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Trauma-Informed Care in Behavioral Health

Introduction 3

What is Trauma? 3

Types of Trauma 5

- Single Incident Trauma 5
- Developmental Trauma 5
- Complex or Repetitive Trauma 5
- Adverse Childhood Experiences 5
- Intergenerational Trauma 8
- Historical Trauma 9
- Community Trauma 11
- Post-Traumatic Stress Disorder 13

What is Trauma-Informed Care? 16

- The Four Rs of Trauma-Informed Care 16
- Six Principles of Trauma-informed Care 17

Continuum of Trauma-Informed Practice 21

- Preparing to administer TIP 21
- Engaging Clients in TIP 21
- Asking about Trauma 22
- Making Links to Trauma 23
- Skill Building & Empowerment 23
- Practitioner Challenges to TIP 23
- Implementing Trauma-Informed Care on an Organizational Level 24

Trauma & Substance Use Disorders 25

Trauma & Mental Health Disorders 27

Trauma & Physical Health 28
Common Reactions to Trauma 29
Immediate Symptoms 29
Long-Term Symptoms 31
Trauma Screening 32
Trauma Assessment 35
Evidence-Based Treatment 37
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) 37
Eye Movement Desensitization and Reprocessing (EMDR) 40
Prolonged Exposure Therapy (PE) 42
Cognitive Processing Therapy (CPT) 44
Post-Traumatic Growth 47
Impacts of Treating Trauma on Behavioral Healthcare Providers 48
Conclusion 49
References 50
Appendix A: Adverse Childhood Experiences (ACE) Questionnaire 53
Appendix B: Global Psychotrauma Screen (GPS) 56
Appendix C: Primary Care PTSD Screen for DSM-5 (PC-PTSD-5) 60

Introduction

Individuals who experience trauma will often be affected in various ways. Their trauma histories may contribute to developing post-traumatic stress disorder, substance use disorders, mood disturbances, dissociative disorders, and other issues. While many people seeking mental health and substance misuse treatment have extensive trauma histories, they are unaware of how trauma has impacted their day-to-day lives. As a result, they may fail to recognize the connection between trauma and their presenting problems or avoid the topic altogether. Behavioral health professionals and organizations must recognize the consequences of traumatic experiences in order to build a trauma-informed continuum of care. It is estimated that 70% of adults in the United States have experienced at least one traumatic event in their lives. For adults seeking behavioral health services, it is estimated that 90% have experienced at least one traumatic event in their life. These statistics show why it is so important for behavioral health professionals to be educated in trauma-informed care (NCBH, 2022).

What is Trauma?

Trauma is a cognitive, emotional, and physical response caused by a traumatic event, series of events, or circumstances experienced as harmful or life-threatening (CDC, 2022).

The APA Dictionary of Psychology defines trauma as "any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person's attitudes, behavior, and other aspects of functioning. Traumatic events include those caused by human behavior, such as rape, war, or industrial accidents, as well as by nature, such as earthquakes, hurricanes, and tornados,

and often challenge an individual's view of the world as a just, safe, and predictable place" (APA, 2023).

SAMSHA defines trauma with the three E's; event(s), the experience of those event(s), and the long-term adverse effects of the event(s). The event(s) or circumstances the individual experiences is physically and/or emotionally harmful or life-threatening, and it has lasting adverse effects on the person's functioning, including mental, physical, social, emotional, and spiritual health. Not all traumatic events result in adverse results. A person's and communities resilience is a protective factor against adverse outcomes to traumatic exposure, including abuse, neglect, violence, and disasters (SAMSHA, 2021).

An event is considered traumatic if it is perceived as potentially life-threatening and overwhelms one's ability to cope. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines trauma as "Exposure to actual or threatened death, serious injury, or sexual violence." (APA, 2013). Exposure is defined as directly experiencing trauma, witnessing trauma happening to someone else, learning that a traumatic event has happened to someone close to you, such as a parent, child, spouse, sibling, close friend, or relative, or repeatedly experiencing extreme details or the effects of traumatic events such as seeing or collecting remains, providing first aid or medical care to persons experiencing life-threatening events, or responding to the scene of disasters, wars, violent acts, or fires (Mancini, 2020).

The effects of traumatic experiences can be diverse and long-lasting. Trauma, particularly interpersonal violence, disrupts one's ability to form and maintain healthy relationships with other people. Trauma can lead to negative beliefs about the self, others, and the world that manifest in a sense of personal helplessness, shame and worthlessness, fear and mistrust for others, and a sense of hopelessness for the future. Experiencing trauma can also lead to emotional dysregulation, dissociation, negative effects on memory and concentration, and a reduced ability to cope with future stress and adversity. These effects can lead to

depressed mood, anxiety, hypervigilance, and avoidant behaviors such as substance use and social withdrawal (Mancini, 2020).

Types of Trauma

Single Incident Trauma

This presents as an overwhelming or unexpected event such as an accident, sudden loss, or natural disaster. Professionals are less likely to see someone with a single incident trauma in a treatment setting, as people who present to therapy typically have multiple traumas (Corbiell, 2019).

Developmental Trauma

This type of trauma often impacts development and healthy attachment. It frequently results from exposure to early, ongoing, and repetitive trauma that often impacts one's social learning and engagement systems. Survivors present with attachment challenges, difficulties with engagement, and emotional regulation issues (Corbiell, 2019).

Complex or Repetitive Trauma

It is an ongoing or repeated incidence of trauma, such as abuse, domestic violence, and betrayal. Complex trauma is most often associated with the childhood experience of sexual or physical abuse and neglect in the home or homes where intimate partner violence occurs (Mancini, 2020).

Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) are potentially traumatic events that occur in childhood, such as experiencing abuse, neglect, violence, witnessing violence at home, and having a family member attempt or die by suicide. Of additional importance in such events is the children’s environment, which can impact their sense of stability, bonding, and safety. Problematic situations include being raised

in a home with substance use, mental health difficulties, or instability due to parents' separation or incarceration of a parent, sibling, or another member of the household. It is important to note that ACEs may overlap with trauma but are not necessarily traumatic. Some adverse events are not considered life-threatening as defined by the DSM-5. However, they have long-term negative emotional and physical health impacts (SAMSHA, 2021 & Mancini, 2020).

Adverse childhood events that are known to impact behavioral health include:

Child Maltreatment

- Emotional abuse
- Sexual abuse
- Physical abuse
- Physical neglect
- Emotional neglect

Toxic Family Stress

- Household mental illness or substance abuse
- Someone close had a bad accident or illness
- Parents always arguing
- Mother treated violently
- Parental divorce
- Household member incarcerated
- No good friends

Peer, School, and Community-Based Toxic Stress

- Property victimization

- Peer victimization
- Community violence exposure
- Socioeconomic status
- Below-average grades

Other Domains Which Need Additional Research

- Death of parent
- Lack of access to food
- Experiencing discrimination (Mancini, 2020).

ACEs can negatively impact a person's health regardless if the person develops PTSD on any level. One longitudinal ACE study evaluated over 17,000 middle-class, employed, college-educated people with good health insurance. It found that experiencing any adverse childhood events can have negative health consequences later in life. ACEs were very common, with about two-thirds of the participants having experienced at least one ACE (87% had more than one) and one in eleven people having experienced six or more ACEs. The study affirmed the impact of trauma on the brain and body, which can place people at risk for a range of negative behavioral, social, and physical health problems later in life (Mancini, 2020).

A higher number of ACEs has been linked to higher rates of diabetes, cancer, heart disease, and autoimmune diseases. The impact of ACEs on health happens in a dose-response relationship. For example, four or more ACEs increased one's risk for chronic obstructive pulmonary disease by 390%, hepatitis by 240%, depression by 460%, and attempted suicide by 1220%. A person with an ACE score of 6 was 4600% more likely to be an IV drug user and 3100% to 5000% more likely to attempt suicide than a person with 0 ACEs. For every increase in ACE score, the risk for suicide attempts increased by 60%. Experiencing any one identified ACE

increased suicide attempts by 200–500%. Furthermore, experiencing six ACEs shortened life expectancy by 20 years (Mancini, 2020).

Intergenerational Trauma

Emotional and psychological effects can also be experienced by those living with trauma survivors. The coping strategies and adaptor patterns developed in response to trauma can be passed down from generation to generation. Intergenerational trauma generally refers to how trauma experienced in one generation affects the health and well-being of future generations (Corbiell, 2019 & SAMSHA, 2021).

Intergenerational trauma is a phenomenon where the descendants of a person who has experienced a traumatic event have similar adverse emotional and behavioral symptoms as their ancestors who experienced the trauma. These reactions vary by generation but often include shame, increased anxiety, and guilt, a heightened sense of vulnerability and helplessness, low self-esteem, depression, suicidality, substance abuse, dissociation, hypervigilance, intrusive thoughts, difficulty with relationships and attachment to others, difficulty in regulating aggression, and extreme reactivity to stress. (APA Dictionary, 2023).

The way generational trauma may be passed down to children includes

- DNA modifications (epigenetics)
- in utero
- memory
- cultural messages and conditioning
- cultural patterns
- cumulative emotional wounding
- dominant family narratives

- normalization of hatred, cruelty, and dehumanization toward others
- parents bypassing or not coping with their trauma
- aggressions and micro-aggressions (PsychCentral, 2022).

Trauma can be passed from one generation to the next. Trauma can leave a chemical mark on a person's genes, which can be passed down to future generations. This mark doesn't cause a genetic mutation but alters the mechanism by which the gene is expressed. This alteration is not genetic but epigenetic. Genetics is the study of hereditary characteristics, and epigenetics is the study of inheritable changes caused by the modification of gene expression (Skewes & Blume, 2019).

Historical Trauma

Historical trauma is related to the cumulative, psychological, and emotional impacts of trauma over the lifespan between generations, resulting from group trauma, genocide, colonialism, and slavery-induced inter-generational trauma, which is part of historical trauma. Historical trauma as a concept can be understood as consisting of three primary elements: a "trauma" or wounding, the trauma is shared by a group of people rather than an individually experienced, and the trauma spans multiple generations, such that contemporary members of the affected group may experience trauma-related symptoms without having been present for the past traumatizing event(s) (Corbiell, 2019 & SAMSHA, 2021).

Historical trauma is multigenerational trauma experienced by a specific cultural, racial, or ethnic group. These groups have experienced significant events that oppressed their community because of their status or identity. Examples include slavery, the Holocaust, forced migration, and the violent colonization of Native Americans. While many in the affected group will not experience any effects of the historical trauma, others may experience poor overall physical and behavioral health, including low self-esteem, depression, self-destructive behavior, marked propensity for violent or aggressive behavior, substance misuse and addiction,

high rates of suicide, and cardiovascular disease. Acute problems of domestic violence or alcohol misuse that are not directly linked to historical trauma may be exacerbated by living in communities with unaddressed grief and behavioral health needs. Parents' experience of trauma may disrupt typical parenting skills and contribute to behavior problems in children. Further complicating this familial or intergenerational trauma, historical trauma often involves the additional loss of a damaged cultural identity (ACF, 2023).

Clinical social workers first described historical trauma among descendants of the Holocaust and the children of Japanese Americans interned during World War II. The children and grandchildren of survivors commonly experience attachment issues and isolation from their parents. Considerable work has also been done with communities of Native Americans, who experienced repeated massacres and the forced removal of children to federal and mission boarding and day schools. Maria Yellow Horse Brave Heart is a researcher and clinician who works with tribal communities. She describes historical trauma as the "cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma experience."

Similarly, African Americans experienced generations of slavery, segregation, and institutionalized racism, contributing to physical, psychological, and spiritual trauma. For members of any of these communities, daily reminders of racial discrimination can exacerbate individual responses to trauma. One group that is often not initially included on lists of groups who have experienced historical trauma is the disability community. People with disabilities have been subjected to biases and misrepresentations about their capabilities and lived experiences. Attempts to eradicate people with disabilities have included eugenics campaigns, compulsory sterilization, forced psychiatric treatment, and the institutionalization of people with intellectual disabilities (ACF, 2023).

Community Trauma

Trauma has impacts on the community as a whole. The community can be defined geographically, such as a neighborhood; virtually, such as a shared identity; or organizationally, such as a place of worship.

Community trauma can be a result of decades of economic, political, and social isolation, a lack of investment in economic development and for the maintenance and improvement of the built environment, the loss of social capital with the flight of middle-class families, and the concentration of poverty and exposures to high levels of violence. The causes of community trauma can vary based on the community experience. They are often a result of adverse community experiences such as social inequities, including racism, poverty, oppression, and erasure of culture/communities. They are also a result of adverse community environments such as community-level inequities (e.g., limited economic opportunities, lack of social services, poor housing conditions, systemic racism, and prevalent violence) that traumatize entire communities. Adverse community experiences and environments are part of community trauma, just as ACEs are part of an individual's trauma (Weisner, 2020).

Adverse community experiences harm overall well-being. Individuals living in adverse environments are disadvantaged by conditions that contribute to individual-level traumas and impede their ability to address trauma when it occurs effectively.

Community trauma disproportionately impacts minority communities, as they are more likely to be impacted by violence, historical discrimination, oppression, and poverty.

Community trauma can be transmitted generationally. The community-level effects of trauma may be less about the traumatic event and more about the lack of resources for the community to make sense of, respond to, and heal from the trauma. The lack of resources results in a lack of resiliency.

Symptoms of community trauma can fall into three categories:

Physical: Deteriorated and unhealthy public spaces and the unavailability of healthy products

Socio-Cultural: Damaged social relations and networks, elevated destructive social norms, low sense of collective political and social efficacy, and widespread fear and shame.

Economic & Educational: Intergenerational poverty, long-term unemployment, business/job relocation, limited employment opportunities, community disinvestment.

Addressing community trauma can be challenging, taking on adverse environments that have deteriorated a community's resilience, efficacy, and capacity to address issues. Creating system changes that have been entrenched for centuries requires a significant commitment to resources, time, and effort (Weisner, 2020).

Traumatic events can be broken down into different domains. They include

Accidents, Illnesses, and Disasters

- Natural disasters (floods, hurricanes, earthquakes, tornados)
- Fire
- Transportation Accidents (car, boat, bus)
- Other serious accident
- Exposure to environmental toxic substances

Interpersonal Violence

- Sexual assault
- Any unwanted or uncomfortable sexual experience

- Physical assault (punched, slapped, kicked, threatened with a weapon)
- Captivity (held/detained, held hostage, kidnapped)

War, Community Violence, Poverty

- Experiencing war or combat exposure (civilian or military)
- Witnessing or experiencing severe human suffering (war, famine, extreme poverty)

Death and Injury

- The sudden and unexpected death of someone close
- Life-threatening illness or injury
- Serious injury, harm, or death you caused to someone else
- Sudden and violent death such as suicide or homicide (witnessing or learning about it happening to someone) (Mancini, 2020).

While the DSM-5 requires traumatic events to be potentially life-threatening, events such as experiencing discrimination, learning that your spouse has been having an affair or wants a divorce, getting fired, loss of one's home, loss of ability (eyesight, paralysis), or learning one has a chronic disease can be so life-shattering and unexpected that they overwhelm our ability to cope. These events can also lead to significant trauma symptoms (Mancini, 2020).

Post-Traumatic Stress Disorder

According to the DSM-5-TR, individuals must meet certain criteria to have a diagnosis of PTSD. Symptoms must have been experienced for at least one month and are severe enough that they are impacting their ability to function, including in their interpersonal lives, employment or education, and their activities of daily living.

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

- Directly experiencing the traumatic event
- Witnessing the traumatic experience of someone else
- Learning of a traumatic event that happened to a close family member or friend.
- Experiencing repeated or extreme exposure to details of the traumatic event (ex. first responders & military personnel)

Criteria B: Experiencing one or more of the following intrusive symptoms

- Reoccurring, involuntary, intrusive, and distressing memories of the traumatic event
- Repeated vivid nightmares of the traumatic event
- Dissociative reactions such as flashbacks where the person experiences the trauma as if it is recurring
- Experiencing cognitive, emotional, or physiological reactions to reminders/ cues/triggers of the event

Criteria C: Avoidance of reminders of the traumatic event by one or both of the following:

- Avoiding internal reminders of the traumatic event (thoughts, feelings, images), possibly through the use of substances, self-harm, and high-risk behaviors.
- Avoidance of external reminders of traumatic events (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings.

Criteria D: At least two symptoms of negative alterations in cognition and mood that began or worsened after the traumatic event

- Inability to remember important aspects of the traumatic event
- Persistent negative beliefs or expectations about oneself, others, and the world
- Persistent distorted cognitions about the causes or consequences of the traumatic event that causes the people to blame themselves or others
- Persistent negative emotional state
- Diminished interest or participation in previously significant activities
- Feelings of detachment or estrangement from others
- Inability to experience positive emotions

Criteria E: At least two symptoms of heightened arousal and reactivity that began or worsened after the traumatic event

- Irritable behavior and angry outbursts, verbal or physical aggression toward people or objects
- Reckless or self-destructive behavior
- Hypervigilance
- Exaggerated startle response
- Problems with concentration
- Sleep disturbances (APA, 2022)

What is Trauma-Informed Care?

Trauma-informed care incorporates knowledge of trauma even though the treatment may focus on other areas such as substance use, mental health disorders, or physical health needs. In contrast, trauma-specific treatment is specifically designed to address trauma.

The experience of trauma and untreated symptoms related to full or partial PTSD can increase the risk for comorbid health and behavioral health issues and hinder recovery from these conditions. Trauma-informed organizations prioritize clients' safety and promote trust, collaboration, healing, empowerment, and recovery from the effects of trauma. Behavioral health providers who operate from a trauma-informed care lens:

- Recognize the impact of trauma on health and behavioral health and integrate trauma awareness into all practices, policies, and procedures
- Understand the strategies that lead to recovery
- Routinely screen and assess for the signs and symptoms of trauma
- Eliminate practices that have the potential to be re-traumatizing to clients
- Deploy practices that are responsive to those who may have experienced trauma and that create a practice environment that promotes safety, empowerment, and healing (Mancini, 2020).

The Four Rs of Trauma-Informed Care

The four R's are assumptions about providing trauma-informed care are:

Realize: Behavioral health providers realize that trauma is common and has a major impact on health. They view symptoms, behaviors, and problems through a trauma lens. They ask: What happened? What happened to this person? What happened to this family? What happened to this school? What happened to this

community? They assume that trauma is the driving force behind behaviors that lead to negative health consequences.

Recognize: Behavioral health providers are aware and sensitive to the prevalence and impact of trauma and can recognize trauma in those they serve. They understand the signs and symptoms of trauma and PTSD and how trauma impacts the mind and body. They use universal screening and assessments in a sensitive manner.

Respond: Trauma-informed organizations respond to trauma by integrating trauma-informed services that are integrated throughout the organization. They have trained staff, policies, procedures, and practices designed to create a safe, welcoming environment and provide clients with access to effective treatments and services that address the multidimensional impact of trauma on individual, social, and environmental levels.

Resist: Trauma-informed behavioral health providers and organizations resist practices that are toxic and re-traumatizing to clients and staff by providing environments that are safe, nurturing, and facilitate the development of one's well-being (Mancini, 2020).

Six Principles of Trauma-informed Care

The six guiding practice principles of trauma-informed care create an environment that respects people's experiences and limits the incidence of re-traumatization.

Safety

Throughout the organization, clients and staff feel physically and psychologically safe. This may include:

- Ensuring physical and emotional safety
- Meeting people where they are

- Respecting the person's culture and incorporating it into all stages of the intervention
- Identifying and completing ongoing assessment of triggers and formulating plans to address these
- Establishing and maintaining predictable routines to increase the sense of safety
- Maintaining a calm environment to decrease hyperarousal
- Supporting and promoting positive and stable relationships in the person's life
- Ensuring opportunities for success

Trust and Transparency

Decisions are made to build and maintain trust and transparency.

- Trust is maximized through transparency, clear tasks, interpersonal boundaries, and consistency
- Clear information is provided on where, when, and by whom services will be rendered
- Clinicians say what they will do and when they will do it. They take responsibility if they are unable to complete what they said what they would
- Uncomfortable subjects are not avoided; the good and the bad are discussed
- Clinicians avoid "tricking" or "catching" people

Peer Support

People with shared experiences are integrated into the organization's service delivery.

Collaboration and Mutuality

Power differences are minimized between staff, clients, and organizational staff to support shared decision-making.

- Power is shared
- The client's goals or priorities are explored
- Service plans are developed by the client with the support of providers. Goals and treatment services are adjusted as needed.
- Continued assessment occurs to evaluate what services are effective
- Expectations for the helping relationship are shared
- During emotional times, it is asked, "How can I support you right now?"

Empowerment and Choice

Client and staff strengths are recognized, built on, and validated, including a belief in resilience and the ability to heal from trauma, which include:

- Prioritizing empowerment and skill-building
- Focusing on empowerment instead of management and control
- Building upon strengths and promote resilience
- Maximizing the clients' experiences of choice and control
- Determining when and where you will meet
- Knowing how the person prefers to communicate

- Knowing how the person prefers to be addressed
- Determining who will be on the team
- Determining what services the person wants
- Allowing the individual to decide what goals to work on first
- Encouraging the individual to determine when to terminate services

Cultural, Historical, and Gender Issues

Biases and stereotypes (based on race, ethnicity, sexual orientation, age, and geography) and historical trauma are recognized and addressed.

- The organization moves past cultural stereotypes and biases
- It incorporates policies, protocols, and processes that are responsive to the racial, ethnic, and cultural needs of individuals served; and recognizes and addresses historical trauma (CHCS, 2021 & VanDillen, 2020).

Trauma-informed care can be viewed on both a micro and macro level. Trauma-informed care looks at evidence-based interventions such as Trauma-Focused Cognitive Behavioral Therapy at the micro, individual level. Trauma-informed practices are implemented throughout service delivery programs at a macro, systems level, such as acknowledging possible traumatic exposure within healthcare, educational, and law enforcement systems. Trauma-informed care is the implementation of interventions at both the micro and macro system levels (SAMSHA, 2021).

Continuum of Trauma-Informed Practice

Preparing to administer TIP

- Understand yourself as a practitioner and your biases and assumptions on trauma survivors and recovery, including your triggers, background, and diversity.
- Prepare to ask questions on a need-to-know basis
- Educate yourself on the common reactions to trauma and be able to recognize and explain these to your clients where appropriate
- Consider enhancing your cultural competency, including increasing your knowledge on how various cultures understand and respond to trauma
- Be mindful of language
    - Trauma responses are often normal responses to abnormal events
    - Trauma responses are viewed as attempts to cope and adapt
    - Shift away from deficit-based descriptions and labels

Engaging Clients in TIP

- Barriers must be considered (personal, organizational, cultural, etc.)
- Address immediate needs, including signs of substance use
- Consistency and transparency are key
- Be clear on boundaries and limits; don't overcommit
- Outline all treatment expectations and provide copies in writing
- Follow-up when commitments are made, such as with referrals
- Develop a mutual understanding of the meaning of safety

    - What does safety mean to you? What does safety mean to clients? Have they ever experienced a sense of safety?
- Obtain informed consent and revisit often
    - Pay attention to both verbal and non-verbal communication (sometimes people will say they agree, but body language shows they truly don't or do not understand what is involved in informed consent)
- Use statements that make collaboration and choice explicit
- Explore and problem-solve barriers to participation
- Elicit the individuals' priorities and hopes
- Seek regular feedback
- Utilize agenda setting (frequently, there will be a lot of crisis management)

Asking about Trauma

- Disclosure is not required
- Review and clarify limits to confidentiality
- Keep conversations safe, contained, and present focused
- Evaluate if the information being gathered will strengthen the individuals' engagement and recovery
- Watch for common signs of trauma
- Provide rationales for questions and normalize the process when possible
- Be mindful of power dynamics
- Ask about strengths, interests, goals, coping, etc.

Making Links to Trauma

- Emphasize resilience and hope
- Normalize responses
- Provide education on common reactions to trauma
- Be mindful of time, pacing, and readiness
- Be aware of power dynamics

Skill Building & Empowerment

- Remain present with challenging emotions
- Offer verbal encouragement and grounding
- Encourage clients to open their eyes and use the environment to ground and orient
- Monitor body responses and words
- Continuously revisit consent

Practitioner Challenges to TIP

- Asking for details
- Labeling or focusing on the negative
- Making assumptions
- Over committing
- Providing information without asking for permission or without seeking permission
- Talking more than the client and not checking in

- Using technical language
- Taking on the role of the expert
- Not tailoring the approach
- Overloading clients with too many skills
- Being too general when helping clients develop skills (Corbiell, 2019).

Implementing Trauma-Informed Care on an Organizational Level

The following considerations need to be made at an administrative level when trauma-informed care is being implemented within an organization:

- Trauma-informed care should be embraced by the highest levels of leadership. Peers with lived experience in trauma should be included in organizational decision-making processes, staff training, and the delivery and evaluation of services. Empowered champions for trauma-informed care should be positioned throughout the organization to increase the acceptance and adoption of TIC practices.
- Trauma-informed care approaches should be part of the organization's operations, written specifically into all policy and procedure manuals, and be a part of the organization's mission and vision.
- The organization's physical environment should be safe, welcoming, and collaborative.
- Trauma-informed care approaches should guide all decisions regarding organizational partnerships and collaborations. Referrals to outside services should only be to trauma-informed agencies and service sectors.
- All providers receive continuous training in screening, assessment, and treatment services that are trauma-sensitive and culturally responsive.

- Trauma sensitivity is a consideration in hiring, supervising, and evaluating all staff and leadership.
- Procedures are in place to ensure that staff have adequate access to self-care strategies and resources.
- Trauma-informed care is integrated into records, billing, and monitoring systems (Mancini, 2020).

Trauma & Substance Use Disorders

Research shows a strong connection between trauma exposure and substance use disorders. Many people who have experienced child abuse, natural disasters, criminal attacks, war, or other traumatic events begin using alcohol or drugs to help them cope with bad memories, emotional pain, difficulties sleeping, guilt and shame, nervousness, and fear. People who struggle with substance use issues are more likely to experience traumatic events than those without substance use problems. As a result, people find themselves in a vicious cycle of exposure to traumatic events that lead to increased substance use, which leads to new traumatic exposures, which leads to even worse substance use, and so forth. Trauma-related issues and substance use disorders often occur together. Trauma-related disorders, including post-traumatic stress disorder and depression, frequently occur among people with substance use disorders and vice versa. Trauma-related disorders and substance use problems wreak havoc on the person who has them and often creates significant problems for relationships with family members and friends (ISSTS, 2023).

People who have experienced traumatic events are more likely to abuse alcohol and other substances. For example,

- Up to 3/4 of people who have survived abusive or violent traumatic events report problem alcohol use.

- Up to 1/3 of people who survive accidents-, illness-, or disaster-related trauma report problems with alcohol use.
- Up to 80% of Vietnam veterans receiving treatment for PTSD also have an alcohol use disorder.
- Veterans over the age of 65 with PTSD and problems with alcohol use or depression are at an increased risk for attempted suicide.
- Women with traumatic exposure are at an increased risk for alcohol use disorder.
- Women and men reporting sexual abuse have higher rates of substance use disorders than non-abused peers.
- Adolescent sexual assault victims are 4.5 times more likely to experience alcohol abuse/dependence, four times more likely to experience marijuana abuse/dependence, and nine times more likely to experience hard drug abuse/dependence than peers who have not experienced sexual assault.
- Adolescents with PTSD are four times more likely to experience alcohol abuse/dependence, six times more likely to experience marijuana abuse/dependence, and nine times more likely to experience hard drug abuse/dependence when compared to peers without PTSD (ISTSS, 2023).

Using substances can provide temporary relief for a traumatized person who may be struggling with debilitating issues impacting their thoughts, feelings, behaviors, and relationships with themselves and others. While substance use may be well-intentioned and provide temporary relief, there are also harmful side effects that are ultimately self-destructive, including:

- Reduced concentration
- Difficulties with work and life productivity
- Lack of restful sleep

- Difficulty coping with traumatic memories
- Difficulty coping with external stressors
- Increased emotional numbing (to all emotions)
- Social isolation
- Anger and irritability
- Depression
- Hypervigilance (ISTSS, 2023)

Due to the high comorbidity of substance use and trauma, it is imperative that behavioral health professionals assess for both issues when working with high-risk populations.

Trauma & Mental Health Disorders

Individuals experiencing traumatic stress and substance use often have other psychological problems. It is estimated that 50% of adults who are diagnosed with PTSD and alcohol use disorder also have one or more mental or physical health problems. Individuals with substance abuse disorders and PTSD are also frequently diagnosed with:

- Anxiety Disorders (panic attacks, phobias, and generalized anxiety disorder)
- Mood Disorders (major depressive disorder or persistent depressive disorder)
- Disruptive Behavior Disorders (attention-deficit/hyperactivity disorder or antisocial personality disorder)
- Multiple Addictive Behaviors (alcohol abuse, illicit drug use, or abuse of prescription medications) (ISTSS, 2023).

In addition:

- Not everyone who experiences trauma will develop PTSD; approximately 20% will meet the diagnostic criteria for PTSD.
- 90% of Dissociative Disorders are linked to trauma; this includes Dissociative Identity Disorder, Dissociative Fugue, and Depersonalization/Derealization Disorder.
- Anywhere from 30%-90% of Borderline Personality Disorder cases are linked to childhood neglect and abuse (PychCentral, 2022).

PTSD increases the odds of experiencing other behavioral health disorders, including all anxiety disorders, major depressive disorders, substance use disorders, and antisocial and borderline personality disorders. Persons with PTSD are three times more likely to have a co-occurring mood disorder, over 2.5 times more likely to have an anxiety disorder, and 1.5 times more likely to have a substance use disorder. Despite the prevalence of PTSD, only 60% of persons with the condition receive treatment with a 4.5-year delay, on average, between onset and treatment (Mancini, 2020).

Trauma & Physical Health

People who have experienced trauma frequently have physical health problems. They are at greater risk for chronic diseases such as diabetes, heart disease, and liver disease; many experience chronic physical pain, some due to physical injury or illness but other times, there is no clear physical cause (ISTSS, 2023).

PTSD is associated with higher rates of chronic diseases such as cardiovascular and cerebrovascular disease, cancer, hypertension, metabolic disease, and autoimmune diseases (Mancini, 2020).

Common Reactions to Trauma

It is important for trauma-informed providers to be aware of the common reactions to trauma because clients are not going to present with "I have X symptom because I have experienced a trauma." They will present with common symptoms without connecting them to the source. The provider will often need to educate clients on the connection between the trauma and the symptoms they are experiencing.

Common reactions to trauma can be divided into immediately experienced or acute symptoms and long-term, more chronic symptoms.

Immediate Symptoms

Cognitive Symptoms

- Difficulty concentrating
- Confusion
- Impaired judgment
- Minimizing
- Ruminating
- Self-deprecation

Emotional Symptoms

- Impatience
- Frustration
- Anger
- Fear
- Panic

- Confusion
- Helplessness
- Numbness
- Worry
- Clingy or Distant
- Crying spells
- Disorientation
- Flat mood
- Rage
- Guilt
- Shame
- Depression
- Anxiety
- Outbursts of emotions
- Mood swings

Physical Symptoms

- Agitation
- Nightmares
- Sleep disturbance, changes in sleep pattern
- Numbness
- Changes in heart rate, heart palpitations

- Changes in temperature, sweating
- Changes in breath
- Tension
- Digestion issues
- Constipation or diarrhea
- Physical pain
- Backache
- Headaches
- Stomachaches
- Itching
- Easily startled by noises or unexpected touch
- Changes in appetite
- More susceptible to colds and illnesses

Long-Term Symptoms

- Addiction, Eating Disorders, Substance Use Issues
- Insomnia
- Relationship Problems
- Panic Attacks
- Flashbacks
- Hypervigilance
- Dissociative Disorders

- Attention Difficulties
- Self-Hatred
- Generalized Anxiety
- Amnesia
- Hopelessness
- Avoidance
- Loss of interest
- Apathy
- Depression
- Self-Destructive Behaviors
- Grief
- Sexual Problems
- Tendency to isolate oneself or feelings of detachment
- Difficulty trusting and/or feelings of betrayal
- Self-blame, survivor guilt, or shame
- Diminished interest in everyday activities (Corbiell, 2019 & NCBH, 2022).

Trauma Screening

Trauma Screening is a "wide-net" process. It consists of focused and brief questioning to see if individuals have experienced one or more traumatic events, if they have had a reaction to the traumatic events, and if they have mental health

needs. If trauma is indicated, providing a referral for a comprehensive trauma-informed mental health assessment is essential.

The two key components of trauma screening are:

1. Has the person been exposed to a potentially traumatic event or experience?
2. Is the person experiencing traumatic stress symptoms or reactions?

Not all people who experience a traumatic event have a traumatic reaction, so the purpose of screening is to determine if someone requires additional support. While PTSD will always involve trauma; trauma will not always result in PTSD. It depends on the person's resiliency and ability to cope and recover. It is also important to note that even though individuals may not meet the criteria for a PTSD diagnosis, they may still be struggling due to their trauma experiences and would likely benefit from treatment (Corbiell, 2019 & NCTSN, 2023).

Screening should include assessing for adverse childhood experiences, traumatic events, and symptoms of PTSD. Universal screening for traumatic stress and PTSD is key to trauma-informed care. Initial trauma screening should be completed in a sensitive manner, and conversations about the impact of stress and trauma on health can signal to reluctant clients that they are in a safe place to discuss their trauma. Providers should educate clients about the role of trauma in health regardless of whether they disclose experiencing trauma. If they do disclose, providers should normalize the symptoms often associated with traumatic events. Positive screenings should lead to further assessment and access to onsite trauma services or a referral to outside behavioral health settings specializing in trauma-focused care (Mancini, 2020).

Effective screening and assessment for traumatic stress are rooted in safety, trust, respect, and compassion. Clients need to feel that they are in a safe place to disclose traumatic experiences and that their stories will be heard and validated. They also need to trust that their responses are confidential and must be made

fully aware of any limitations to confidentiality or reporting requirements before being asked about trauma. Providers need to ensure that they ask about trauma in a private setting, use active listening skills, and show respect and compassion. When needed, language interpreters should be independent professionals rather than family members or friends of the client. Persons who disclose trauma need to feel like telling their story is going to be beneficial. A trauma assessment should also be ongoing, and the relationship between provider and client must be able to develop over time (Mancini, 2020).

Screening should be followed by conversations about trauma in the person's life. The behavioral health provider should clarify whether individuals have experienced a traumatic event by asking them to identify the event they believe has led to their symptoms. The event must be life-threatening for a PTSD diagnosis as defined by the DSM-5. Experiencing troubling or stressful events that are not necessarily traumatic but lead to depressed or anxious symptoms may be better diagnosed as an adjustment disorder. Symptoms must also have interfered with work or interpersonal functioning. It is important to assess whether any traumatic events the client identified, such as ongoing violence, continue to happen. Clients who disclose ongoing violence should be provided resources and referrals to legal and advocacy services, social services, behavioral health counseling and crisis response services, shelters, childcare services, and hotlines if safe to do so. Trauma-informed practice requires health settings that screen for trauma to offer services to survivors of violence onsite or through an active warm referral process agreed upon by the client. If the incident requires mandated reporting, clients must be consulted on how best to file the report to enhance their safety rather than diminish it (Mancini, 2020).

Examples of evidence-based screening tools include:

Adverse Childhood Experiences Questionnaire (ACEs): This is a 10-question self-report screening that looks at family dysfunction and experiences of abuse,

neglect, and violence the person may have been exposed to during childhood. See Appendix A

Global Psychotrauma Screen (GPS): This 23-question self-report screening for stress and trauma experienced over the past month. It looks at trauma experiences and symptoms, as well as risk and protective factors. See Appendix B

Primary Care-Post Traumatic Stress Disorder Screen for DSM-5 (PC-PTSD-5): This is a five-question, yes or no answers screening tool that assesses if a person has experienced symptoms associated with a traumatic event in the past month. A positive screen is three or more items with a yes answer, indicating the need for further assessment for PTSD. See Appendix C

A positive or high score on any of the above or other screening tools indicates the need for additional follow-up assessment.

Trauma Assessment

Trauma-informed mental health assessment is an in-depth process. It includes a clinical interview, standardized measures, and behavioral observations to gather an understanding of the nature, timing, and severity of the traumatic events, the effects of those events, current trauma-related symptoms, and functional impairment. Mental health providers use an assessment to understand a person's trauma history and symptoms, to determine the person's social, emotional, and behavioral deficiencies and needs, to inform case conceptualization and treatment planning, and to monitor progress over time (NCTSN, 2023).

One example of a structured trauma assessment is the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5). It is a 30-question interview that assesses PTSD symptoms as well as the onset and duration of symptoms, subjective distress, the impact of symptoms on social and occupational functioning, any improvement in symptoms, overall PTSD severity, and evaluation of dissociative symptoms,

including depersonalization and derealization. The interview lasts for 45-60 minutes. Below are examples of questions and how the interview is structured:

- In the past month, have you had any unwanted memories of (EVENT) while you were awake (not counting dreams)?
- How does it happen that you start remembering (EVENT)?
- (If not clear: Are these unwanted memories, or are you thinking about [EVENT] on purpose?)
- How much do these memories bother you?
- Can you put them out of your mind and think about something else?
- How often have you had these memories in the past month?

After the interview, the client is given a severity rating scale of 0-4.

0. Absent: The client denied a problem, or the symptoms do not fit the DSM-5 symptom criteria.

1. Mild/subthreshold: The client described a problem consistent with the symptom criteria, but the symptoms are not severe enough to be considered clinically significant to lead to a PTSD diagnosis.

2. Moderate/threshold: The client described a clinically significant problem. The problem satisfies the DSM-5 symptom criteria for a PTSD diagnosis. Therefore, the problem would be a target for intervention.

3. Severe/markedly elevated: The client described a problem above the threshold. The problem is difficult to manage and, at times, overwhelming and would be a prominent target for intervention.

4. Extreme/incapacitating: The client described dramatic symptoms far above the threshold. The problem is pervasive, unmanageable, and overwhelming and would be a high-priority target for intervention (VA, 2023).

Evidence-Based Treatment

The four most used evidence-based treatments for trauma are prolonged exposure therapy, eye movement and desensitization and reprocessing therapy, trauma-focused cognitive behavioral therapy, and cognitive processing therapy. All four of these treatment approaches have aspects of cognitive behavioral therapy to them. The themes in CBT approaches are that thoughts, emotions, and behaviors are connected and that distorted thinking patterns about oneself, others, and the world create negative emotions and lead to maladaptive behaviors. The solution for more positive emotions and healthier behaviors is to identify and challenge distorted or negative thinking patterns. On average, treatments are provided over 10-15 sessions.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

TF-CBT is an evidence-based therapy for treating trauma. Studies show it reduces PTSD-related symptoms, including abuse-related distress, behavioral issues, anxiety, and depression (Mancini, 2020). The practice aspects include cognitive processing therapy, relaxation, and imaginal exposure. TF-CBT is an evidence-based treatment approach for children and adolescents, which can also be used with adults.

There are three general phases as part of TF-CBT. In the first phase, clients and providers build trust and develop supportive and therapeutic working relationships. This phase then progresses through psychoeducation, coping skills, and safety planning. The second phase focuses on developing and processing the trauma narrative. In the final phase, consolidation and closure activities are prioritized (Mancini, 2020).

Psychoeducation: After establishing rapport, the initial phase covers psychoeducation about trauma symptoms, the cognitive-behavioral model of PTSD, and learning potential triggers to traumatic responses. Part of this phase includes identifying themes surrounding the trauma, which will be addressed

throughout therapy and help establish treatment goals. Examples of themes may include themes around lack of safety and being able to trust others or themes of self-blame. For children involved with TF-CBT, the behavioral health provider may offer sessions with non-offending caregivers covering psychoeducation about trauma, parenting skills, ways to create safe and supportive environments, ways to correct maladaptive thinking patterns, and how to use skills to manage behavioral issues or emotional dysregulation effectively (Mancini, 2020).

Coping Skills: Clients are then taught relaxation and coping skills designed to improve their ability to manage symptoms and behaviors. Relaxation skills include breathing exercises, progressive muscle relaxation, yoga, mindfulness approaches, and imagery work. Affective coping skills are taught and modeled to teach clients how to appropriately express positive and negative emotions. This may include teaching the client how to identify and express emotions appropriately through role-plays and modeling. To increase the ability to tolerate distressing emotions and manage affective dysregulation, providers teach clients distraction strategies (e.g., exercise, playing games, contacting friends), mindfulness strategies (e.g., identifying feelings or sensations and viewing them without judgment), strategies to identify emotions in other people, and cognitive coping strategies that help the client identify negative thoughts and replace them with more accurate and positive thoughts or interpretations. For children involved with TF-CBT, the coping skills are also reviewed with caregivers in parallel sessions so that they can utilize and reinforce them in the home (Mancini, 2020).

Safety Plans: The final aspect of the first phase is enhancing safety and developing a safety plan. Safety plans include

1. understanding how to protect oneself and avoid danger through personal safety skills
2. accessing external resources for assistance with needs (i.e., how to ask for help)

3. addressing self-harm and reckless behaviors
4. educating caregivers about triggers
5. practicing appropriate behavioral responses to dysregulation that can lead to an enhanced sense of safety and security
6. identifying and developing nurturing relationships with trusting and safe adults in the community
7. developing a repertoire of activities that enhance well-being and help to develop healthy interpersonal relationships (Mancini, 2020).

The second phase focuses on developing and processing the trauma narrative. The skills learned in phase one are implemented to prepare the client to successfully navigate the stress and emotional content of processing trauma memories. Clients are ready to begin phase two when they can consistently self-regulate emotions. This phase is not always provided in TF-CBT. Studies have found that eliminating this phase has been associated with better behavioral management and fewer externalizing behaviors. However, including the trauma narrative has been associated with less anxiety, fear, and abuse-specific distress (Mancini, 2020).

The trauma narrative can be written in any form the person is comfortable with, be that as a story, play, poem, or song. Single-event traumas focus on the sensory, emotional, behavioral, and cognitive aspects of the event, while complex trauma can involve themes identified by the client that cut across multiple traumas. The trauma narrative develops as a collaboration between the provider and the client over several sessions. The client is asked to revise the narrative repeatedly as the therapist and client work together to reframe negative thoughts about the event regarding safety, trust, responsibility, healthy relationships, and self-esteem. At the end of these stories, clients are able to rewrite their futures positively to integrate the event as something that is only one part of their lives. They can share their narratives repeatedly with the therapist one-on-one. With children, the provider also shares elements of the narrative development process with the

caregiver in parallel sessions. This is done to prepare the caregiver to hear the narrative in a conjoint session with the client and to educate and inform the caregiver about how the child experienced the trauma. Silence and avoidance are often a part of trauma, and caregivers may not understand the nuances of how the client has experienced the events. The purpose of developing the trauma narrative is for the client to develop new meaning and understanding of the trauma and become habituated to the event through repeated imaginal exposure while the narrative is written. Like prolonged exposure, this phase may also involve the creation of a fear hierarchy and gradual in-vivo exposure exercises to external elements related to the trauma that are subjects of avoidance by the client, such as situations (being alone, the dark), places (school, playground), or people (Mancini, 2020).

The third phase involves consolidation and closure activities. The clients share their trauma narrative with a caregiver in a joint session as a means to transition the trust built with the provider to the caregiver. This also provides reassurance for the child to trust that the caregiver can handle the trauma and respond in a caring manner. The provider may continue to meet with the child and/or caregiver to support skills they have learned and help problem-solve any issues that may arise. This phase may also involve grief work to address losses clients may have experienced that they could not process previously due to their trauma (Mancini, 2020).

Eye Movement Desensitization and Reprocessing (EMDR)

EMDR is highly effective in reducing PTSD, anxiety, dissociation, and depressive symptoms, with results similar to Prolonged Exposure Therapy. EMDR involves the combination of cognitive processing and imaginal exposure and is designed to open up new opportunities to re-process past traumatic events and make more adaptive associations between events and thoughts. The approach also focuses on the desensitization of external cues for PTSD symptoms. EMDR can take from 8 to 12 sessions, depending on the number of traumatic events. Single traumatic

events can be addressed in about six sessions. More complex or multiple traumas may take longer to address. EMDR providers take a thorough client history of trauma experiences and identify specific traumatic events and thoughts. Clients also receive psychoeducation on how trauma impacts the mind and body, the EMDR approach, and skills to manage distressing symptoms both at home and during sessions. These skills can include progressive relaxation or mindfulness-based approaches to managing distress.

EMDR is designed to help clients reduce emotional reactivity related to the trauma, process and resolve traumatic memories, and reframe negative, maladaptive thoughts related to the event. The client is asked to engage in an imaginal exposure exercise where they revisit the traumatic event in their mind and narrate the thoughts they experienced during the event and their current thoughts about it. These thoughts may include themes such as mistrust of others, self-blame, incompetence, guilt, shame, taking too much responsibility for the event, or lack of control over one's life. They are also asked to identify bodily, physical, and emotional sensations related to the distress. Clients are asked to identify a more positive belief they would like to hold about the event and themselves in relation to the traumatic event. They are asked to rate the level of their belief in the positive thought on a scale of 1–10, with 1 being no belief and 10 being complete belief in the thought.

As clients focus on the thoughts, anxiety, and heightened physical hyper-arousal from the event, they are simultaneously asked to focus their attention on visually tracking an object (pen, fingers) that the therapist slowly moves laterally across their visual field. They are also asked to notice their bodily sensations and thoughts as they focus on the event and track the object. The provider and client may engage in these stimulation sessions for various lengths. At the end, the provider asks the client to let go of all of their thoughts, take deep breaths, and then just notice and report what feelings, thoughts, images, or sensations come into their minds. This process occurs until habituation, or the reduction in arousal, is achieved. The client and therapist may engage in repeated sets during one

session. Once the anxiety has been reduced, the client is asked to name a maladaptive thought experienced during the trauma and replace it with a more adaptive thought. For instance, "It's all my fault" is replaced with "I did the best I could with the knowledge I had at the time," or "It was an accident – I am not responsible for what happened."

The maladaptive thought of "bad things happen to bad people" may be replaced with "bad things can happen to anyone" or "something bad happened to me, but it does not define who I am." The thought "I was weak and powerless" can be replaced with "I have survived something terrible. It has not broken me, and it is in the past." When the anxiety or distress has been reduced for the target memory, the provider will ask clients to re-rate their level of belief in the positive thought they identified and then use that thought to focus on additional distressing memories.

The theory behind EMDR is that the bilateral movement helps distract the client and reduce emotional tension while helping the client access the traumatic memory. Accessing the memory allows the client to associate the memory with more adaptive thoughts or information. Taking in new information and making new, more adaptive associations leads to resolution or a more complete and accurate understanding of the events. This resolution can lead to a sense of relief and reduced distress, arousal, and avoidance behaviors (Mancini, 2020).

Prolonged Exposure Therapy (PE)

Prolonged exposure therapy for PTSD is an effective frontline treatment and has been successfully implemented in primary care settings. It has been shown to reduce comorbid depression, anxiety, and PTSD symptoms in people with co-occurring substance use disorders. The theory behind PE is that PTSD symptoms are rooted in a fear structure maintained and reinforced by avoidance behaviors (Mancini, 2020).

PE addresses this fear structure through three avenues (Mancini, 2020).

1. **Psychoeducation about trauma, symptoms, and treatment**

   During the psychoeducational phase of treatment, information about trauma's cognitive, emotional, and behavioral impact and how PE works to mitigate these effects is explained. The provider addresses how fear structures are reinforced through avoidance and how exposure to traumatic memories can challenge this avoidance directly in a safe space and reduce symptoms and create and integrate a healthier and more realistic counter-narrative to the trauma.

2. **In vivo and imaginal exposure**

   In vivo exposure is when clients refrain from avoiding traumatic external stimuli such as places, objects, sounds, and smells associated with the trauma. Clients are asked to routinely and slowly expose themselves to these feared stimuli gradually and safely. Clients may develop a hierarchy of feared stimuli that they rate from a scale of 1 (low fear) to 100 (high or extreme fear). Clients then work their way up from low fear-producing stimuli to high fear-producing stimuli. Exposure should never place the client at risk for re-traumatization or re-victimization.

   In imaginal exposure, the therapist asks the client to relive the trauma memory by reimagining the traumatic event and narrating the details of what happened, what they were thinking, and how they felt. Clients are asked to engage with the emotional content of the trauma, and as they recite the memory, they will be asked to describe how they felt at particular moments of the traumatic event. The client will narrate each episode of the trauma from beginning to end using present tense language and highlight parts of the trauma narrative that were particularly intense and distressing. During the narration, the therapist will ask the client to "rate" their distress using a subjective unit of distress scale, which is a scale of 1–100, with lower scores indicating less distress and higher scores indicating more

distress. A rating is taken at baseline, during distressing elements of the trauma, and then at the end.

3. **Emotional processing**

   During and after exposure, therapists work with clients to process emotions related to the trauma by discussing how the trauma has impacted their lives and the thoughts and feelings they experience in relation to the trauma. Effective emotional processing of beliefs about the trauma and subjective distress after exposure sessions have been associated with increased symptom improvement. Therapists ask clients to talk about how their beliefs about themselves and others regarding safety, control, self-efficacy, and relationships have changed since the trauma and how these views have shifted since the start of therapy. Therapists encourage two to three exposure exercises during each therapy session and also encourage clients to practice in vivo exposure in between sessions if it is safe to do so. Repeated exposure over time usually results in habituation and a reduction in intensity and intrusiveness of symptoms in 10–12 sessions. Therapists will also teach clients grounding techniques to combat dissociation and numbing that may be associated with trauma as well as relaxation techniques and the use of coping cards in order to help clients manage hyperarousal symptoms during and between sessions.

Cognitive Processing Therapy (CPT)

Experiencing traumatic events can result in maladaptive beliefs about oneself, others, and the world. Cognitive processing therapy focuses on exploring and challenging maladaptive thoughts related to the trauma that can lead to negative emotions and unhealthy avoidant behaviors. The goal of CPT is to change maladaptive thinking patterns about the trauma to more realistic beliefs that can lead to less emotional reactivity (fear, anger, depression) and teach more adaptive coping behaviors. This is accomplished through psychoeducation, imaginal exposure, and thought-changing activities to be completed during sessions and at

home. The treatment is designed to improve self-efficacy, safety, coping skills, and the survivor's ability to form healthy, trusting relationships while reducing avoidance, depression, and anxiety symptoms (Mancini, 2020).

Treatment begins with a history of traumatic events and psychoeducation about how trauma and maladaptive thinking patterns impact the self and relationships with others. Therapy then transitions into developing an impact statement with clients that outlines their views of why the trauma happened and how the trauma has changed their lives in relation to self-esteem, functioning, relationships, emotions, thoughts, and behaviors. Next, the client is asked to write a full account of the traumatic event, including sensory details such as sights, sounds, smells, thoughts, and emotions experienced. The client is asked to read the account daily, and is encouraged to experience feelings without avoiding them. The client revises the account as new details and information emerges. The provider and the client work together to identify maladaptive thinking patterns and cognitive distortions. Cognitive distortions include all-or-nothing thinking, overgeneralizing, negative filtering, or thinking that is biased toward an overemphasis on negative information and ignoring evidence of positive traits, accomplishments, or developments (Mancini, 2020).

CPT has five areas that are addressed, including (Mancini, 2020):

Safety: The provider and client identify and challenge unrealistic beliefs about safety so that they are more balanced. These beliefs can include irrational expectations about personal vulnerability, the perceived ability to control one's safety, and the overestimation of the dangerousness of other people and the outer world. These irrational beliefs can lead to anxiety, social withdrawal, and impairment of interpersonal functioning.

Trust: The provider and client explore how the client trusts their own judgment and the intent of others. Trauma often leads to maladaptive beliefs around trust, such as believing one has to have perfect judgment at all times, not trusting oneself to make decisions, or not trusting others' intentions. These thoughts can

cause problems in interpersonal functioning, leading to self-doubt, anger, fear of being left behind, anxiety, and suspicion.

Control: The provider and client identify and challenge maladaptive thoughts around power and control. These beliefs tend to be at extremes of either over-control or helplessness. Symptoms associated with these beliefs can include numbing, problems with boundaries, avoidance, feelings of anger, passivity, submissiveness/lack of assertiveness, self-destructive behaviors, and anger. The goal is for clients to identify what they can and cannot control, how to share power, and how to set boundaries with others.

Self-esteem: The provider and client identify and challenge unrealistic and negative beliefs about the self, such as beliefs of worthlessness and unlovability that can lead to shame, guilt, anxiety, depression, self-destructive behavior, fear of being alone, panic, dependency in relationships, and avoidance through drugs or alcohol. Clients may harbor maladaptive beliefs that they are bad people since a bad thing happened to them. Corrective thoughts would shift this to their trauma experience does not make them bad. The goal is to improve their ability to cope with the trauma experience through improved self-esteem and self-soothing skills.

Intimacy: The provider helps clients focus on repairing their ability to connect with themselves and others, which involves both feeling comfortable with themselves and developing healthy intimate relationships with others. Trauma disrupts the ability to form relationships and connections with oneself and other people leading to loneliness, alienation, emptiness, and social isolation. This increases the risk of self-destructive behaviors, including substance use and suicide, as well as anger, aggression, and emotional numbing. Healthy intimate relationships involve taking risks and being vulnerable, which are areas impacted by trauma. This area challenges unrealistic thoughts about intimate relationships and helps people develop the communication skills needed to nurture intimate relationships.

Post-Traumatic Growth

Research suggests that 30-70% of individuals who experience trauma also report positive change and growth from the traumatic experience (Manitoba Trauma Information and Education Centre, 2023). Post-traumatic growth is the experience of individuals whose development, at least in some areas, surpassed what was present before the traumatic event. The person has not only survived but has experienced important changes that go beyond their previous functioning. Individuals have described profound changes in their view of themselves, their relationships, and their philosophy of life.

It is essential to understand that post-traumatic growth is not a result of trauma but how the individual processes it. Examples of positive outcomes include improved relationships with others where individuals felt nurtured and validated, experiencing acceptance by others, and the ability to connect with others. It is critical not to imply failure or minimize the impact of the trauma in an effort to promote post-traumatic growth. Post-traumatic growth is not the outcome for everyone, and it's important not to imply any failure or minimize the impact of the trauma. It is also important to be aware that even with post-traumatic growth, distress is not necessarily absent. Both can occur simultaneously.

Post-traumatic growth can be considered an outcome as well as a process. It is about maintaining a sense of hope that not only can a person who has experienced trauma survive, but that individual can also experience positive life changes and thrive. It is not the event that defines post-traumatic growth but what can develop from within the person; behavioral health providers can play a significant role in this process (Manitoba Trauma Information and Education Centre, 2023).

Impacts of Treating Trauma on Behavioral Healthcare Providers

Self-care and counselor wellness are necessary to cope with vicarious trauma and secondary traumatic stress and avoid burnout. One study found that 85% of clients seeking substance use disorder treatment had experienced at least one traumatic event in their lifetime (Jones & Branco, 2020). Many studies have found a high comorbidity between substance use diagnoses and post-traumatic stress disorder, reporting that substance users are anywhere from two to three times more likely to experience PTSD than non-substance users. Other research argues this rate is potentially higher due to PTSD being under-assessed, under-diagnosed, and under-treated in substance use treatment programs. Thus, it is likely that substance use counselors are exposed to secondary trauma through their interactions with their clients, leading to their experience of vicarious trauma and burnout (Jones & Branco, 2020).

Burnout is a psychological response to chronic emotional and interpersonal stress on the job leading to exhaustion, depersonalization, and inefficacy. Burnout in the mental health profession is often due to working with clients with multiple treatment needs. Substance use clients often have multiple, high-level needs requiring attention. Burnout in behavioral health providers does lead to lower quality of care for clients. Clinical supervision is key to preventing burnout by addressing the emotional demands on behavioral health providers as they happen (Jones & Branco, 2020).

Vicarious trauma is the cumulative impact of exposure to traumatic content, which occurs as a result of the counselor engaging with clients who are trauma survivors or who are experiencing trauma. Behavioral health providers experience vicarious trauma as the result of their “empathic engagement,” meaning they experience similar emotions to the trauma survivor. This negatively impacts their view of themselves, others, and their general worldview (Jones & Branco, 2020).

Secondary traumatic stress (STS) occurs when providers who provide treatment to traumatized clients become indirectly traumatized and experience adverse reactions after witnessing clients battle with the effects of trauma. STS symptoms are similar to PTSD; the difference is the person did not experience the event directly but indirectly through hearing about it. STS is different from vicarious trauma in that the person experiences observable symptoms in STS, whereas vicarious trauma is more of an internalized shift in thinking (Jones & Branco, 2020).

Conclusion

Many people seeking mental health, substance use, and physical health treatment have extensive trauma histories. They may be unaware of how their trauma impacts their daily lives and may fail to see the connection between their trauma and the presenting problem for which they seek treatment. Therefore, behavioral health providers must be aware of the short and long-term consequences traumatic experiences can have and make the connection for their clients to provide trauma-informed care.

Trauma-informed care is a paradigm of how to view and conceptualize trauma and how one relates and connects with clients on a relational level. It's not necessarily about specific techniques or treatment modalities. Instead, it is a principles-based approach. The goal is to empower people to use their discernment to make choices and take control back in their lives (Corbiell, 2019).

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Appendix A: Adverse Childhood Experiences (ACE) Questionnaire

Retrieved May 2023 from https://www.theannainstitute.org/Finding%20Your%20ACE%20Score.pdf

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …

Swear at you, insult you, put you down, or humiliate you?

or

Act in a way that made you afraid that you might be physically hurt? Yes No
If yes enter 1 _____

2. Did a parent or other adult in the household **often** …

Push, grab, slap, or throw something at you?

or

Ever hit you so hard that you had marks or were injured? Yes No
If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…

Touch or fondle you or have you touch their body in a sexual way?

or

Try to or actually have oral, anal, or vaginal sex with you? Yes No
If yes enter 1 _____

4. Did you **often** feel that …

No one in your family loved you or thought you were important or special?

or

Your family didn't look out for each other, feel close to each other, or support each other? Yes No

If yes enter 1 _____

5. Did you **often** feel that …

You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

or

Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? Yes No

If yes enter 1 _____

6. Were your parents **ever** separated or divorced? Yes No
If yes enter 1 _____

7. Was your mother or stepmother: **Often** pushed, grabbed, slapped, or had something thrown at her?

or

Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

or

Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
Yes No

If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? Yes No

If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide? Yes No

If yes enter 1 _____

10. Did a household member go to prison? Yes No
If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score.

An ACE Score of 0 suggest that you reported no exposure to childhood trauma. An ACE Score of 10 suggests that you reported exposure to childhood trauma. The higher your ACE Score, the greater your risk for developing one or more physical or mental health problems.

Appendix B: Global Psychotrauma Screen (GPS)

Retrieved May 2023 from

https://www.global-psychotrauma.net/gps

Global Psychotrauma Screen (GPS) |__|__|__|__| Participant Identification Number
Gender o Female o Male o Other
Age (years) |__|__|__|
Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic.
Briefly describe the event or experience that currently affects you the most: _____ _____ _____
This event happened: o last month o last half year o last year o longer ago
This event: o was a single event occurring, at age |__|__| o happened during a longer period / multiple times, between ages |__|__| and |__|__|

Which of the below characterize the event (more answers possible):

Physical violence: o to yourself o happened to someone else

Sexual violence: o to yourself o happened to someone else

Emotional abuse: o to yourself o happened to someone else

Serious injury: o to yourself o happened to someone else

Life threatening: o to yourself o happened to someone else

o Sudden death of a loved one

o You causing harm to someone else

o Corona virus (COVID-19)

Considering the above event, in the past month have you….

1. … had nightmares about the past traumatic life event(s) you have experienced or thought about the event(s) when you did not want to?
o No o Yes

2. … tried hard not to think about past traumatic life event(s) or went out of your way to avoid situations that reminded you of the event(s)?
o No o Yes

3. … been constantly on guard, watchful, or easily startled?
o No o Yes

4. … felt numb or detached from people, activities, or your surroundings?
o No o Yes

5. … felt guilty or unable to stop blaming yourself or others for past traumatic life event(s) or any problems the event(s) caused?
o No o Yes

6. … tended to feel worthless? o No o Yes
7. … experienced angry outbursts that you could not control? o No o Yes 8. … been feeling nervous, anxious, or on edge? o No o Yes
9. … been unable to stop or control worrying? o No o Yes
10. … been feeling down, depressed, or hopeless? o No o Yes
11. … been experiencing little interest or pleasure in doing things? o No o Yes
12. … had any problems falling or staying asleep? o No o Yes
13. … tried to intentionally hurt yourself? o No o Yes
14. … perceived or experienced the world or other people differently, so that things seem dreamlike, strange or unreal? o No o Yes
15. … felt detached or separated from your body (for example, feeling like you are looking down on yourself from above, or like you are an outside observer of your own body)? o No o Yes
16. … had any other physical, emotional or social problems that bothered you? o No o Yes
17. … experienced other stressful events (such as financial problems, changing jobs, moving to another house, relational crisis in work or private life)? o No o
18. … tried to reduce tensions by using alcohol, tobacco, drugs or medication? o No o Yes

19. … missed supportive people near you that you could readily count on for help in times of difficulty (such as emotional support, watch over children or pets, give rides to hospital or store, help when you are sick)? o No o Yes
20. During **your childhood** (0-18 years), did you experience any traumatic life events (e.g., a serious accident or fire, physical or sexual assault or abuse, a disaster, seeing someone be killed or seriously injured, or having a loved one die)?
21. Have you **ever** received a psychiatric diagnosis or have you ever been treated for psychological problems (for example, depression, anxiety or a personality disorder)? o No o Yes
22. Do you **generally** consider yourself to be a resilient person? o No o Yes
23. How would you rate your present functioning (at work/home)? Poor 1 2 3 4 5 6 7 8 9 10 Excellent

Appendix C: Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)

Retrieved May 2023 from

https://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide.

Have you ever experienced this kind of event?

YES NO

If no, screen total = 0. Please stop here.

If yes, please answer the questions below.

In the past month, have you...

1. Had nightmares about the event(s) or thought about the event(s) when you did not want to?

   YES NO

2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?

   YES NO

3. Been constantly on guard, watchful, or easily startled?

   YES NO

4. Felt numb or detached from people, activities, or your surroundings?

   YES NO

5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?

   YES NO

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