuse prevention, and mental health and substance abuse treatment. NREPP offers several interventions that address trauma and PTSD.

National Sexual Violence Resource Center

http://www.nsvrc.org
123 North Enola Drive
Enola, PA 17025
Phone: 717-909-0710
Fax: 717-909-0714

The National Sexual Violence Resource Center (NSVRC) was founded by the Pennsylvania Coalition Against Rape in 2000 and is partially federally funded by grants from the Centers for Disease Control and Prevention. NSVRC advocates for changes in Federal and State legislation to further the goal of ending sexual violence in all communities, in addition to collecting and disseminating a wide range of resources on sexual violence, including statistics, research, position statements, statutes, training curricula, prevention initiatives and program information. NSVRC does not provide direct services to survivors of sexual violence but acts as a resource to support these services.

National Voluntary Organizations Active in Disasters

http://www.nvoad.org
1501 Lee Highway
Suite 170
Arlington, VA 22209-1109
Phone: 703-778-5088
Fax: 703-778-5091
Email: info@nvoad.org

National Voluntary Organizations Active in Disasters (NVOAD) coordinates planning efforts by many voluntary organizations responding to disaster. Member organizations provide more effective service and less duplication by getting together before disasters strike. Once disasters occur, NVOAD or an affiliated State VOAD encourages members and other voluntary agencies to convene on site. This cooperative effort has proven to be the most effective way for a wide variety of volunteers and organizations to work together in a crisis. NVOAD's principles are cooperation, coordination, communication, education, mitigation, convening mechanisms, and outreach.

Office for Victims of Crime Training and Technical Assistance Center

https://www.ovcttac.gov/
9300 Lee Highway
Fairfax, VA 22031-6050
Phone: 866-682-8822
TTY: 866-682-8880
Fax: 703-279-4673
Email: TTAC@ovcttac.org

The Office for Victims of Crime Training and Technical Assistance Center provides comprehensive, quality technical assistance and training resources to victims' service providers and allied professionals. Its mission is to support the development of the field by increasing the Nation's capacity to provide crime victims with skilled, capable, and sensitive assistance. Its core functions are needs assessment, capacity building, evaluation, and reporting.

Rape, Abuse & Incest National Network

http://www.rainn.org
1220 L Street NW
Suite 505
Washington, DC 20005
Phone: 202-544-1034
Email: info@rainn.org

The Rape, Abuse & Incest National Network (RAINN) is a nonprofit organization, founded in 1994, that is partially funded by a grant from the Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice. RAINN provides support for survivors of sexual assault via a telephone hotline and an online hotline and works with the Department of Defense (DoD) to provide a hotline for members of the DoD community who have experienced sexual assault.

SAMHSA's Tribal Training and Technical Assistance Center

http://beta.samhsa.gov/tribal-ttac
201 Corporate Drive
Suite 800
Landover, MD 20785
Phone: 240-650-0257
Email: TA-Request@tribaltechllc.com

SAMHSA's Tribal Training and Technical Assistance Center (Tribal TTAC) is committed to providing comprehensive broad, focused, and/or intensive training and technical assistance to federally recognized Tribes and other American Indian and Alaska Native communities seeking to address and prevent mental and substance use disorders and suicide while promoting mental health. The goal of the Tribal TTAC is to use a culturally relevant, evidence-based, holistic approach to support Native communities in their self-determination efforts through infrastructure development, capacity building, and program planning and implementation.

Sanctuary Model

http://www.sanctuaryweb.com
Phone: 888-538-3124

The goals of the Sanctuary Model include increasing the perceived sense of community/cohesiveness; the degree of social immunity to the spread of violence; the capacity for social learning; the making of decisions democratically and the sharing of responsibility in solving problems and resolving conflicts; the ability to deal with complexity; opportunities for all clients and staff members to experience a truly safe and connected community; opportunities for troubled clients to have corrective emotional, relational, and environmental experiences; and recovery, healing, and growth.

Seeking Safety

http://www.seekingsafety.org
Treatment Innovations
28 Westbourne Road
Newton Centre, MA 02459
Phone: 617-299-1610
Fax: 617-701-1295
Email: info@seekingsafety.org

This Web site provides information about Seeking Safety, a psychotherapeutic intervention for treating trauma, PTSD, and substance abuse. Seeking Safety is a present-focused therapy to help people attain safety from both PTSD and substance abuse. The treatment is also available as a book, which provides both client handouts and guidance for clinicians. The site includes topics included in the treatment program, sample materials, relevant empirical studies, and supplementary articles.

Sidran Institute

http://www.sidran.org
P.O. Box 436
Brooklandville, MD 21022-0436
Phone: 410-825-8888
Fax: 410-560-0134
Email: info@sidran.org

The Sidran Institute is a nationally focused nonprofit organization devoted to helping people who have experienced traumatic life events through education and advocacy. The Institute's education and advocacy focuses on:

- The early recognition and treatment of trauma-related stress in children.
- The understanding of trauma and its long-term effect on adults.
- The strategies in engaging in mutual-help recovery for trauma survivors.
- The clinical methods and practices leading in aiding trauma victims.
- The development of public policy initiatives responsive to the needs of adult and child survivors of traumatic events.

Substance Abuse and Mental Health Services Administration

http://www.samhsa.gov
1 Choke Cherry Lane
Rockville, MD 20857
Phone: 877-726-4727
Fax: 240-221-4292
Email: SAMHSAInfo@samhsa.hhs.gov

SAMHSA is the Federal agency within HHS charged with improving the quality and availability of prevention, treatment, and rehabilitative services to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illness. The Emergency Mental Health and Traumatic Stress Services Branch, a branch of SAMHSA's Center for Mental Health Services, works with FEMA to provide crisis counseling training and technical assistance to State and local mental health professionals. SAMHSA offers several publications regarding trauma and PTSD, as well as a publication focusing on creating a seclusion-free and restraint-free environment.

Traumatic Stress Institute

http://www.traumaticstressinstitute.org
Klingberg Family Centers
370 Linwood Street
New Britain, CT 06052
Phone: 860-224-9113

The Traumatic Stress Institute (TSI) works to increase understanding of the psychological impact of trauma and to help victims of violence restore meaning and wholeness to their lives. In meeting these goals, TSI is involved in clinical service, professional training, community education, and research. TSI offers forensic assessment and expert testimony, professional education, training opportunities, and publications. TSI developed the "Risking Connections" trauma treatment program and provides training in the use of this model.

Tulane University Traumatology Institute

http://sites.google.com/site/charlesfigley/Home/traumatologyinstitute
Tulane School of Social Work
6823 St. Charles Ave., Building 9
New Orleans, LA 70118
Phone: 800-631-8234
Email: figley@tulane.edu

The Traumatology Institute, founded in 1996, brings together health and mental health professionals from a wide array of disciplines from throughout the United States and around the world to develop cutting-edge research, treatment approaches, and training programs in the field of traumatology. The Institute facilitates the development of knowledge about the traumatization experience of victims, survivors, and the professionals who serve them. The Traumatology Institute conducts research, education, and service activities toward reducing the deleterious effects of trauma on individuals, families, communities, and entire societies.

Veterans Affairs PTSD Support Services

http://www.ptsdsupport.net/va.html
P.O. Box 5574
Woodland Park, CO 80866
Email: russ@ptsdsupport.net

The Department of Veterans Affairs Medical Centers provide a network of more than 100 specialized programs for veterans with PTSD, working closely in conjunction with the Veterans Web Site (http://www.vetcenter.va.gov) operated by VA's Readjustment Counseling Service. Each specialized PTSD program offers veterans education, evaluation, and treatment conducted by mental health professionals from a variety of disciplines (such as psychiatry, psychology, social work, counseling, and nursing). See also: National Center for PTSD.

White Bison Wellbriety Training Institute

http://www.whitebison.org
701 N. 20th Street
Colorado Springs, CO 80904
Phone: 877-871-1495
Email: info@whitebison.org

White Bison is an American Indian nonprofit charitable organization that focuses on offering sobriety, recovery, addictions prevention, and wellness/Wellbriety learning resources to the Native American community nationwide. White Bison's Wellbriety Training Institute provides training, tools, and resources for historical and intergenerational trauma to trainers and mental health professionals.

Resources for Children and Adolescents

The following section provides resources that address the needs of children and adolescents who are affected by traumatic stress.

American Academy of Child & Adolescent Psychiatry

http://www.aacap.org
3615 Wisconsin Avenue NW
Washington, DC 20016-3007
Phone: 202-966-7300
Fax: 202-966-2891

The American Academy of Child & Adolescent Psychiatry (AACAP) is a national professional medical association dedicated to treating and improving the quality of life for children, adolescents, and families affected by mental, behavioral, and developmental disorders. AACAP distributes information to promote an understanding of mental illnesses and remove the shame associated with them, to advance efforts in prevention of mental illnesses, and to ensure proper treatment and access to services for children and adolescents.

American Professional Society on the Abuse of Children

http://www.apsac.org
350 Poplar Avenue
Elmhurst, IL 60126
Phone: 630-941-1235
Fax: 630-359-4274
E-mail: apsac@apsac.org

The mission of the American Professional Society on the Abuse of Children (APSAC) is to enhance the ability of professionals to respond to children and families affected by abuse and violence. Among other initiatives, APSAC provides education and other sources of information to professionals who work in the child maltreatment and related fields.

Anna Institute

http://www.theannainstitute.org
21 Ocean Street
Rockland, ME 04841
Email: afj@gwi.net

The Anna Institute was founded in memory of artist Anna Caroline Jennings; it focuses on educating both the public and mental health professionals about the effects of sexual abuse and trauma on children. The Anna Institute's Web site provides articles on incorporating

trauma-informed care into existing behavioral health models, presentations on childhood trauma and retraumatization, and handouts for teachers at primary and secondary schools.

Caring for Every Child's Mental Health Campaign

http://www.samhsa.gov/children
P.O. Box 2345
Rockville, MD 20847-2345
Email: nmhic-info@samhsa.hhs.gov

SAMHSA's Caring for Every Child's Mental Health communications campaign is a national public information and education operation. Its goals are to increase public awareness about the importance of protecting the mental health of young people; foster the recognition that many children have mental health problems; and encourage caregivers to seek early, appropriate treatment and services. It also strives to reduce discrimination associated with mental health problems. The campaign is a technical assistance program that is part of the Comprehensive Community Mental Health Services Program for Children and Their Families.

Child Study Center

http://www.aboutourkids.org
One Park Avenue
7th Floor
New York, NY 10016
Phone: 212-263-6622
Email: webmaster@aboutourkids.org

The New York University Child Study Center Web site offers information to parents of children and adolescents with learning, behavioral, and emotional disorders, including PTSD and substance use disorders. An online newsletter is available. Its research initiatives advance understanding of the causes and treatments of child mental disorders, and these findings are integrated into clinical care to provide state-of-the-art service.

Child Trauma Academy

http://www.childtrauma.org
5161 San Felipe
Suite 320
Houston, TX 77056
Phone: 866-943-9779
Email: cta@childtrauma.org

The mission of the Child Trauma Academy is to help improve the lives of traumatized and maltreated children. Through education, service delivery, and program consultation, the academy seeks to advance systems that educate, nurture, protect, and enrich these children.

Child Trauma Institute

http://www.childtrauma.com
P.O. Box 544
Greenfield, MA 01302-0544
Phone: 413-774-2340
Email: cti@childtrauma.com

The Child Trauma Institute provides training, consultation, information, and resources for those who work with trauma-exposed children, adolescents, and adults. The Web site has information for parents, publications for parents and professionals, and links to other child trauma Web sites.

Child Welfare Information Gateway

http://www.childwelfare.gov
Children's Bureau/ACYF
1250 Maryland Avenue SW
Eighth Floor
Washington, DC 20024
Phone: 800-394-3366
Email: info@childwelfare.gov

The Child Welfare Information Gateway (CWIG) is a service of the Children's Bureau in the Administration for Children and Families, part of HHS, which provides information

to child welfare and mental health professionals about programs, research, laws and policies, training approaches, and statistics regarding child welfare, child abuse and neglect, and adoption. CWIG offers educators' toolkits for preventing and responding to child abuse and neglect, a function to search State statutes about child abuse and neglect, and logic model builder toolkits for program administrators.

Child Welfare League of America

http://www.cwla.org
1726 M Street NW
Suite 500
Washington DC, 20036
Phone: 202-688-4200
Fax: 202-833-1689

Through its member child welfare agencies, the Child Welfare League of America develops and disseminates practice standards as benchmarks for high-quality services that protect children and youth; promotes high-quality services through training, consultation, conferences, and publications; formulates and promotes public policies that contribute to the well-being of children and youth; ensures that all child welfare services are provided in a manner that demonstrates respect for cultural and ethnic diversity; and promotes open exchange of data, resources, and ideas within and across systems that serve children, youth, and families.

Eunice Kennedy Shriver National Institute of Child Health and Human Development

http://www.nichd.nih.gov/Pages/index.aspx
31 Center Drive
Building 31, Room 2A32
Bethesda, MD 20892-2425
Phone: 800-370-2943

Established in 1962, NIH's National Institute of Child Health and Human Development (NICHD) focuses on human development processes from conception to later years. The Institute implements, conducts, and supports laboratory research, clinical trials, epidemiological research, and other studies that explore health processes and the impact of disabilities, diseases, and variations on the lives of individuals. NICHD sponsors training for scientists and healthcare providers to promote the goals of the Institute.

National Center for Children Exposed to Violence

http://www.nccev.org
Yale Child Study Center
230 South Frontage Road
P.O. Box 207900
New Haven, CT 06520-7900
Phone: 877-496-2238
Email: colleen.vadala@yale.edu

The National Center for Children Exposed to Violence (NCCEV) seeks to increase the capacity of individuals and communities to reduce the incidence and impact of violence on children and families; to train and support the professionals who provide intervention and treatment; and to increase professional and public awareness of the effects of violence on children, families, communities, and society. The Center's Web site is a rich source of information. NCCEV is supported by grants from the Office of Juvenile Justice and Delinquency Prevention, the Department of Justice, SAMHSA, and the Department of Education.

National Center on Substance Abuse and Child Welfare

http://www.ncsacw.samhsa.gov
P.O. Box 2345
Rockville, MD 20847-2345
Phone: 866-493-2758
Email: ncsacw@cffutures.org

The National Center on Substance Abuse and Child Welfare (NCSACW) is an initiative of HHS and is jointly funded by SAMHSA's Center for Substance Abuse Treatment and the Administration on Children, Youth and Families, Children's Bureau's Office on Child Abuse and Neglect. NCSACW seeks to develop and implement a comprehensive program of information gathering and dissemination, to provide technical assistance, and to develop knowledge that promotes effective practical, organizational, and systemic changes at the local, State, and national levels. Its Web site includes PowerPoint presentations, online tutorials and training, technical assistance presentations, and additional print resources.

National Child Traumatic Stress Network

http://www.nctsnet.org
NCTSN—University of California, Los Angeles
11150 W. Olympic Boulevard
Suite 650
Los Angeles, CA 90064
Phone: 310-235-2633
Fax: 310-235-2612

The National Child Traumatic Stress Network (NCTSN), currently comprising 54 treatment centers nationwide, is funded by SAMHSA's Center for Mental Health Services through the Donald J. Cohen National Child Traumatic Stress Initiative and coordinated by Duke University and the University of California, Los Angeles. The purpose of this congressionally mandated initiative is to improve the quality, effectiveness, provision, and availability of therapeutic services delivered to all children and adolescents experiencing traumatic events. NCTSN works with SAMHSA to raise public awareness of the effects of traumatic stress on children and families, and with other systems of care (including the health, mental health, education, law enforcement, child welfare, juvenile justice, and military family service systems) to ensure that there is a comprehensive trauma-informed continuum of accessible care. Additionally, NCTSN offers a list of evidence-based and promising practices.

National Institute for Trauma and Loss in Children

http://www.starrtraining.org/trauma-and-children
42855 Garfield Road
Suite 111
Clinton Township, MI 48038
Phone: 877-306-5256
Fax: 586-263-4915
Email: TLC@starrtraining.org

The National Institute for Trauma and Loss in Children provides school professionals, crisis intervention teams, medical and mental health professionals, child care professionals, and clinicians with trauma education, training, consultation, referral services, and trauma-specific intervention programs and resource materials needed to help those traumatized by violent or nonviolent trauma-inducing incidents.

National Native Children's Trauma Center

http://iers.umt.edu/National_Native_Childrens_Trauma_Center
Institute for Educational Research and Service
McGill Hall 026
The University of Montana
Missoula, MT 59812-6376
Phone: 406-243-5344
Fax: 406-243-2197
Email: iers@mso.umt.edu

The National Native Children's Trauma Center (NNCTC) is a federally funded organization created by SAMHSA and affiliated with the National Child Traumatic Stress Network. It

is run by the University of Montana. NNCTC offers trauma interventions and trainings to address trauma in American Indian/Alaska Native children, primarily through clinicians, Tribal programs, school systems, and community agencies.

Training Opportunities

The following resources highlight various training and credentialing opportunities for behavioral health professionals interested in gaining more education in treating and providing services to those affected by trauma. It is not an exhaustive list, but provides a starting place for service providers looking for further training.

The Web site of the ISTSS has posted a directory of trauma-related academic and training opportunities (http://www.istss.org/LearningAboutTrauma.htm). It includes links to the institutions providing the programs. The Association for Traumatic Stress Specialists (http://www.atss.info) offers three levels of recognition for education and experience:

- Certified Trauma Specialist (CTS)—designed for counselors, clinicians, and treatment specialists who provide intervention services or individual, group, and/or family counseling. This certification requires 240 hours of education and training in trauma treatment, plus 2,000 hours of trauma counseling and intervention experience.
- Certified Trauma Responder (CTR)—designed for those who provide immediate trauma interventions. It requires a minimum of 40 hours of experience on a crisis or critical incident response team, an associate degree or a high school diploma with successful completion of disaster or critical incident stress debriefing training, and 72 hours of crisis response training.
- Certified Trauma Services Specialist (CTSS)—designed for those who provide immediate trauma intervention, crisis support, advocacy, or victim assistance. It requires 1 year of experience in a trauma-related field, plus specific training.

Some colleges and universities, such as the International Trauma Studies Program at New York University and the Center for Anxiety and Related Disorders at Boston University, provide specialty trauma training for mental health practitioners. The University of Missouri at St. Louis offers specialized training in trauma therapy or research at its Center for Trauma Recovery to students in its Clinical Psychology graduate program. The Center for the Treatment and Study of Anxiety at the University of Pennsylvania provides training for health professionals. The Department of Counseling at the University of Nevada, Las Vegas offers a graduate and undergraduate course on Trauma and Addiction; graduate students can receive training in trauma and addictions as part of the Advanced Graduate Certificate in Addiction Studies. The Medical University of South Carolina offers Web-based courses in trauma-focused cognitive–behavioral therapy (TF-CBT) and in using TF-CBT for childhood traumatic grief. Many universities have faculty members with expertise in trauma and trauma-related subjects, so that training can be accessed through many graduate programs.

The Addiction Technology Transfer Center (ATTC) Network, a resource established in 1993 by the SAMHSA's Center for Substance Abuse Treatment, is a network of 14 independent regional centers with a national office. One of its programs provides long-distance education for clinicians on various topics. Among hundreds of self-paced, self-directed, and supervised courses available online (http://www.attcnetwork.org/learn/education/

dasp.asp) are Substance Abuse Treatment for Trauma Survivors, Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues, Chemical Dependency and Posttraumatic Stress Disorder, Clinical Self-Care for Addiction Counselors and Clinical Supervisors, Eye Movement Desensitization and Reprocessing, Battered Women and Addictions, and Posttraumatic Stress Disorder. ATTC training and educational opportunities are based on empirical research and are intended to bring science to service. Undoubtedly, more distance-learning courses in this specialized area of interest will be developed as professional attention to co-occurring disorders increases.

SAMHSA's Center for Mental Health Services provides training for FEMA-approved crisis counseling programs using Stafford Act funding. These funding resources are available to select agencies designated to provide crisis counseling in the wake of a Presidential Disaster Declaration. Other funding for trauma training may be found through special programs of funding for target groups, such as those who provide mental health services and case management for victims of crime (e.g., Office for Victims of Crime in the U.S. Department of Justice; see p. 257).

The American Red Cross provides limited disaster mental health training. The focus of this training is to orient licensed mental health professionals to the Red Cross Disaster services system and their roles as volunteers.

The National Center for Post-Traumatic Stress Disorder was originally created in 1989 within the U.S. Department of Veterans Affairs (VA) to address the needs of veterans with military-connected PTSD. Its focus has since broadened to include trauma in general. The Center provides a variety of training opportunities for both VA and non-VA mental health personnel, including a PTSD 101 course developed specifically for clinicians who provide services to clients who have experienced trauma (see http://www.ptsd.va.gov/professional/index.asp).

Seeking Safety offers training in trauma, PTSD, and co-occurring disorders to mental health professionals on all levels, from counselors to nurses to administrators. The EMDR International Association (EMDRIA) provides training to clinicians for certification in EMDR via a curriculum including instruction, supervised practicum, and consultation; EMDRIA additionally provides basic training in the field, separate from the certification process. EMDR training is also provided by the EMDR Humanitarian Assistance Program, a nonprofit organization with a training-focused model to assist clinicians in treating trauma.

ISTSS was founded in 1985 to bring attention to the study, assessment, and treatment of traumatized people (http://www.istss.org). ISTSS is a professional society and provides face-to-face training during its annual meeting, especially through the preconference institutes. The ISTSS Web site offers numerous video and audio trainings for continuing education credits. ISTSS and the Figley Institute (http://www.figleyinstitute.com) have established best practice standards. The American Academy of Experts in Traumatic Stress provides training and certification in several different areas (http://www.aaets.org). Similarly, the International Society for the Study of Dissociation (http://www.issd.org) specializes in promoting therapies for dissociative disorders. In 2002, the Green Cross Academy of Traumatology (http://www.greencross.org) established a Commission on Accreditation of Traumatology Education Programs to increase and maintain the high standards in the education and training of traumatologists.

Appendix C—Historical Account of Trauma

Historically, symptoms of traumatic stress have been recorded in both military and civilian populations (Lasiuk & Hegadoren, 2006). Early accounts described the effect of battle conditions on soldiers; "soldier's heart" and "nostalgia" were the terms for traumatic stress reactions used during the American Civil War. As warfare techniques and strategies changed, so did the depiction of soldiers' traumatic stress reactions. The advent of heavy explosives in World War I led to the attribution of symptoms to "shell shock," giving a more physiological description of the effects from explosions (Benedek & Ursano, 2009). On the civilian side, the industrial revolution gave rise to larger and more dramatic catastrophes, including industrial and railway accidents. These, as well as other disasters, are noted in occupational health histories, newspapers, and contemporary literature.

Even with a more physical explanation of traumatic stress (i.e., shell shock), a prevailing attitude remained that the traumatic stress response was due to a character flaw. For instance, a soldier's pain at that time was often seen as a symptom of homesickness. In spite of the efforts of Charcot, Janet, and Freud, who described the psychogenic origin of symptoms as a response to psychological trauma (Lasiuk & Hegadoren, 2006), World War II military recruits were screened in attempt to identify those "who were afflicted with moral weakness," which would prevent them from entering military service.

At the same time, there were new treatment innovations for war-related trauma during World War II. One approach treated soldiers in the field for what was then called "battle fatigue" by allowing some time for rest before returning to battle. During the Korean and Vietnam wars, approaches began to focus more on the use of talk therapy. It was not until the post-Vietnam era that interest in developing treatment alternatives started to take hold. During this time, the U.S. Department of Veterans Affairs (then called the Veterans Administration) developed group therapy for posttraumatic stress disorder (PTSD). Beyond being cost-effective, the technique was well suited to the symptoms of the veterans and fostered socialization and reintegration (Greene et al., 2004).

The publication of the American Psychiatric Association's (APA's) *Diagnostic and Statistical Manual of Mental Disorders,* Third Edition (DSM-III), in 1980 marked the introduction of PTSD as a diagnosis, inspired by symptoms presented by veterans of the Vietnam War (Benedek & Ursano, 2009). The diagnosis in this iteration required the identification of a specific stressor—a catastrophic stressor that was outside the range of usual human experience (APA, 1980)—and classified PTSD as

Historical Approaches to Trauma Healing and Recovery

First Generation of Approaches to Trauma Healing and Recovery
The first generation approaches to trauma healing and recovery focused on individual and clinical interventions to address the symptoms of PTSD and moved toward integration of trauma effects into ongoing life activities. The rapidly developing recognition of additional groups with violence and trauma histories—beyond those with war and captivity experiences (e.g., survivors of natural disasters and terrorism, refugees and immigrants fleeing homeland violence and persecution)—presented issues and needs that incited a second generation of approaches to trauma healing and recovery.

Second Generation of Approaches to Trauma Healing and Recovery
The second generation approaches focused on psychosocial education and empowerment models designed to tap into self-healing forces to energize personal and social movement. These approaches often are based on group and peer support models, and provide both support and education on the management of trauma and its affects. These approaches are not designed to replace clinical or alternative therapies; rather, they provide a social context for care.

Concurrent to the development of psychosocial educational empowerment approaches, we also learned that if the approaches are not implemented in organizations or programs that are trauma-informed, they will not take root and may lose effectiveness.

Trauma-Informed Care: A New Paradigm for Public Health Services
Trauma-informed care is a new paradigm for organizing public mental health and human services. Trauma-informed care changes the opening question for those seeking services from "What is wrong with you?" (patient or consumer) to "What has happened to you?" (survivor). Trauma-informed care is initiated by assumption that every person seeking services is a trauma survivor who designs his or her own path to healing, facilitated by support and mentoring from the service provider.

In a trauma-informed environment, survivors are empowered to proactively set goals and to manage progress toward those goals. For most existing organizations or programs, that requires movement from a traditional "top down" hierarchical clinical model to a psychosocial empowerment partnership that embraces all possible tools and paths to healing. In a pluralistic public health system with many levels and types of services and treatment, this is coming to be accepted as a "sine qua non," or "without which not," for humane, dignified, cost-effective, genuinely person-centered support and assistance in moving forward.

Source: Salasin, 2011, p. 18.

an anxiety disorder (Lasiuk & Hegadoren, 2006). Beginning with this definition, the body of research grew, and the scope of application began to broaden, but not without considerable debate on what constituted a trauma.

The social revolution that began in the 1960s, combined with the women's movement and the call for more attention to diverse and disenfranchised groups, set the stage for an increase in the acknowledgement and treatment of victims of interpersonal violence and crime-related trauma (Figley, 2002). The introduction of rape trauma syndrome as a condition highlighted the psychological consequences of sexual assault and the subsequent lack of support from society and the social services system (Kramer & Green, 1997). Subsequently, research began to focus more on interpersonal violence, thus leading to the identification of risk factors and treatment approaches unique to this form of violence and trauma (Olff, Langeland, Drajer, & Gersons, 2007).

With input from international and national mental health organizations and research, the DSM-IV further modified the definition of trauma to include a broader interpretation of the identified stressor (Andreasen, 2010). DSM-5 has maintained the modified definition of trauma, but the criterion requires being explicit as to whether qualifying traumatic events were experienced directly, witnessed, or experienced indirectly (APA, 2013b).

Paralleling the change in DSM criteria, cognitive–behavioral therapy for traumatic stress was developed along with other skills-based approaches (Greene et al., 2004).

Researchers, such as Foa, Resick, D'Zurilla, and Michenbaum, added to the body of knowledge and gave clinicians a variety of tools; these approaches continue to develop and show efficacy even today. There was also renewed interest in the long- and short-term effects of childhood sexual abuse and domestic violence. Interest in documenting the effects of trauma expanded further, including traumatic brain injury, significant orthopedic injuries, and multiple traumas (Starr et al., 2004). So too, the consumer movement in health care began. Consumers insisted on patient rights, humane treatment, and involvement in the treatment process; as a result, the paternalistic approach to health care began to change. As consumers set the initial stage and Federal agencies (e.g., the Substance Abuse and Mental Health Services Administration and its centers) and national organizations promoted the need for trauma-informed policies and care, national studies began to demonstrate the prevalence of traumatic experiences. Research including the Adverse Childhood Experiences and the Women, Co-Occurring, and Violence studies clearly demonstrated the pervasive long-term impact of trauma, reinforcing the call for trauma-informed policies and care. (For more information on the development of trauma-informed care, see Harris and Fallot, 2001b, as well as Jennings, 2004.)

Appendix D—Screening and Assessment Instruments

This appendix provides a selected sample of available tools for screening and assessment of traumatic events and trauma-related symptoms. This is not an exhaustive list, nor does this list focus on screening instruments that capture a broader range of symptoms related to trauma (such as sleep hygiene and dissociation) or other features important in providing trauma-informed care (e.g., resilience level, coping skill style, resource availability). For more information on a broad range of available instruments, refer back to Part 1, Chapter 4. Many of the instruments listed below use criteria found in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR; APA, 2000), but with the release of the DSM-5 (APA, 2013a), instruments will evolve, and new versions will be available under the same contact information.

Screening and Assessment Measures

- Clinician Administered PTSD Scale (CAPS)
- Davidson Trauma Scale (DTS)
- Distressing Event Questionnaire (DEQ)
- Evaluation of Lifetime Stressors (ELS)
- Impacts of Event Scale Revised (IES-R)
- Mississippi Scale for Combat-Related PTSD (M-PTSD)
- Penn Inventory for Posttraumatic Stress Disorder
- Posttraumatic Diagnostic Scale (PDS)
- PTSD Symptom Scale-Interview (PSS-I)
- PTSD Symptom Scale: Self-Report Version (MPSS-SR)
- Screen for Posttraumatic Stress Symptoms (SPTSS)
- Structured Interview for PTSD (SI-PTSD)
- Trauma Assessment for Adults (TAA)
- Trauma Assessment for Adults (TAA)–Self Report
- Trauma History Questionnaire (THQ)
- Trauma Symptom Inventory (TSI)
- Traumatic Stress Schedule

Screening and Assessment Measures

Clinician Administered PTSD Scale (CAPS)

Domains:	Posttraumatic stress disorder (PTSD), acute stress disorder (ASD)
Timeframe:	CAPS-Sx: Lifetime and current (past week) CAPS-Dx: Current (past month)
Response format:	Other
Format of administration:	Structured
Number of items:	30
Completion time:	30–60 minutes
Qualifications to administer:	Administered by clinicians and clinical researchers who have a working knowledge of PTSD and by appropriately trained paraprofessionals
How to obtain scale:	Contact Danny G. Kaloupek, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Populations sampled: veterans, car accident survivors Reliability: alpha = .94, test-retest = .90–.98 Validity: sensitivity = .85, specificity = .95 (compared with Structured Clinical Interview for DSM Disorders [SCID]), r = .91 (with MS Scale for Combat-related PTSD) kappa = .77 against the SCID diagnosis; item-total correlations = .49–.82; internal consistency = .94
Author(s):	Dudley David Blake, Frank W. Weathers, Linda M. Nagy, Danny G. Kaloupe, Dennis S. Charney, and Terence M. Keane
Contact:	Danny G. Kaloupek, Ph.D. National Center for PTSD Boston VA Medical Center, 11B 150 South Huntington Avenue Boston, MA 02130
Relevant citations:	Blake, D. D. (1994). Rationale and development of the clinician-administered PTSD scales. *PTSD Research Quarterly, 5,* 1–2. Blake, D. D., Weathers, F. W., Nagy, L. M., Kaloupek, D. G., Gusman, F. D., Charney, D. S., & Keane, T. M. (1995). The development of a clinician-administered PTSD scale. *Journal of Traumatic Stress, 8*, 75–90.

Gray, M., Litz, B., Hsu, J., & Lombardo, T. (2004). Psychometric properties of the Life Events Checklist. *Assessment, 11*, 330–341.

Weathers, F. W., Keane, T. M., & Davidson, J. R. (2001). Clinician-Administered PTSD Scale: A review of the first ten years of research. *Depression and Anxiety, 13*, 132–156.

Davidson Trauma Scale (DTS)

Domains:	PTSD symptoms
Timeframe:	Current (past week)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	17
Completion time:	10–15 minutes
Qualifications to administer:	Bachelor's degree in psychology. Must have related field and course work in the use of assessment instruments or special training in the use of this instrument. Education/training requirements may be waived for those granted the right to administer tests at this level (B) in their jurisdiction.
How to obtain scale:	Contact Mental Health Systems, Inc.
Cost or public domain:	Cost: $15.00
Psychometrics:	Populations sampled: rape victims, veterans, hurricane victims, miscellaneous traumas Reliability: alpha = .99, test-retest = .86
Author(s):	Jonathan R.T. Davidson
Contact:	Mental Health Systems, Inc. 908 Niagara Falls Boulevard North Tonawanda, NY, 14120-2060 800-456-3003
Relevant citations:	Davidson, J. R. T., Book, S. W., Colket, J. T., Tupler, L. A., Roth, S., David, D., Hertzberg, M., Mellman, T., Beckham, J.C., Smith, R., Davison, R. M., Katz, R., & Feldman, M. (1997). Assessment of a new self-rating scale for posttraumatic stress disorder. *Psychological Medicine, 27,* 153–160. Davidson, J. R., Tharwani, H. M., & Connor, K. M. (2002). Davidson Trauma Scale (DTS): Normative scores in the general population and effect sizes in placebo-controlled SSRI trials. *Depression and Anxiety, 15*, 75–78.

Distressing Event Questionnaire (DEQ)

Domains:	Posttraumatic Stress Disorder (PTSD) for multiple events
Timeframe:	Lifetime
Response format:	Self-administered
Format of administration:	Structured
Number of items:	35
Completion time:	10–15 minutes
Qualifications to administer:	Contact Edward Kubany, Ph.D.
How to obtain scale:	Contact Edward Kubany, Ph.D.
Cost or public domain:	Contact Edward Kubany, Ph.D.
Psychometrics:	Population sampled: veterans, battered women Reliability: inter-item r = .93, test-retest = .95; validity: Pearson's r reliability coefficient = .83 (with Penn Inventory, Pearson's r reliability coefficient = .76 (with Beck Depression Inventory)
Author(s):	Edward Kubany, Mary Beth Leisen, Aaron S. Kaplan, Martin P. Kelly
Contact:	Edward Kubany, Ph.D. National Center for PTSD Pacific Islands Division Department of VA Suite 307 Honolulu, HI 96813 Kubany.Edward@honolulu.va.gov
Relevant citations:	Kubany, E. S., Leisen, M. B., Kaplan, A. S., & Kelly, M. P. (2000). Validation of a brief measure of posttraumatic stress disorder: The distressing event questionnaire (DEQ). *Psychological Assessment, 12*, 197–209.

Evaluation of Lifetime Stressors (ELS)

Domains:	Trauma history
Timeframe:	Lifetime
Response format:	Other
Format of administration:	Structured
Number of items:	56
Completion time:	10–20 minutes for screening, 1–3 hours for complete interview
Qualifications to administer:	Should be administered by trained clinicians only

How to obtain scale:	Contact Karen Krinsley, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Populations sampled: male veterans, female sexual abuse survivors Reliability: r = .4–1.0
Author(s):	Karen Krinsley, Frank W. Weathers, Elana Newman, Edward A. Walker, Danny G. Kaloupek, Rachel Kimerling
Relevant citations:	Corcoran, C. B., Green, B. L., Goodman, L. A., & Krinsley, K. E. (2000). Conceptual and methodological issues in trauma history assessment. In A. Y. Shalev, R. Yehuda, & A. C. McFarlane (Eds.), *International handbook of human response to trauma* (pp. 22–232). Dordrecht, Netherlands: Kluwer Academic Publishers. Krinsley, K. (1996). Psychometric review of the Evaluation of Lifetime Stressors (ELS) Questionnaire and Interview. In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation (*pp. 160–162). Lutherville, MD: Sidran Press.

Impact of Event Scale Revised (IES-R)

Domains:	PTSD for a single event
Timeframe:	Current (past week)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	22
Completion time:	5–10 minutes for screening
Qualifications to administer:	None
How to obtain scale:	http://consultgerirn.org/uploads/File/trythis/try_this_19.pdf
Cost or public domain:	Public domain
Psychometrics:	Populations sampled: earthquake survivors, emergency disaster workers, Vietnam veterans, violence and sexual assault victims Reliability: alpha = .79–.92, test-retest = .89–.94, Pearson's r reliability coefficient = .74–.87
Author(s):	Daniel Weiss and Charles R. Marmar
Relevant citations:	Sundin, E. C. & Horowitz, M. J. (2002). Impact of Event Scale: Psychometric properties. *British Journal of Psychiatry, 180,* 205–209. Weiss, D. S. & Marmar, C. R. (1996).The Impact of Event Scale-Revised. In J. Wilson & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 399–411). New York: Guilford Press. (Includes measure in its entirety.)

Mississippi Scale for Combat-Related PTSD (M-PTSD)

Domains:	PTSD for multiple events
Timeframe:	Contact National Center for PTSD at ncptsd@ncptsd.org
Response format:	Self-administered
Format of administration:	Structured
Number of items:	35
Completion time:	10–15 minutes
Qualifications to administer:	Contact National Center for PTSD at ncptsd@va.gov
How to obtain scale:	To order the scale contact the National Center for PTSD
Cost or public domain:	Free (ncptsd@va.gov)
Psychometrics:	Population sampled: veterans Reliability: inter-item r = .94, test-retest = .97 Validity: sensitivity = .93, specificity = .89
Author(s):	Terence M. Keane
Contact:	National Center for PTSD (116D) VA Medical Center 215 N. Main St. White River Junction, VT 05009 http://www.ptsd.va.gov/
Relevant citations:	Engdahl, B. & Eberly, R. (1994). Assessing PTSD among veterans exposed to war trauma 40–50 years ago. *NCP Clinical Quarterly, 4,* 13–14. Keane, T. M., Caddell, J. M., & Taylor, K. L. (1988). Mississippi Scale for Combat-Related Posttraumatic Stress Disorder: Three studies in reliability and validity. *Journal of Consulting and Clinical Psychology, 56,* 85–90.

Penn Inventory for Posttraumatic Stress Disorder

Domains:	PTSD for multiple events
Timeframe:	Current (past week)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	26
Completion time:	5–15 minutes

Qualifications to administer:	Contact Melvyn Hammarberg, Ph.D.
How to obtain scale:	Contact Melvyn Hammarberg, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Population sampled: veterans, oil-rig disaster survivors Reliability: alpha = .94, test-retest = .96
Author(s):	Melvyn Hammarberg
Contact:	Melvyn Hammarberg, Ph.D. Department of Anthropology University of Pennsylvania 325 University Museum 33rd and Spruce Street Philadelphia, PA 19104-6398
Relevant citations:	Hammarberg, M. (1996). Psychometric review of the Penn Interview for Post Traumatic Stress Disorder. In B. H, Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 231–235). Lutherville, MD: Sidran Press. (Includes measure in its entirety.) Steel, J. L., Dunlavy, A. C., Stillman, J., & Pape, H. C. (2011). Measuring depression and PTSD after trauma: Common scales and checklists. *Injury, 42,* 288–300.

Posttraumatic Diagnostic Scale (PDS)

Domains:	DSM-IV PTSD symptom clusters
Timeframe:	Current (past month)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	49
Completion time:	10–15 minutes
Qualifications to administer:	Bachelor's degree in psychology. Must have related field and course work in the use of assessment instruments or special training in the use of this instrument.
How to obtain scale:	Contact National Computer Systems (NCS)
Cost or public domain:	Cost: $15.00
Psychometrics:	Population sampled: accident/fire, disaster, assault, sexual assault, sexual abuse, major illness Reliability: alpha = .92, test-retest = .83 Validity: sensitivity = .89, specificity = .75

Author(s):	Edna B. Foa, Ph.D.
Contact:	National Computer Systems (NCS) 5605 Green Circle Drive Minnetonka, MN 55343
Relevant citations:	Foa, E. (1996). *Post-traumatic Diagnostic Scale manual*. Minneapolis, MN: National Computer Systems. Foa, E., Cashman, L., Jaycox, L., & Perry, K. (1997). The validation of a self-report measure of PTSD: The Post-traumatic Diagnostic Scale (PDS). *Psychological Assessment, 9*, 445–451. Steel, J. L., Dunlavy, A. C., Stillman, J., & Pape, H. C. (2011). Measuring depression and PTSD after trauma: Common scales and checklists. *Injury, 42,* 288–300.

PTSD Symptom Scale-Interview (PSS-I)

Domains:	PTSD single event
Timeframe:	Current (past 2 weeks)
Response format:	Other
Format of administration:	Structured
Number of items:	17
Completion time:	20 minutes
Qualifications to administer:	Can be administered by a master's level interviewer after a few hours of training.
How to obtain scale:	Contact Edna B. Foa, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Population sampled: female sexual assault victims, female assault victims Reliability: alpha = .85, test-retest = .80; validity: sensitivity = .88, specificity = .96 (compared with SCID); Pearson's r reliability coefficient = .48–.80 (with Impact of Events intrusion and avoidance, State portion of State-Trait Anxiety Inventory, and MPSS-SR)
Author(s):	Edna B. Foa and Gregory A. Leskin
Contact:	Edna B. Foa, Ph.D. Medical College of Pennsylvania Department of Psychiatry 3200 Henry Avenue Philadelphia, PA 19129-1137

Relevant citations:	Foa, E. B., Riggs, D. S., Dancu, C. V., & Rothbaum, B. O. (1993). Reliability and validity of a brief instrument for assessing post-traumatic stress disorder. *Journal of Traumatic Stress, 6*, 459–474. Foa, E. & Tolin, D. F. (2005). Comparison of the PTSD Symptom Scale-Interview Version and the clinician administered PTSD Scale. *Journal of Traumatic Stress, 13*, 181–191. Leskin, G. A. (1999). Screening for trauma and PTSD in a primary care clinic. *NC-PTSD Clinical Quarterly, 8*, 68–69.

PTSD Symptom Scale: Self-Report Version (MPSS-SR)

Domains:	PTSD for multiple or unknown events
Timeframe:	Current (past 2 weeks)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	17
Completion time:	10–15 minutes
Qualifications to administer:	Contact Sherry Falsetti, Ph.D.
How to obtain scale:	Contact Sherry Falsetti, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Reliability: alpha = .96–.97 Validity: sensitivity = .89, specificity = .65
Author(s):	Sherry Falsetti, Patricia A. Resick, Heidi S. Resnick, Dean G. Kilpatrick
Contact:	Sherry Falsetti, Ph.D. University of Illinois College of Medicine Department of Family and Community Medicine 1601 Parkview Avenue Rockford, IL 61107-1897
Relevant citations:	Bonin, M. F., Norton, G. R., Asmundson, G. J., Dicurzio, S., & Pidlubney, S. (2000). Drinking away the hurt: The nature and prevalence of PTSD in substance abuse patients attending a community-based treatment program. *Journal of Behavior Therapy and Experimental Psychiatry, 31*, 55–66. Coffey, S. F., Dansky, B. S., Falsetti, S. A., Saladin, M. E., & Brady, K. T. (1998). Screening for PTSD in a substance abuse sample:

Psychometric properties of a modified version of the PTSD Symptom Scale Self-Report. *Journal of Traumatic Stress, 11,* 393–399.

Falsetti, S. A., Resnick, H. S., Resick, P. A., & Kilpatrick, D. (1993). The Modified PTSD Symptom Scale: A brief self-report measure of post-traumatic stress disorder. *The Behavioral Therapist, 16*, 161–162.

Screen for Posttraumatic Stress Symptoms (SPTSS)

Domains:	PTSD for multiple or unknown events
Timeframe:	Current (past 2 weeks)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	17
Completion time:	5 minutes
Qualifications to administer:	Contact Eve Carlson, Ph.D.
How to obtain scale:	Contact Eve Carlson, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Population sampled: psychiatric inpatients Reliability: split half reliability = .91, test-retest = .82
Author(s):	Eve Carlson, Ph.D.
Contact:	Eve Carlson, Ph.D. National Center for PTSD (352-117-MP) Palo Alto Health Care System 795 Willow Road Menlo Park, CA 94025
Relevant citations:	Carlson, E. (2001). Psychometric study of a brief screen for PTSD: Assessing the impact of multiple traumatic events. *Assessment*, *8*, 431–441.

Structured Interview for PTSD (SI-PTSD)

Domains:	PTSD single event
Timeframe:	Current (past 4 weeks)
Response format:	Other
Format of administration:	Structured
Number of items:	17

Completion time:	20–30 minutes
Qualifications to administer:	Can be administered by mental health professionals or by paraprofessionals after some training.
How to obtain scale:	Contact Jonathan Davidson, M.D.
Cost or public domain:	Public domain
Psychometrics:	Population sampled: veterans Reliability: alpha = .94, test-retest = .71, intraclass r = .97 Validity: sensitivity = .96, specificity = .80 (compared with SCID), Pearson's r reliability coefficient = .61 (with IES), Pearson's r reliability coefficient = .51 (with Hamilton Anxiety Scale)
Author(s):	Jonathan Davidson
Contact:	Jonathan Davidson, M.D. Department of Psychiatry Box 3812 Duke University Medical Center Durham, NC 27710-3812
Relevant citations:	Davidson, J. R. T., Kudler, H. S., & Smith, R. D. (1990). Assessment and pharmacotherapy of posttraumatic stress disorder. In J. E. L. Giller (Ed.), *Biological assessment and treatment of post-traumatic stress disorder* (pp. 205–221). Washington, DC: American Psychiatric Press. (Includes measure in its entirety.) Steel, J. L., Dunlavy, A. C., Stillman, J., & Pape, H. C. (2011). Measuring depression and PTSD after trauma: Common scales and checklists. *Injury, 42,* 288–300.

Trauma Assessment for Adults (TAA)

Domains:	Trauma history
Timeframe:	Lifetime
Response format:	Other
Format of administration:	Structured
Number of items:	13
Completion time:	10–15 minutes
Qualifications to administer:	None specified
How to obtain scale:	Contact Heidi Resnick, Ph.D.
Cost or public domain:	Public domain

Psychometrics:	Populations sampled: adult mental health center clients; face validity established; feasible; validity established via archival records
Author(s):	Connie L. Best, John R. Freedy, Sherry A. Falsetti, Dean G. Kilpatrick, Heidi S. Resnick
Relevant citations:	Cusack, K. J., Frueh, B. C., & Brady, K. T. (2004). Trauma history screening in a community mental health center. *Psychiatric Services, 55,* 157–162. Resnick, H. S. (1996). Psychometric review of Trauma Assessment for Adults (TAA). In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 362–365). Lutherville, MD: Sidran Press.

Trauma Assessment for Adults (TAA)–Self Report

Domains:	Trauma history
Timeframe:	Lifetime
Response format:	Self-administered
Format of administration:	Structured
Number of items:	17
Completion time:	10–15 minutes
Qualifications to administer:	None specified
How to obtain scale:	Contact Heidi Resnick, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	None to date
Author(s):	Connie L. Best, John R. Freedy, Sherry A. Falsetti, Dean G. Kilpatrick, Heidi S. Resnick
Relevant citations:	Resnick, H. S., Falsetti, S. A., Kilpatrick, D. G., & Freedy, J. R. (1996). Assessment of rape and other civilian trauma-related posttraumatic stress disorder: Emphasis on assessment of potentially traumatic events. In T. W. Miller (Ed.), *Stressful life events* (pp. 231–266). Madison, WI: International Universities Press.

Trauma History Questionnaire (THQ)

Domains:	Trauma history
Timeframe:	Lifetime
Response format:	Self-administered
Format of administration:	Structured

Number of items:	24
Completion time:	5–15 minutes
Qualifications to administer:	Contact Bonnie L. Green, Ph.D.
How to obtain scale:	Contact Bonnie L. Green, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Populations sampled: psychiatric outpatients, college students, women with breast cancer Reliability: r = 0.7–0.9, intraclass = .76
Author(s):	Bonnie L. Green
Relevant citations:	Hooper, L., Stockton, P., Krupnick, J., & Green, B., (2011). Development, use, and psychometric properties of the Trauma History Questionnaire. *Journal of Loss and Trauma, 16*, 258–283. Muesser, K. T., Salyers, M. P., Rosenberg, S. D., Ford, J. D., Fox, L., & Carty, P. (2001). Psychometric evaluation of trauma and posttraumatic stress disorder assessments in persons with severe mental illness. *Psychological Assessment, 13*, 110–117. Norris, F. H. & Hamblen, J. L. (2004). Standardized self-report measures of civilian trauma and PTSD. In J. P. Wilson, T. M. Keane & T. Martin (Eds.), *Assessing psychological trauma and PTSD* (pp. 63–102). New York: Guilford Press.

Trauma Symptom Inventory (TSI)

Domains:	Trauma-related symptoms
Timeframe:	Current (last 6 months)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	100
Completion time:	20 minutes
Qualifications to administer:	Bachelor's degree in psychology. Must have related field and courses in the use of assessment instruments or special training in the use of this instrument.
How to obtain scale:	Contact Psychological Assessment Resources
Cost or public domain:	Cost: $15.00
Psychometrics:	Population sampled: general population Reliability: alpha = .84–.87

Author(s):	John Briere
Contact:	Psychological Assessment Resources Box 998 Odessa, FL 33556
Relevant citations:	Briere, J. (1996). Psychometric review of Trauma Symptom Inventory (TSI). In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 381–383). Lutherville, MD: Sidran Press. Briere, J. (1995). *Trauma Symptom Inventory professional manual.* Odessa, FL: Psychological Assessment Resources. Orsillo, S. M. (2001). Measures for acute stress disorder and post-traumatic stress disorder. In M. M. Antony & S. M. Orsillo (Eds.), *Practitioner's guide to empirically based measures of anxiety* (pp. 255–307). New York: KluwerAcademic/Plenum.

Traumatic Stress Schedule

Domains:	Trauma history
Timeframe:	Current (but author suggests any period)
Response format:	Other
Format of administration:	Semi-structured
Number of items:	10 (with 12 probes)
Completion time:	5–30 minutes
Qualifications to administer:	Can be administered by lay interviewer with training
How to obtain scale:	Contact Fran Norris, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Reliability: test-retest = .88, frequency of events equal to National Women's Study PTSD Module
Author(s):	Fran Norris
Relevant citations:	Norris, F. H. (1990). Screening for traumatic stress: A scale of use in the general population. *Journal of Applied Social Psychology*, *20*, 1704–1718. (Includes measure in its entirety.) Norris, F. H. & Hamblen, J. L. (2004). Standardized self-report measures of civilian trauma and PTSD. In J. P. Wilson, T. M. Keane & T. Martin (Eds.), *Assessing psychological trauma and PTSD* (pp. 63–102). New York: Guilford Press.

Appendix E—Consumer Materials

The following are samples of available consumer materials relating to trauma-informed care and traumatic stress. There is a plethora of consumer information available to meet the immediate and long-term needs of consumers of behavioral health services affected by trauma. In order to not waste effort creating new materials for your client's concerns, it is advisable to explore current science-informed resources. In most cases, consumer materials are already available and easily accessible for free.

AfterDeployment.org (2010). *Just the Facts: Resilience*. Available: http://afterdeployment.org/sites/default/files/pdfs/client-handouts/resilience-understanding.pdf

This Web site provides resources to address symptoms related to traumatic stress in addition to other postdeployment adjustment issues. This site provides information and handouts on resilience, triggers, and other trauma-related topics. It is appropriate for service members as well as civilians.

Blanch, A., Filson, B., & Penny, D. (2012). *Engaging Women in Trauma-Informed Peer Support: A Guidebook*. Available: http://www.nasmhpd.org/publications/engagingwomen.aspx

This draft technical assistance guide was created by the National Center for Trauma-Informed Care (NCTIC) and developed under contract with the National Association of State Mental Health Program Directors. This publication is designed to help make trauma-informed peer support available to women who are trauma survivors and who receive or have received behavioral health services. It is a resource for peers providing support in these or other settings who want to learn how to use trauma-informed principles in supporting women or in the peer support groups. It has been a resource used in the delivery of technical assistance through NCTIC.

Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., Steinberg, A., et al. (2006). Appendix E: Handouts. *Psychological First Aid: Field Operations Guide.* Available: http://www.ptsd.va.gov/professional/manuals/manual-pdf/pfa/PFA_Appx_E_handouts.pdf

Developed jointly with the National Child Traumatic Stress Network and the National Center for PTSD, this curriculum provides a science-informed approach to psychological first aid for response workers. The goals of this module are to assist survivors in the immediate aftermath of disaster and/or terrorism, reduce initial distress, and foster short- and long-term adaptive functioning. This link provides specific survivor-oriented material, such as strategies in seeking and giving support, education on common immediate reactions, and parental tips for children across developmental stages.

Center for Mental Health Services (2002). *Dealing with the Effects of Trauma-A Self-Help Guide.* Available: http://store.samhsa.gov/shin/content//SMA-3717/SMA-3717.pdf

This self-help guide gives practical information and tools to address and manage symptoms and other consequences of traumatic stress. It provides education on a variety of topics, including trauma-related symptoms, advice on the key ingredients of quality care, barriers to recovery, and practical strategies to enhance recovery and manage difficult emotions.

Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (2005). *Roadmap to Seclusion and Restraint Free Mental Health Services*. Available: http://store.samhsa.gov/product/Roadmap-to-Seclusion-and-Restraint-Free-Mental-Health-Services-CD-/SMA06-4055

This curriculum concerns the elimination of seclusion and restraint. It provides numerous handouts for consumers as well as staff. Several consumer handouts include common reactions to trauma, a trauma screening tool, and strategies to de-escalate agitation and distress.

Mead, S. (2008). *Intentional Peer Support: An Alternative Approach*. Sherry Mead Consulting. Available: http://www.intentionalpeersupport.org/apps/webstore/products/show/3408520

This interactive workbook is designed for individuals who are in peer support roles and those who use peer support services. It provides goals, tasks, competencies, and skills associated with peer support relationships and guidelines for first interviews.

Najavits, L. M. (2002). *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. New York: Guilford Press.

This evidence-based practice for individuals who have a history of trauma and a substance use disorder provides not only guidelines for clinicians but handouts for individuals. The consumer materials include information on PTSD and substance abuse and their interrelationship, key principles of the Seeking Safety program, coping skills to support safety, and grounding exercises. For additional information and resources, go to http://www.seekingsafety.org.

National Center for PTSD, U.S. Department of Veterans Affairs (2010). *Understanding PTSD*. Available: http://www.ptsd.va.gov/public/understanding_ptsd/booklet.pdf

This booklet provides consumer information on posttraumatic stress, common traumatic stress symptoms, effective treatments, and resources. The National Center for PTSD also provides additional professional and public resources specific to trauma for veterans and civilians.

Sidran Institute (2012). *Healing Self-Injury*. Available: http://healingselfinjury.org/about.html

This Web site provides numerous resources for consumers and professionals to understand self-inflicted violence. It offers publication links, archived newsletters, and a current blog focused on self-harm.

Appendix F—Organizational Assessment for Trauma-Informed Care

The following two resources are organizational assessments, which represent a key strategy in developing or re-evaluating trauma-informed services. The first assessment, presented by the University of South Florida, College of Behavioral and Community Sciences (2012), is designed for staff or key stakeholders. The second assessment comes from the *Trauma-Informed Organizational Toolkit for Homeless Services* (Guarino, Soares, Konnath, Clervil & Bassuk, 2009) and is a consumer version. There are several other assessment tools available, including Fallot and Harris's *Creating Cultures of Trauma-Informed Care (CCTIC): A Self Assessment and Planning Protocol* (2009).

Staff or Key Stakeholder Organizational Assessment Tool
University of South Florida, College of Behavioral and Community Sciences (2012). *Creating Trauma-Informed Care Environments: An Organizational Self-Assessment*. Available: http://www.cfbhn.org/assets/TIC/youthresidentialself%20assess%20Fillable%20FORM%20%282%29.pdf

Consumer Version: Organizational Assessment Tool
Guarino, K., Soares, P., Konnath, K., Clervil, R., & Bassuk, E. (2009). *Trauma-Informed Organizational Toolkit for Homeless Services*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, and the Daniels Fund, the National Child Traumatic Stress Network, and the W.K. Kellogg Foundation. See: pp. 82–93. Available: http://www.familyhomelessness.org/media/90.pdf

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Appendix J: Acknowledgments

Numerous people contributed to the development of this Treatment Improvement Protocol (TIP), including the TIP Consensus Panel (p. vii), the Knowledge Application Program (KAP) Expert Panel and Federal Government Participants (p. ix), SAMHSA Resource Panel (see Appendix G), TIP Field Reviewers (Appendix H), and the KAP Cultural Competency and Diversity Network participants (Appendix I).

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