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

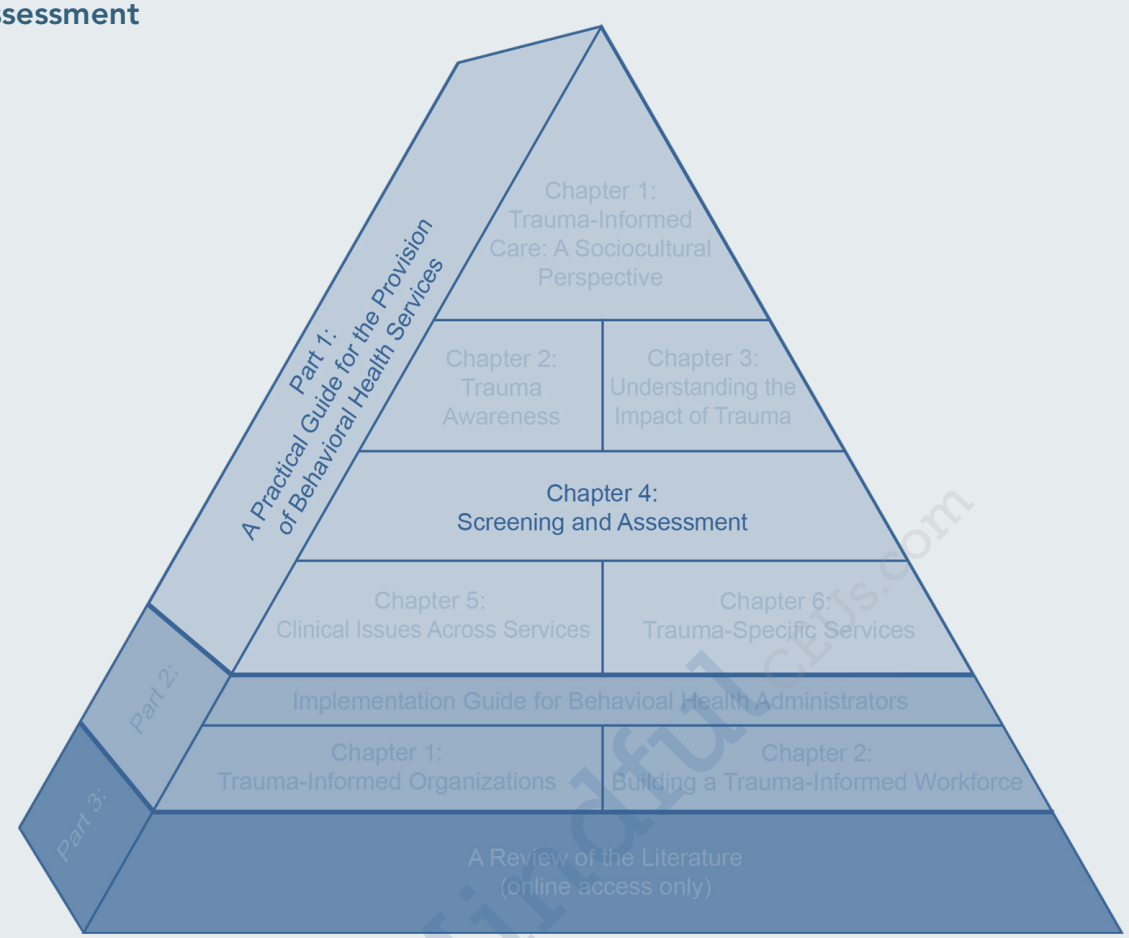
Why screen universally for trauma in behavioral health services? Exposure to trauma is common; in many surveys, more than half of respondents report a history of trauma, and the rates are even higher among clients with mental or substance use disorders. Furthermore, behavioral health problems, including 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

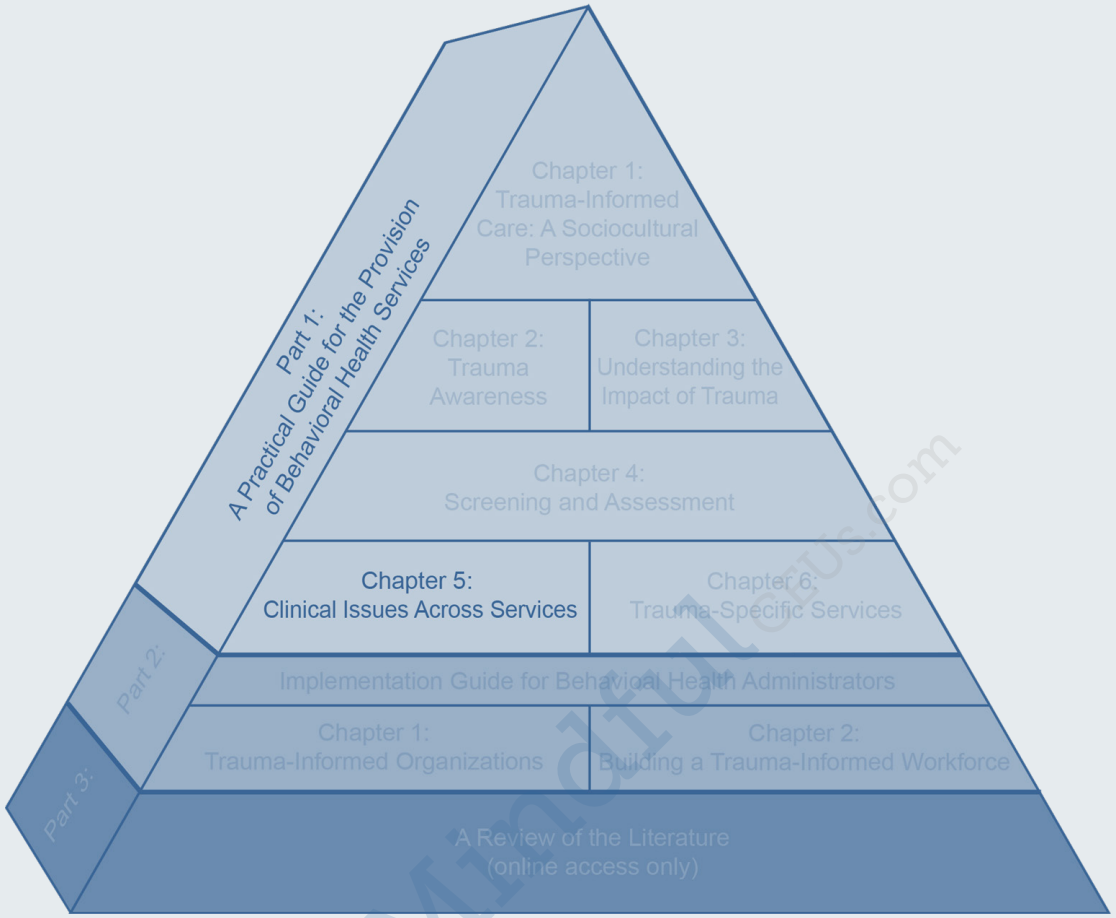
- Trauma Informed Prevention and Treatment Objectives
- Treatment Issues
- Making Referrals to Trauma Specific Services

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.

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).

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."

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.

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.

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.

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

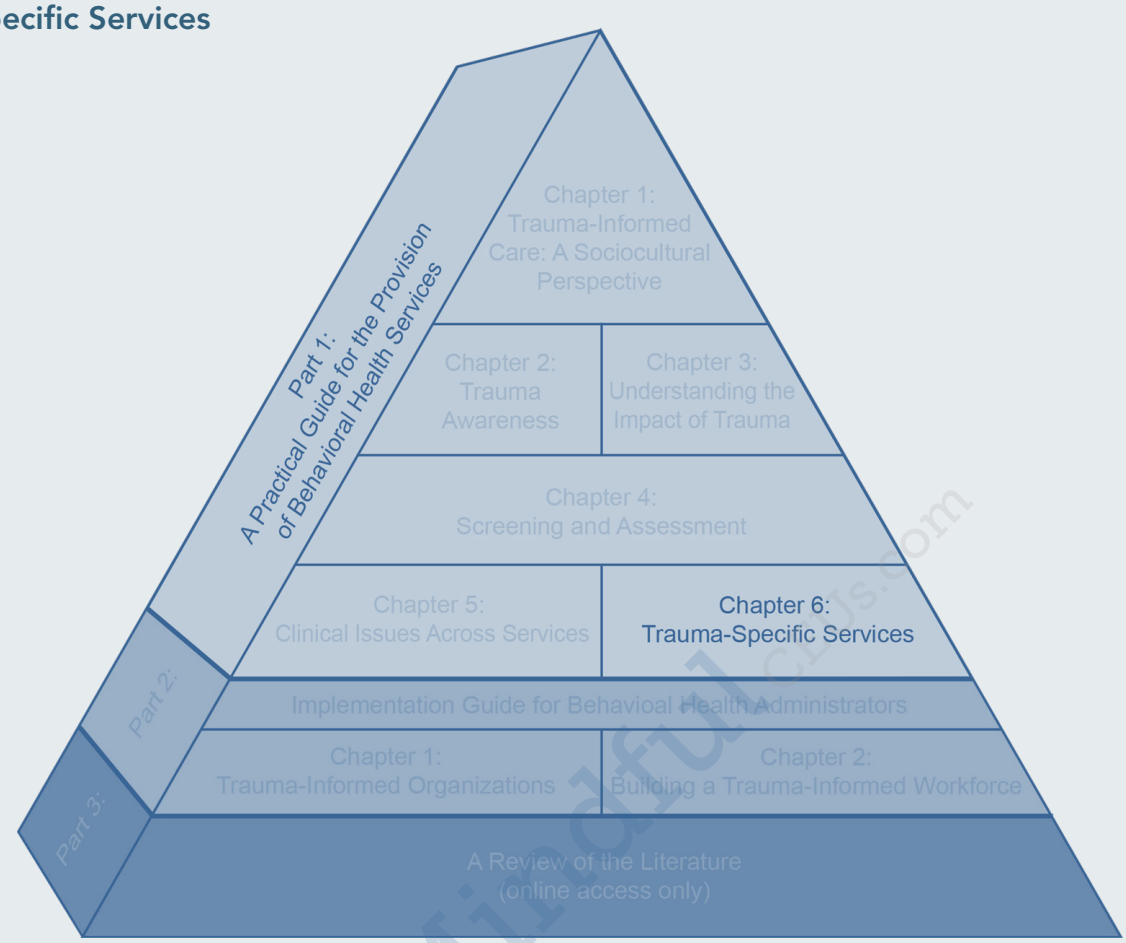
IN THIS CHAPTER

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.

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