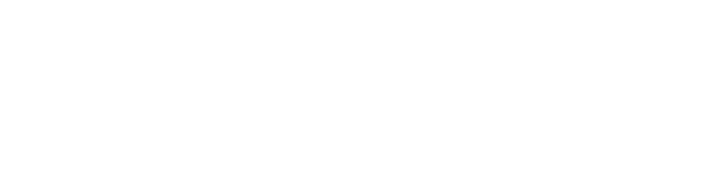
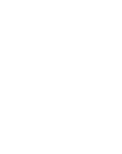
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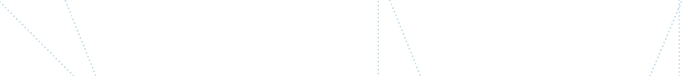
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**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment

1 Choke Cherry Road Rockville, MD 20857

Trauma-Informed Care in Behavioral Health Services

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#### Disclaimer

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**Contents**

[Consensus Panel. vii](#_TOC_250003)

[KAP Expert Panel and Federal Government Participants ix](#_TOC_250002)

[What Is aTIP? xi](#_TOC_250001)

[Foreword xiii](#_TOC_250000)

HowThisTIP Is Organized xv

Terminology xvi

PART 1: A PRACTICAL GUIDE FOR THE PROVISION OF BEHAVIORAL HEALTH SERVICES 1

Chapter 1-Trauma-Informed Care: A Sociocultural Perspective 3

Scope of the TIP 4

Intended Audience 4

Before You Begin 4

Structure of the TIP 6

What Is Trauma? 7

Trauma Matters in Behavioral Health Services 7

Trauma-Informed Intervention and Treatment Principles 11

As You Proceed 32

Chapter 2-TraumaAwareness 33

Types ofTrauma 33

Characteristics of Trauma 46

Individual and Sociocultural Features *52*

Chapter 3-Understandingthe Impact ofTrauma 59

Sequence of Trauma Reactions 60

Common Experiences and Responses to Trauma 61

Subthreshold Trauma-Related Symptoms *75*

Specific Trauma-Related Psychological Disorders 77

Other Trauma- Related and Co-Occurring Disorders 85

Ill

Trauma-Informed Care in Behavioral Health Services

**Chapter 4-Screening and Assessment 91**

Screening and Assessment 92

Barriers and Challenges to Trauma-Informed Screening and Assessment 99

Cross-Cultural Screening and Assessment 103

Choosing Instruments 104

Trauma-Informed Screening and Assessment 106

Concluding Note 110

**Chapter 5-Clinical Issues Across Services 111**

Trauma-Informed Prevention and Treatment Objectives 111

Treatment Issues 127

Making Referrals to Trauma-Specific Services 135

**Chapter 6-Trauma-Specific Services 137**

Introduction 137

Trauma-Specific Treatment Models 139

Integrated Models for Trauma 147

Emerging Interventions 153

Concluding Note 155

**PART 2: AN IMPLEMENTATION GUIDE FOR BEHAVIORAL HEALTH PROGRAM ADMINISTRATORS 157**

**Chapter 1-Trauma-lnformed Organizations 159**

Strategy #1: Show Organizational and Administrative Commitment to TIC 161

Strategy #2: Use Trauma-Informed Principles in Strategic Planning 162

Strategy #3: Review and Update Vision, Mission, and Value Statements 162

Strategy #4: Assign a Key Staff Member To Facilitate Change 163

Strategy #5: Create a Trauma-Informed Oversight Committee 163

Strategy #6: Conduct an Organizational Self-Assessment ofTrauma-lnformed Services 164

Strategy #7: Develop an Implementation Plan 164

Strategy #8: Develop Policies and Procedures To Ensure Trauma-Informed Practices and

To Prevent Retraumatization 166

Strategy #9: Develop a Disaster Plan 166

Strategy #10: Incorporate Universal Routine Screenings 167

Strategy #11: Apply Culturally Responsive Principles 167

Strategy #12: Use Science-Based Knowledge 169

Strategy #13: Create a Peer-Support Environment 169

Strategy#14: Obtain Ongoing Feedback and Evaluations 170

Strategy #15: Change the Environment To Increase Safety 171

Strategy #16: Develop Trauma-Informed Collaborations 171

**Chapter 2-Building aTrauma-Informed Workforce 173**

Introduction 173

Workforce Recruitment, Hiring, and Retention 174

IV

Contents

Training in TIC 177

Trauma-Informed Counselor Competencies 181

Counselor Responsibilities and Ethics 182

Clinical Supervision and Consultation 191

Secondary Traumatization 193

Counselor Self-Care 205

**APPENDICES 215**

**Appendix A-Bibliography 215**

**Appendix B-Trauma Resource List 247**

**Appendix C-HistoricalAccount ofTrauma 267**

**Appendix D-Screening and Assessment Instruments 271**

**Appendix £-Consumer Materials 285**

**Appendix F-Organizational Assessment for Trauma- Informed Care 287**

**Appendix G-Resource Panel 289**

**Appendix H-Field Reviewers 293**

**Appendix I-Cultural Competence and Diversity Network Participants 299**

**AppendixJ-Acknowledgments 300**

**EXHIBITS**

Exhibit 1.1-1: TIC Framework in Behavioral Health Services-Sociocultural Perspective 6

Exhibit 1.1-2: A Social-Ecological Model for Understanding Trauma and Its Effects 15

Exhibit 1.1-3: Understanding the Levels Within the Social-Ecological Model of

Trauma and Its Effects 16

Exhibit 1.1-4: Cross-Cutting Factors of Culture 26

Exhibit 1.2-1: Trauma Examples 35

Exhibit 1.3-1: Immediate and Delayed Reactions to Trauma 62

Exhibit 1.3-2: Cognitive Triad of Traumatic Stress 67

Exhibit 1.3-3: DSM-5 Diagnostic Criteria for ASD 78

Exhibit 1.3-4: DSM-5 Diagnostic Criteria for PTSD 82

Exhibit 1.3-5: ICD-10 Diagnostic Criteria for PTSD 85

Exhibit 1.3-6: Important Treatment Facts About PTSD and Substance Use Disorders 89

Exhibit 1.4-1: Grounding Techniques 98

Exhibit 1.4-2: Key Areas ofTrauma Screening and Assessment 105

Exhibit 1.4-3: SLE Screening 107

Exhibit 1.4-4: STaT: Intimate Partner Violence Screening Tool 108

Exhibit 1.4-5: PC-PTSD Screen 108

Exhibit 1.4-6: The SPAN 108

Exhibit 1.4-7: The PTSD Checklist 109

Exhibit 1.4-8: Resilience Scales 110

Exhibit 1.5-1: OBSERVATIONS: A Coping Strategy 119

V

Trauma-Informed Care in Behavioral Health Services

Exhibit 2.1-1: TIC Planning Guidelines 165

Exhibit 2.2-1: Clinical Practice Issues Relevant to Counselor Training in Trauma-

Informed Treatment Settings 179

Exhibit 2.2-2: Guidelines for Training in Mental Health Interventions forTrauma-

Exposed Populations 180

Exhibit 2.2-3: Trauma-Informed Counselor Competencies Checklist 183

Exhibit 2.2-4: Sample Statement of the Client's Right to Confidentiality From a

Client Bill of Rights 185

Exhibit 2.2-5: Green Cross Academy ofTraumatology Ethical Guidelines for the

Treatment of Clients Who Have Been Traumatized 186

Exhibit 2.2-6: Boundaries in Therapeutic Relationships 189

Exhibit 2.2-7: Counselor Strategies To Prevent Secondary Traumatization 198

Exhibit 2.2-8: Secondary Traumatization Signs 199

Exhibit 2.2-9: ProQOL Scale 201

Exhibit 2.2-10: Your Scores on the ProQOL: Professional Qyality of Life Screening 202

Exhibit 2.2-11: What Is My Score and What Does It Mean? 203

Exhibit 2.2-12: Clinical Supervisor Guidelines for Addressing SecondaryTraumatization 205

Exhibit 2.2-13: Comprehensive Self-Care Plan Worksheet 208

Exhibit 2.2-14: Comprehensive Self-Care Plan Worksheet Instructions 209

Exhibit 2.2-15: The Ethics of Self-Care 210

VI

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X

# What Is a TIP?

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

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

XI

# Foreword

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

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

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

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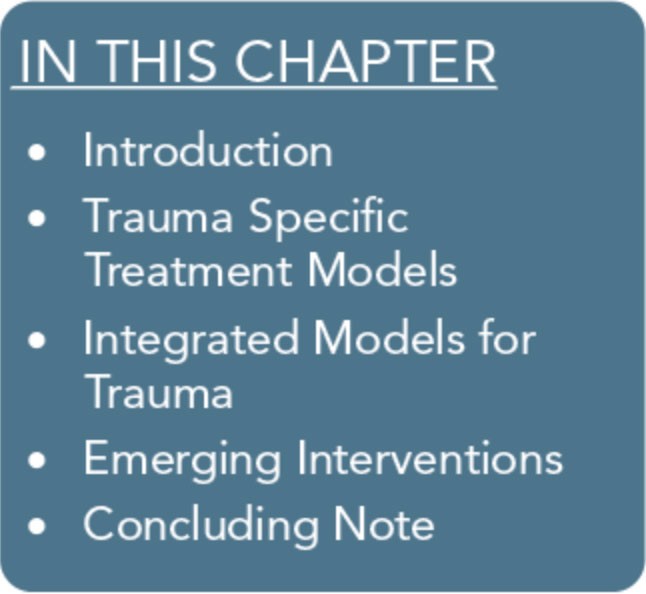
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**XIII**

# 6 Trauma-Specific Services

This chapter covers various treatment approaches designed specifi­ cally 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.

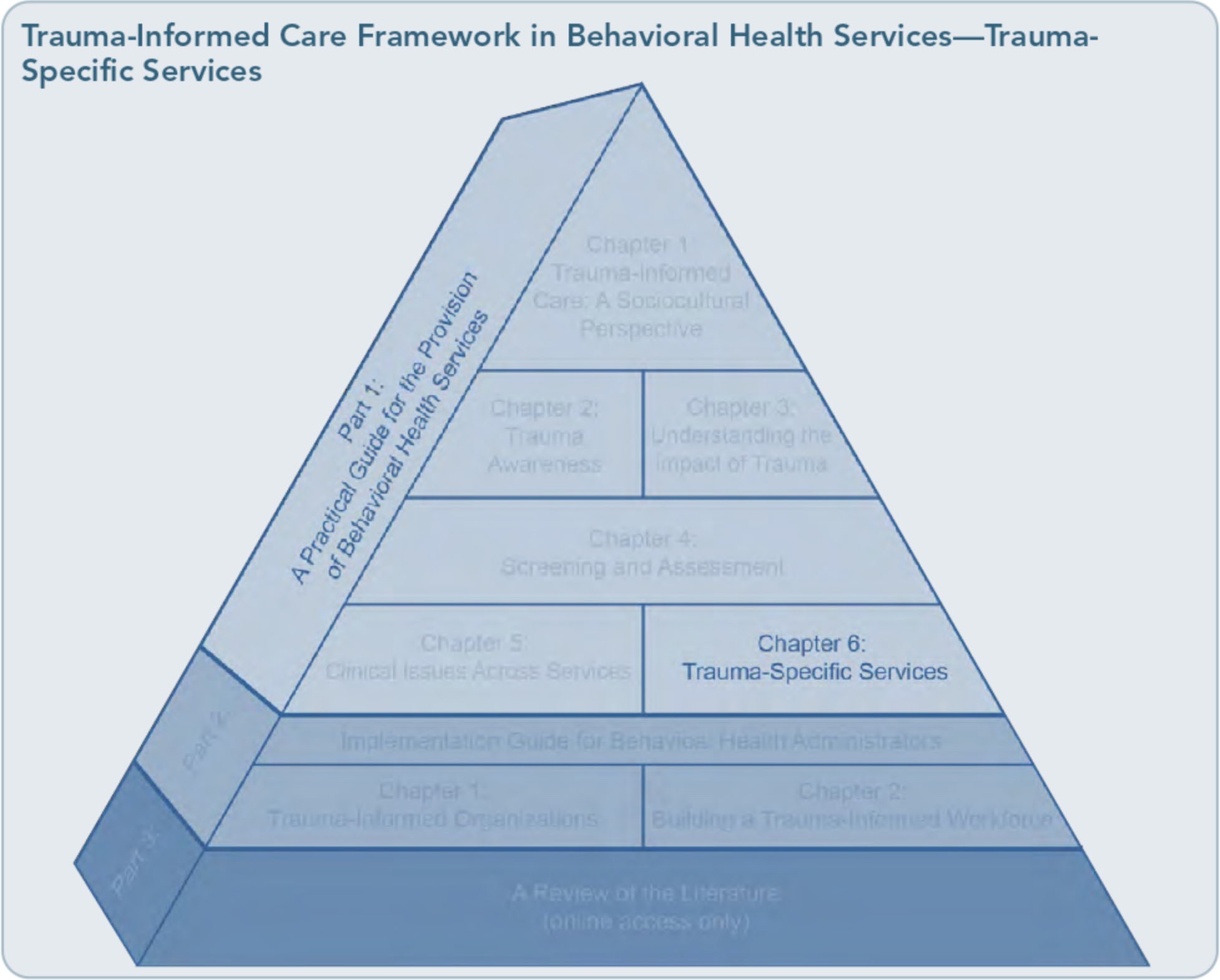
These models require training and supervised experience to be conducted safely and effectively. The chapter begins with a section on trauma-specific treatment models, providing a brief overview of interventions that can be delivered immediately after a trauma, as well as trauma-specific interventions 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 nev­ ertheless 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 symp­ toms. More science-based evidence is available for trauma-specific treatments that occur and extend well beyond the immediate reac­ tions 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 pri­ marily address current coping skills, psychoeducation, and manag­ ing symptoms for better functioning. Past-focused approaches primarily focus on telling the trauma story to understand the im­ pact of the trauma on how the person functions today, experienc­ ing emotions that were too overwhelming to experience in the past, and helping clients more effectively cope in the present with their

137

Trauma-Informed Care in Behavioral Health Services



traumatic experiences. Clients participating in present-focused approaches may reveal some of their stories; past-focused approaches em­ phasize 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. De­ pending 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 develop-

mental 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. Treat­ ment 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; addi­ tional models are described in the literature.

See, for example, the PILOTS database on the Web site of the National Center for PTSD

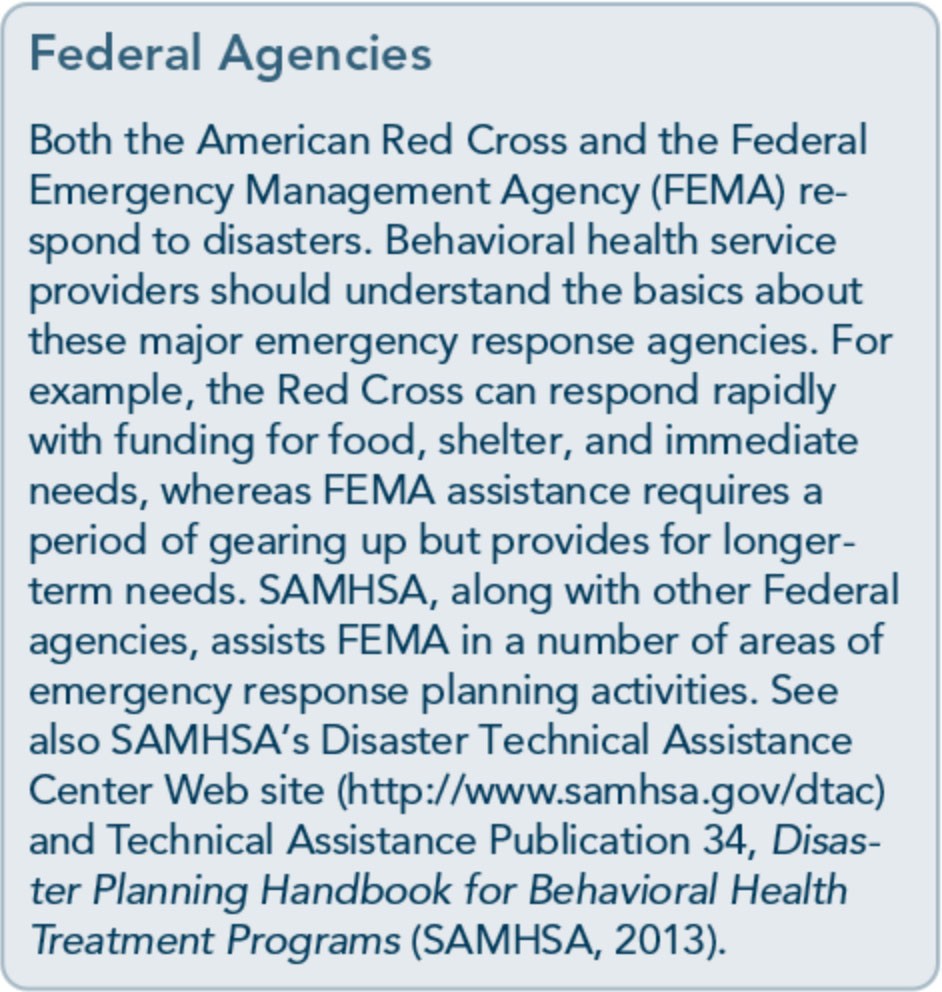
138

Part 1, Chapter 6-T rauma-Specific Services

(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 far De­ veloping 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. Giv­ en 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, evi­ dence based. A good resource for evaluating evidence-based, trauma-specific treatment models is *Effective Treatments far PTSD* (Foa, Keane, Friedman, & Cohen, 2009). Although evidence-based interventions should be a pri­ mary consideration in selecting appropriate treatment models for people with symptoms of trauma that co-occur with mental and sub­ stance use disorders (see Allen, 2001, for an indepth discussion of trauma and serious men­ tal 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 staf£ Although behavioral health counselors can prepare to help their cli­ ents 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 Ser­ vices Administration (SAMHSA) has created the National Registry of Evidence-Based Pro-



grams and Practices (NREPP) as a resource for reviewing and identifying effective treatment programs. Programs can be nominated for con­ sideration as co-occurring disorders programs or substance abuse prevention or treatment programs, and their quality of evidence, readi­ ness for dissemination, and training considera­ tions 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 mod­ els 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).

## Trauma-Specific Treatment Models

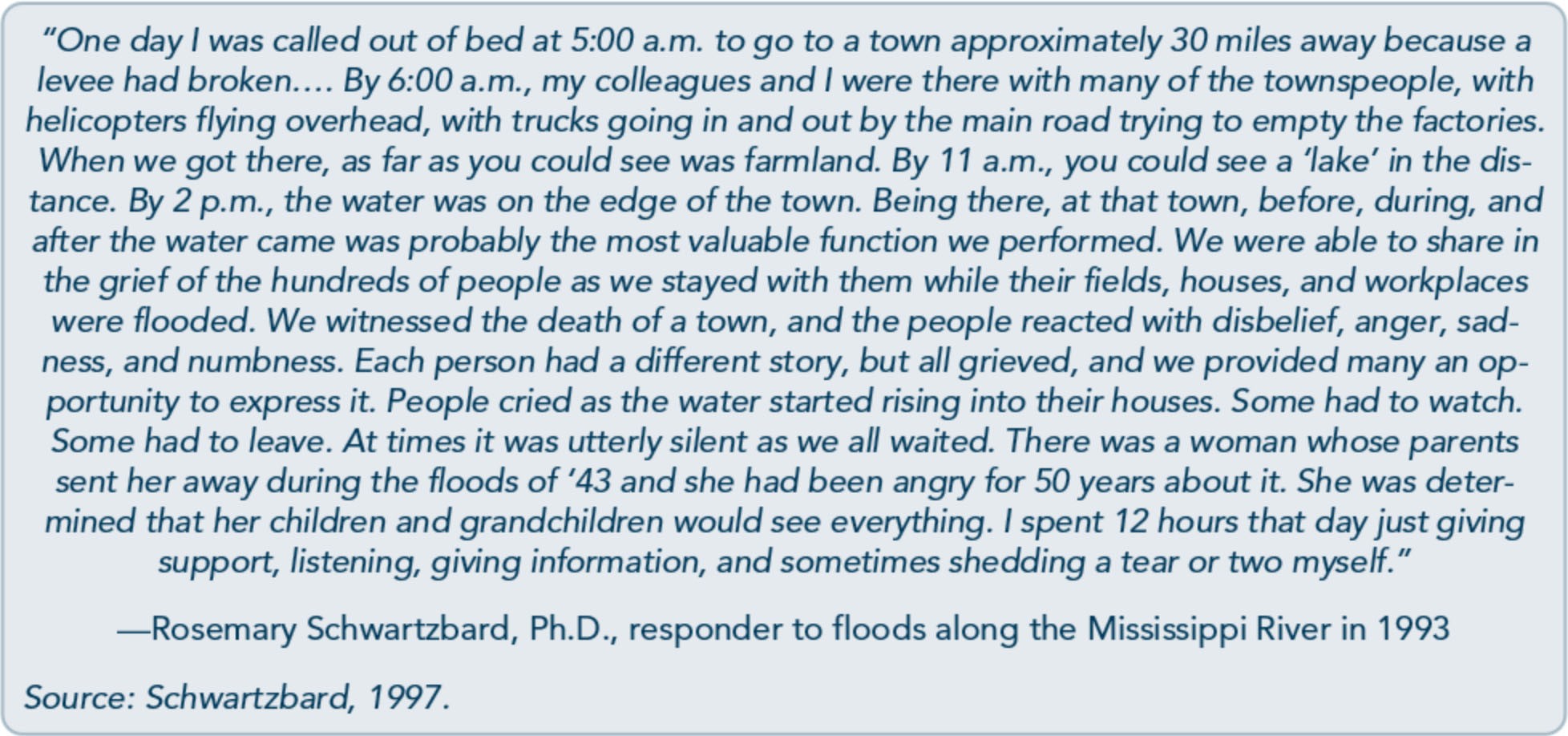
###### Immediate Interventions

***Intervention in the first 48 hours***

The acute intervention period comprises the first 48 hours after a traumatic event. In a

139

Trauma-Informed Care in Behavioral Health Services



disaster, rescue operations usually begin with local agencies prior to other organizations ar­ riving 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 fami­ ly, such as a house fire), a hierarchy of needs should be established: survival, safety, security, food, shelter, health (physical and mental), ori­ entation of survivors to immediate local ser­ vices, 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 profes­ sionally 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 environ-

ment. 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 adminis­ trators in New York had to seek alternative methadone administration options (Frank, Dewart, Schmeidler, & Demirjian, 2006).

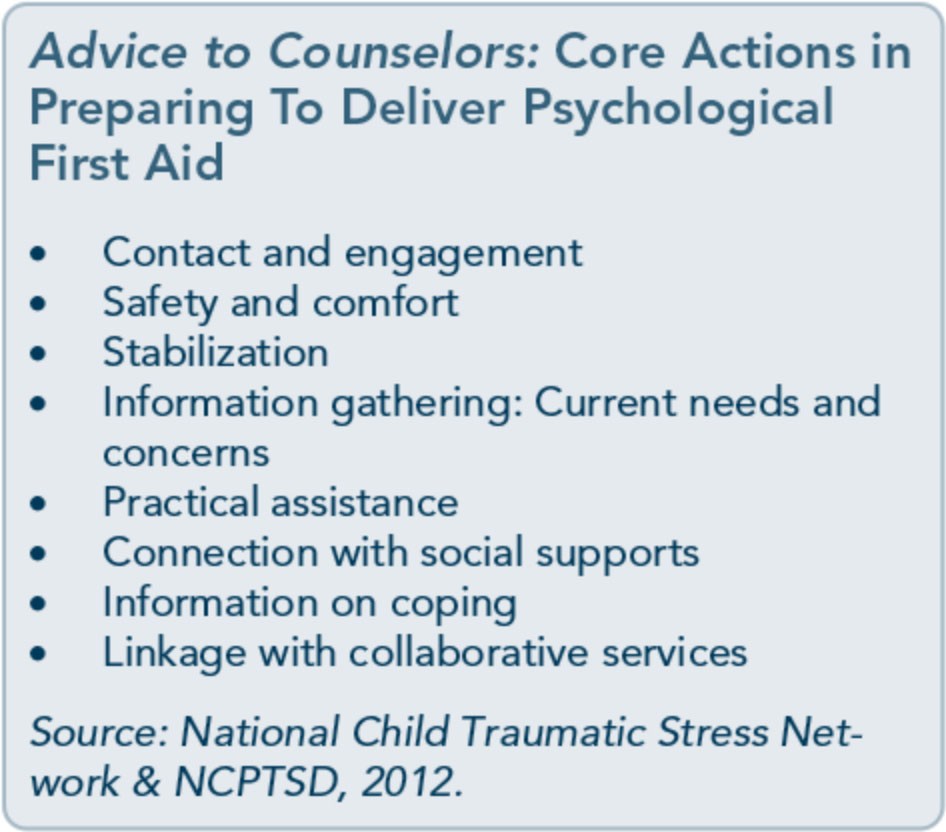
*Psychological first aid*

The psychological first aid provided in the first 48 hours after a disaster is designed to ensure safety, provide an emotionally support­ ive environment and activities, identify those with high-risk reactions, and facilitate com­ munication, including strong, reassuring lead­ ership 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, med­ ical professionals, behavioral health workers (including substance abuse counselors),jour­ nalists, and volunteers-be familiar with rele­ vant aspects of traumatic stress. Approaching

**140**

Part 1, Chapter 6-T rauma-Specific Services



survivors with genuine respect, concern, and knowledge increases the likelihood that the caregiver can **(NCPTSD,** 2002):

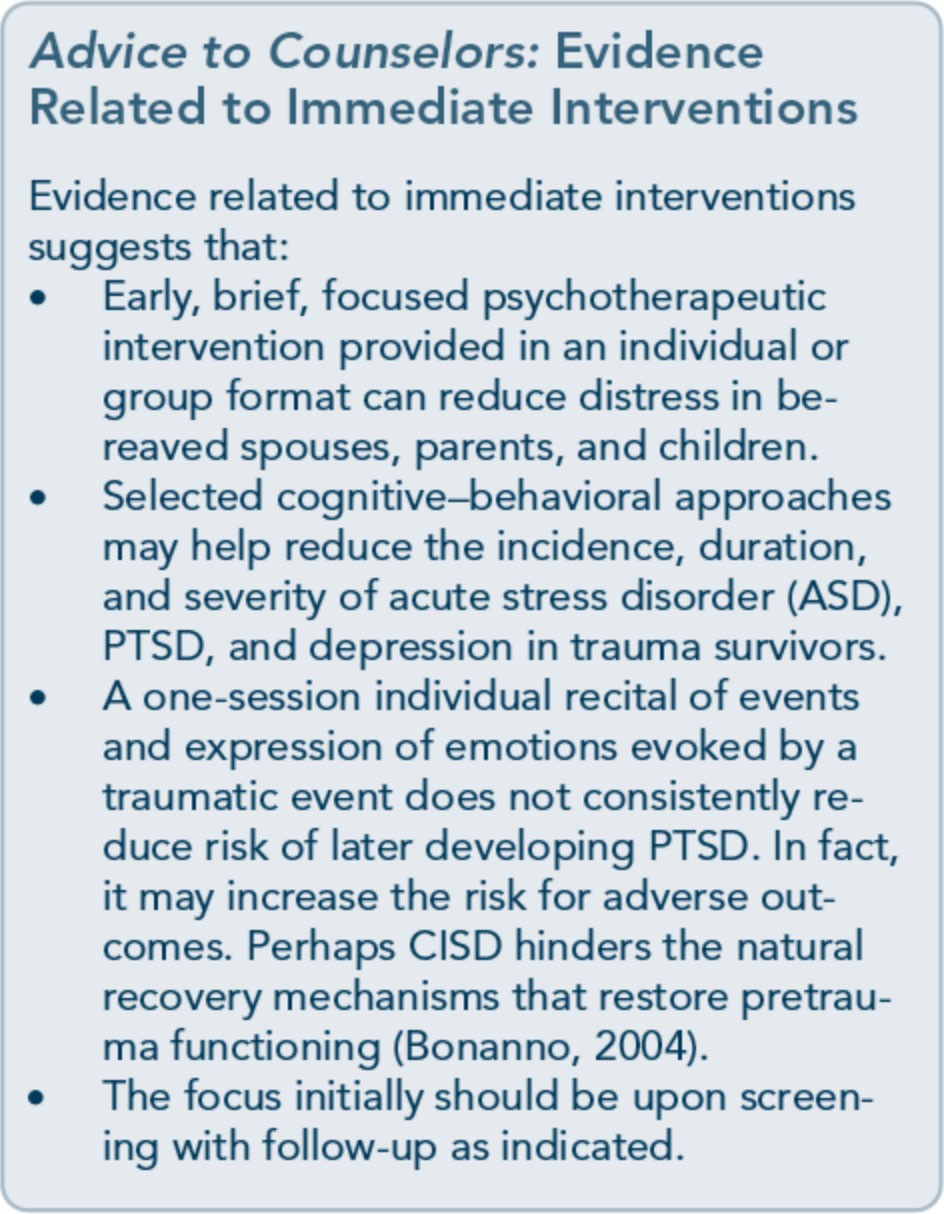
* Answer questions about what survivors may be experiencing.
* Normalize their distress by affirming that what they are experiencing is normal.
* Help them learn to use effective coping strategies.
* Help them be aware of possible symptoms that may require additional assistance.
* Provide a positive experience that will in­ crease 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 ex­ ample, whereas others do not. Similarly, some may want to talk about the event, but others won't. An excellent guide to providing psycho­ logical first aid is available online from the Terrorism and Disaster Branch of the National Child Traumatic Stress Network ([http://www.nctsn.org/content/psychological­](http://www.nctsn.org/content/psychological) first-aid).

***Critical incident stress debriefing*** Initially developed for work with first re­ sponders and emergency personnel, critical incident stress debriefing (CISD; Mitchell &

Everly, 2001) is now widely used and encom­ passes various group protocols used in a varie­ ty of settings. This facilitator-led group intervention is for use soon after a traumatic event with exposed people. The goal is to pro­ vide psychological closure by encouraging par­ ticipants to talk about their experiences and then giving a didactic presentation on com­ mon 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 in­ terventions. Mitchell and Everly (2001) point out that many of the studies showing negative



**141**

Trauma-Informed Care in Behavioral Health Services

**142**

results were not conducted with first respond­ ers; 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.

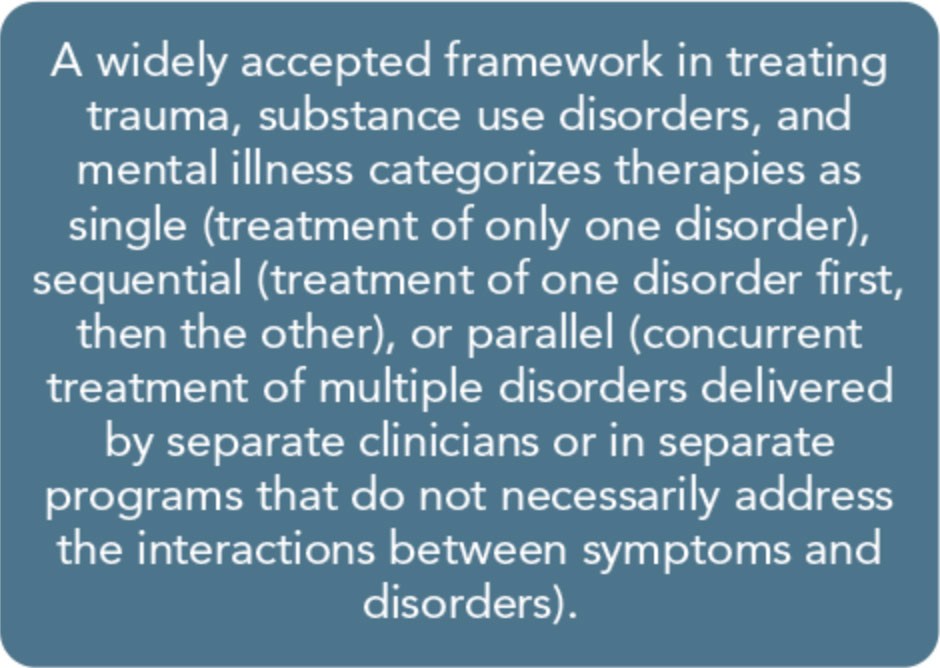
###### Interventions Beyond the Initial Response to Trauma

In the interest of increasing your overall famil­ iarity with relevant approaches, the following sections review several traumatic stress treat­ ment approaches that counselors will most likely encounter when collaborating with cli­ nicians 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 cog­ nitive 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 pat­ terns. In practice, CBT uses a wide range of coping strategies.

There are many different varieties of CBT. CBT originated in the 1970s (Beck, Rush,

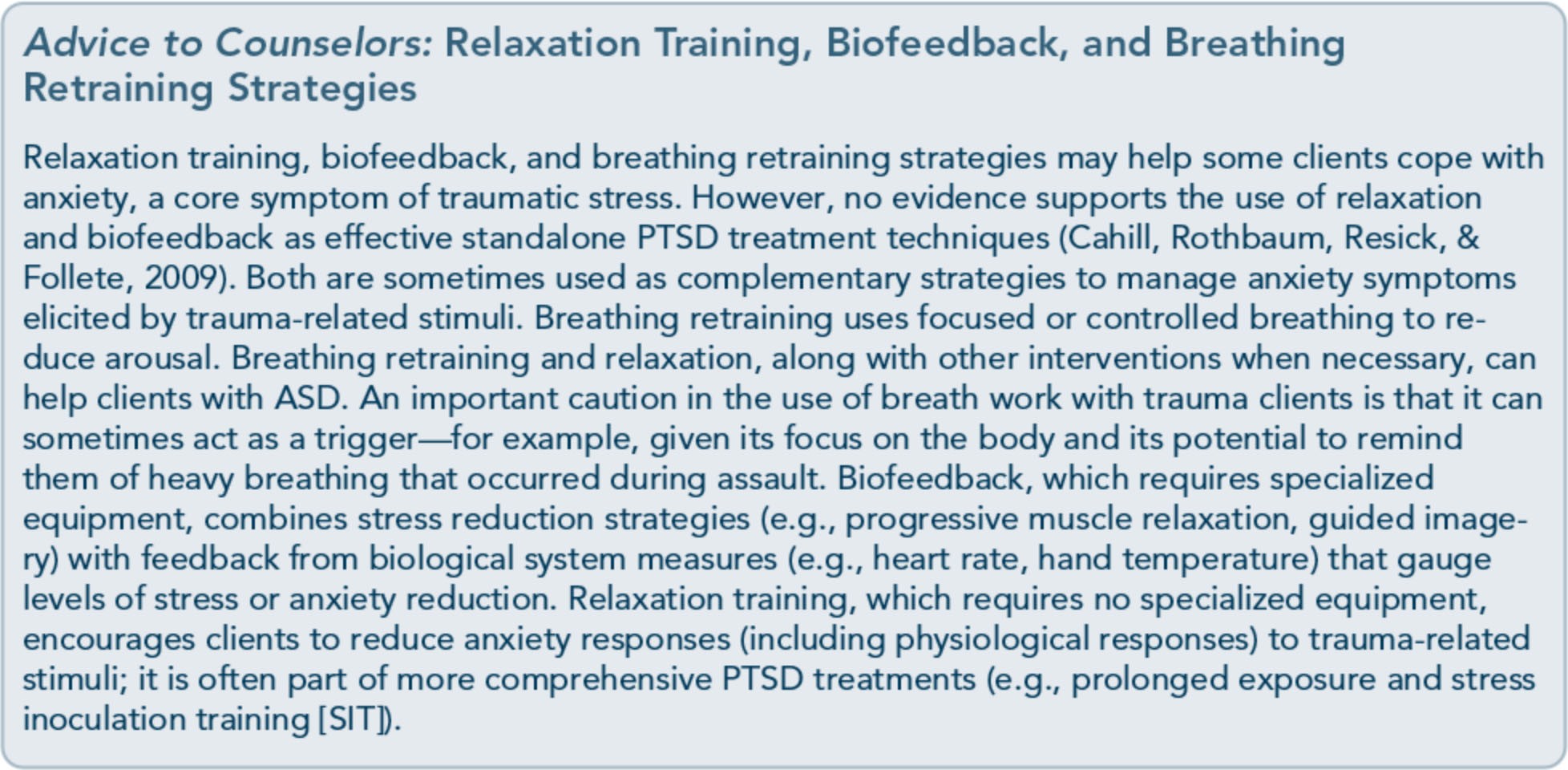


Shaw & Emery, 1979; Ellis & Harper, 1975) and has expanded since then to address vari­ ous populations, including people who use substances, people who experience anxiety, people with PTSD or personality disorders, children and adolescents, individuals involved in the criminal justice system, and many oth­ ers. CBT has also been expanded to include various techniques, coping skills, and ap­ proaches, 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 empha­ sized the therapeutic relationship, a particular­ ly important dynamic in trauma treatment (Jackson, Nissenson, & Cloitre, 2009).

CBT has been applied to the treatment of trauma and has also been widely and effective­ ly 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 communi­ ty, Trauma-Focused CBT, is available from the Medical University of South Carolina ([http://tfcbt.musc.edu/).](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 indi­ vidual 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

Part 1, Chapter 6-T rauma-Specific Services



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 cog­ nitive 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) sup­ port the use of CPT. CPT and prolonged exposure therapy models are equally and high­ ly 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 out­ comes 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 popula-

tions such as individuals with substance de­ pendence, 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 treat­ ment manual, *Cognitive Processing Therapy for Rape Victims: A Treatment Manual.*

##### *Exposure therapy*

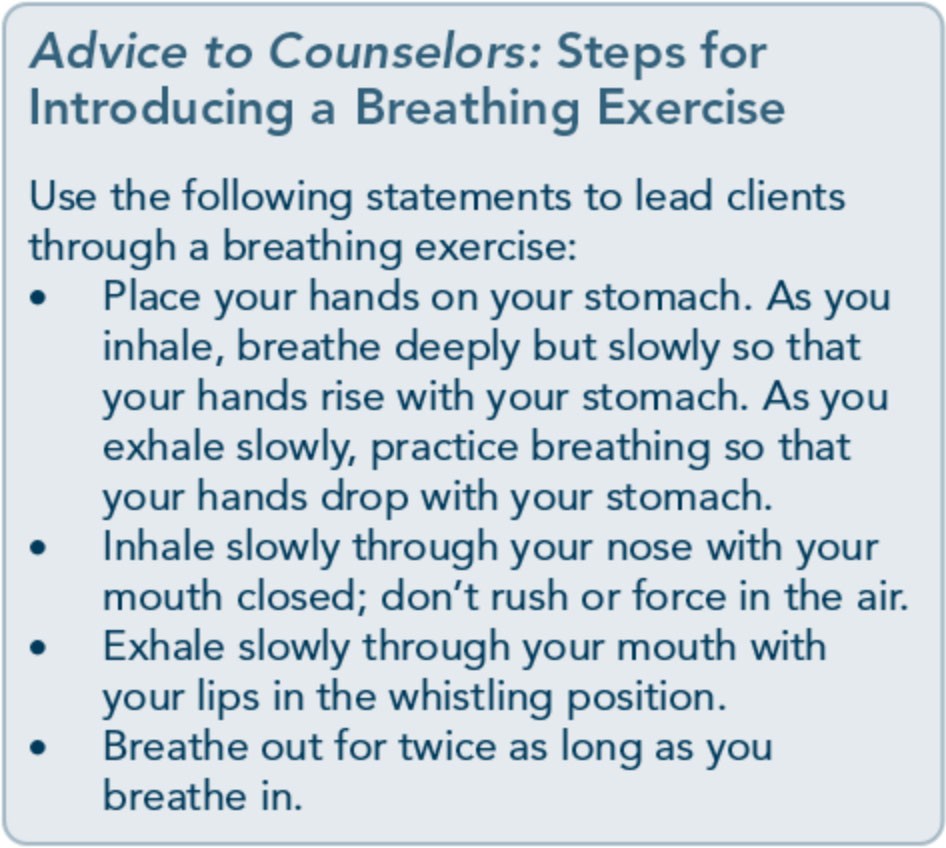
Exposure therapy for **PTSD** asks clients to directly describe and explore trauma-related memories, objects, emotions, or places. In­ tense emotions are evoked (e.g., sadness, anxi­ ety) but eventually decrease, desensitizing clients through repeated encounters with traumatic material. Careful monitoring of the pace and appropriateness of exposure-based interventions is necessary to prevent retrauma­ tization (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

143

Trauma-Informed Care in Behavioral Health Services

144



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 individu­ als who have experienced trauma exhibit an exacerbation of symptoms during or following exposure treatments. Even so, the exacerba­ tion may depend on counselor variables during administration. Practitioners of exposure ther­ apy 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 cli­ ents, 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 exer­ cise caution when using exposure with clients who have not maintained stability in manag­ ing mental illness symptoms or abstinence from substance use disorders. Studies and rou­ tine use of exposure have consistently excluded high-complexity clients such as those with

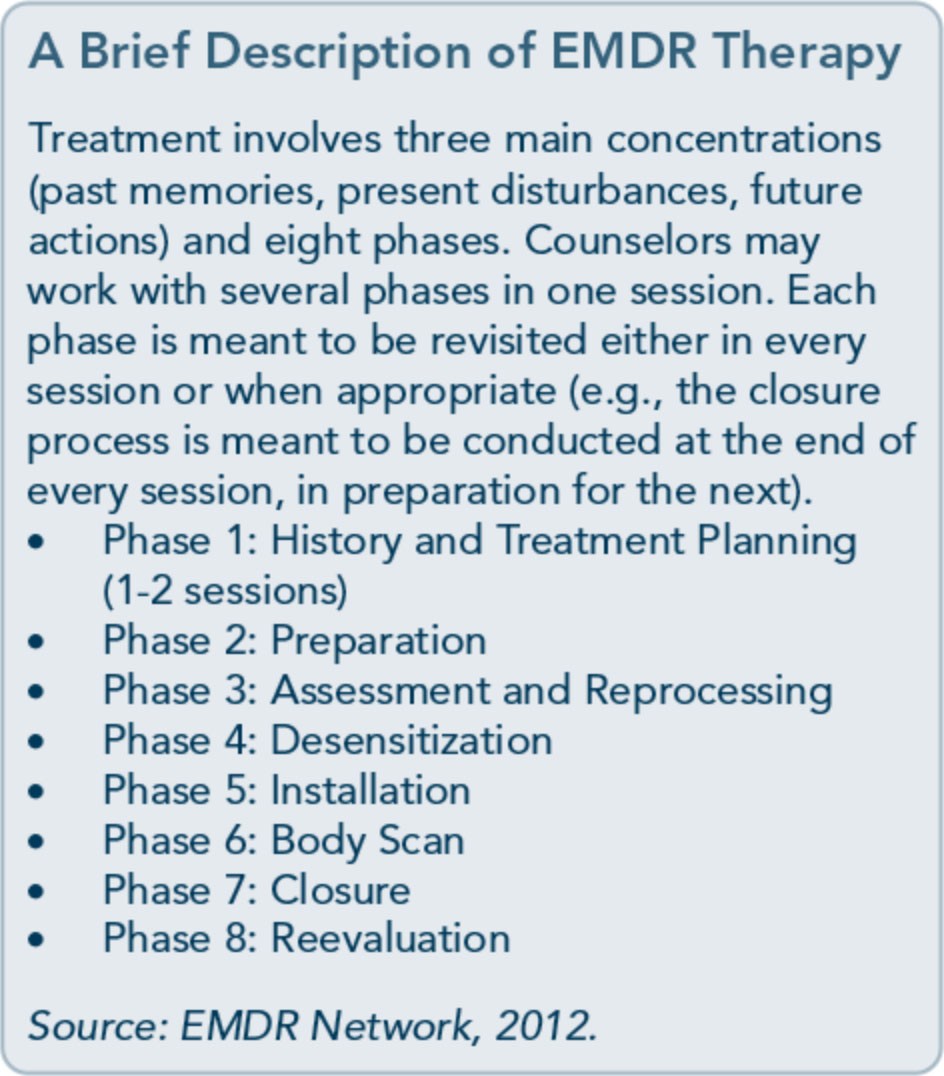
substance dependence, homelessness, current domestic violence, serious and persistent men­ tal illness, or suicidality. The only trial of ex­ posure therapy with a substance dependence sample found that it did not outperform standard substance abuse treatment on most variables (Mills et al., 2012).

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 tech­ niques, including eye movement desensitiza­ tion 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 ofEMDR have evolved into sophisticated paradigms requiring training and, preferably, clinical supervision.

EMDR draws on a variety of theoretical



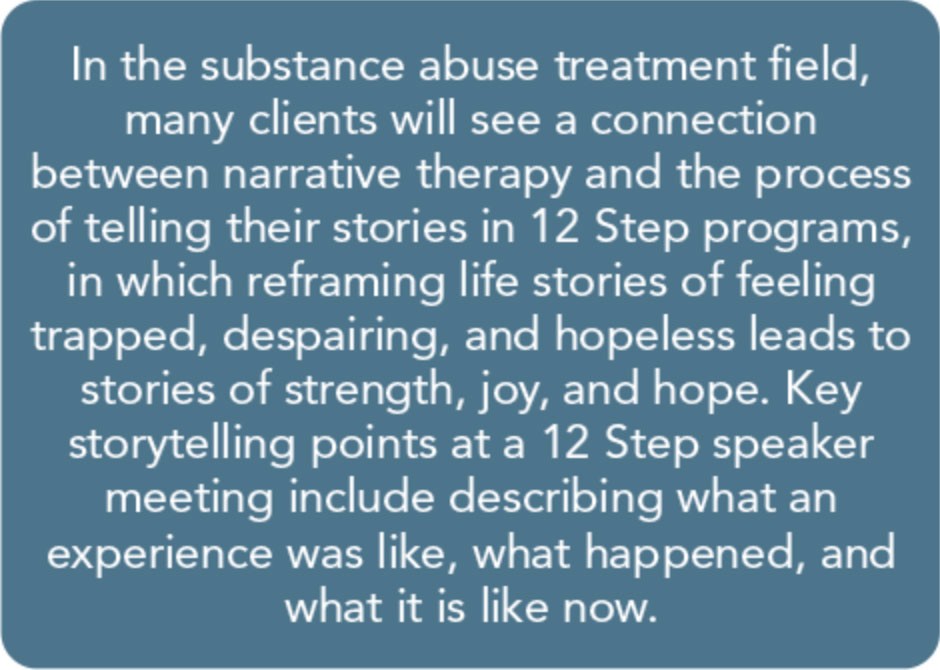
Part 1, Chapter 6-T rauma-Specific Services

frameworks, including psychoneurology, CBT, information processing, and nonverbal repre­ sentation of traumatic memories. The goal of this therapy is to process the experiences that are causing problems and distress. It is an ef­ fective 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 materi­ al. 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 psycho­ therapy 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



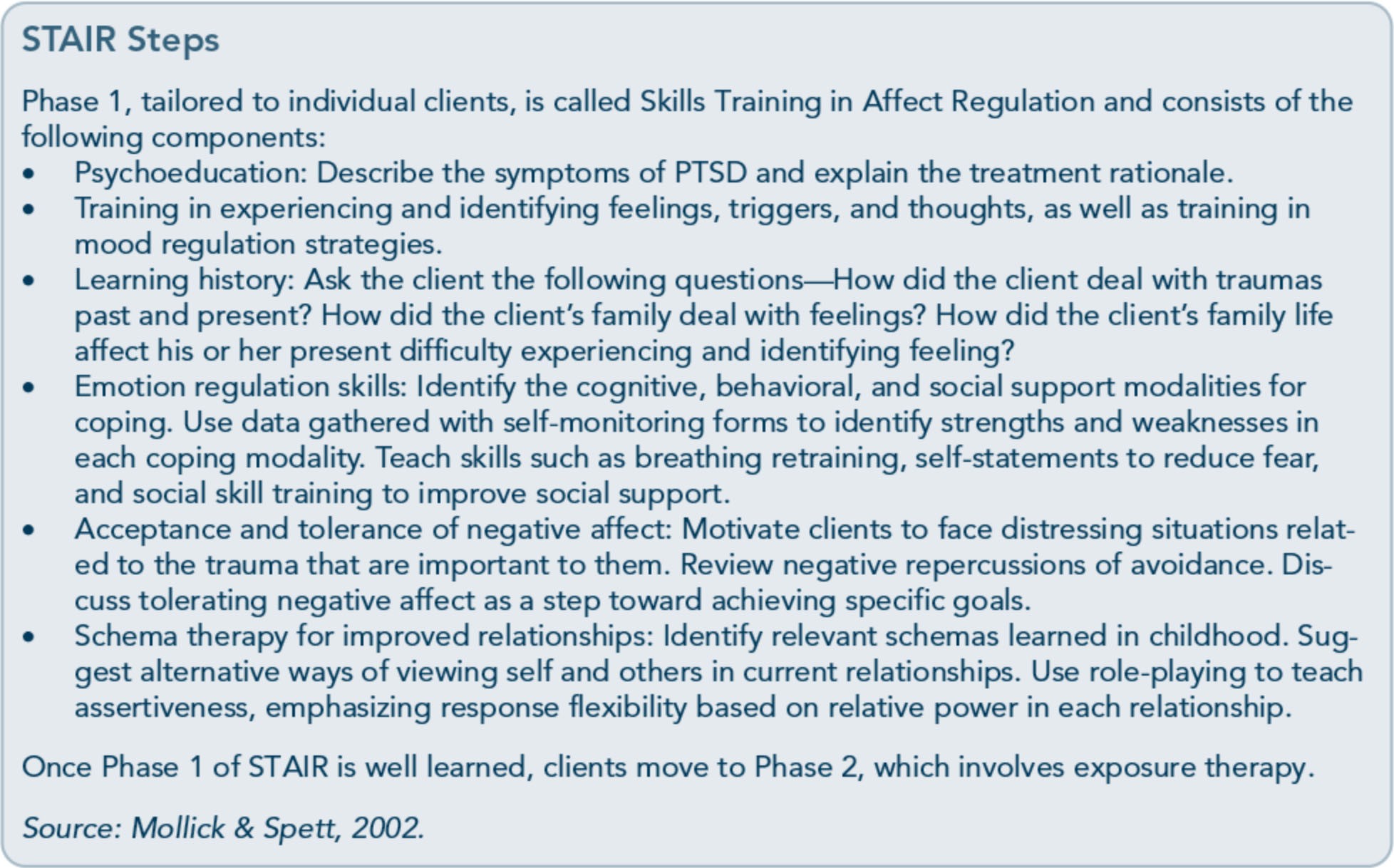
told and retold, expresses the traumatic expe­ rience, puts the trauma in the context of the survivor's life, and defines the options he or she has for change. Narrative structure helps clients connect events in their lives, reveals strings of events, explores alternative expres­ sions of trauma, evokes explanations for cli­ ents' 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).

##### *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 devel­ oped by others into a new package (Cloitre, Koenen, Cohen, & Han, 2002). Phase 1 con­ sists 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 manage­ ment, distress tolerance, acceptance of feel­ ings, identifying trauma-based interpersonal schemas, identifying conflict between trauma­ generated feelings and current interpersonal goals, role-plays on issues of power and con­ trol, and role-plays on developing flexibility in interpersonal situations. Phase 2 features eight

**145**

Trauma-Informed Care in Behavioral Health Services



**146**

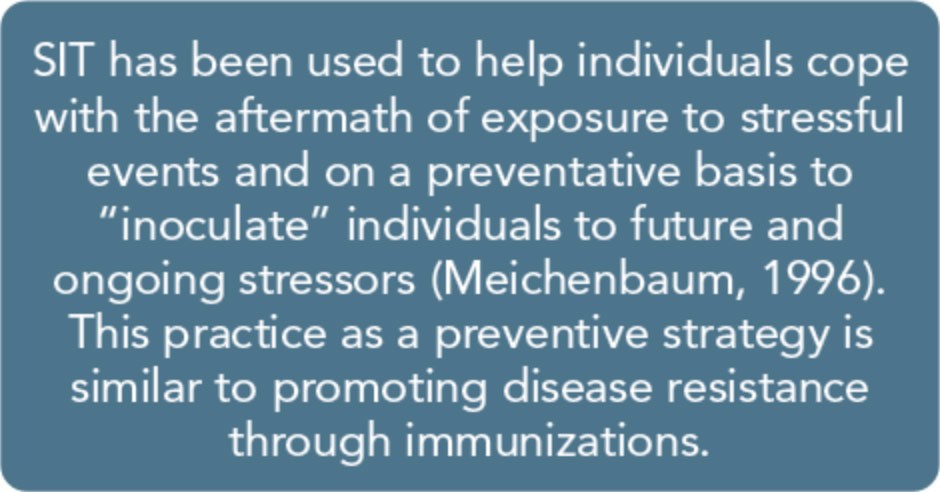
sessions of modified prolonged exposure using a narrative approach.

Cloitre and colleagues (2002) assigned women with PTSD related to childhood abuse ran­ domly to STAIR or a minimal attention wait­ list, excluding clients with current substance dependence as well as other complexities.

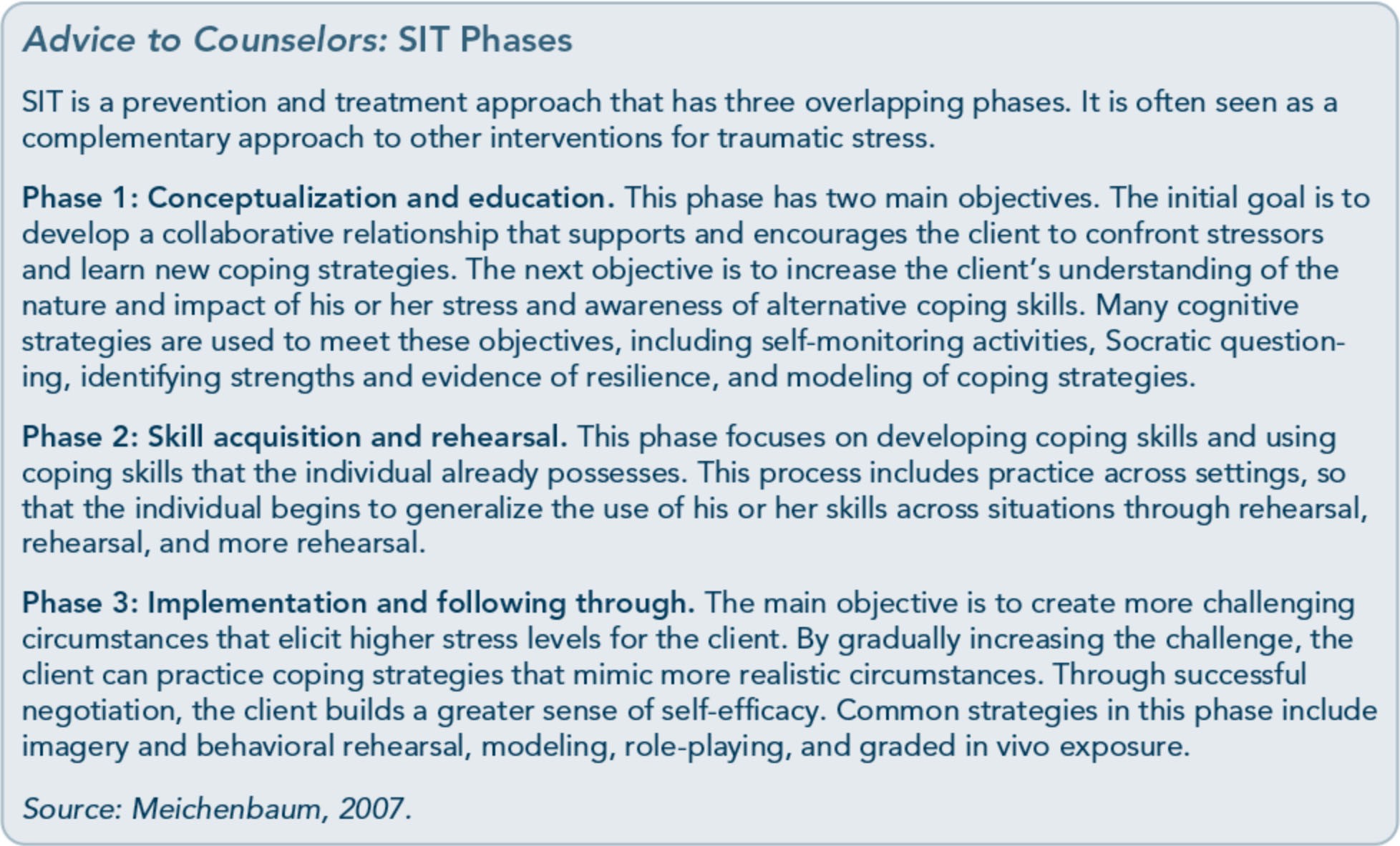
ST AIR participants showed significantly greater gains in affect regulation, interpersonal skills, and PTSD symptoms than the control participants. These gains were maintained through follow-up at 3 and 9 months. How­ ever, it is not clear from this study whether DBT and exposure were both needed. Phase **1** therapeutic alliance and negative mood regula­ tion skills predicted Phase 2 exposure success in reducing **PTSD,** suggesting the importance of establishing a strong therapeutic relation­ ship and emotion regulation skills before con­ ducting 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



Part 1, Chapter 6-T rauma-Specific Services



"STOP" and then redirecting thoughts in a more positive direction]), and skills applica­ tion. The goal is to help clients learn to man­ age 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 treat­ ment), 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 exam­ ple is the traumatic incident reduction (TIR) approach. This brief memory-oriented inter­ vention is designed for children, adolescents, and adults who have experienced traumatic stress (Valentine & Smith, 2001). Listed in

SAMHSA's NREPP, the intervention is de­ signed to process specific traumatic incidents or problematic themes related to the trauma, including specific feelings, emotions, sensa­ tions, attitudes, or pain. It involves having cli­ ents 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 de­ signed 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, 20026; Nixon & Nearmy, 2011). Thus far, research is limited, but what is available suggests that integrated treatment models effectively reduce

147

Trauma-Informed Care in Behavioral Health Services

substance abuse, PTSD symptoms, and other mental disorder symptoms. TIP 42, *Substance Abuse Treatment far Persons With Co-Occurring Disorders* (Center for Substance Abuse Treat­ ment, 2005c), offers a detailed description of integrated treatment. In contrast with inte­ grated models, other model types include sin­ gle (treatment of only one disorder), sequential (treatment of one disorder first, then the other), or parallel (concurrent treat­ ment of multiple disorders delivered by sepa­ rate clinicians or in separate programs that do not necessarily address the interactions be­ tween 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 Inte­ grated Model (ATRIUM; Miller & Guidry, 2001) integrates CBT and relational treatment through an emphasis on mental, physical, and spiritual health. This 12-week model for indi­ viduals and groups blends psychoeducational, process, and expressive activities, as well as information on the body's responses to addic­ tion 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 inter­ personal 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, of­ fering psychoeducation on the nature of trau­ ma, and helping the client assess personal strengths. ATRIUM actively discourages the evocation of memories of abuse or other trau­ ma 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 emphasiz­ es learning new information about trauma and developing additional coping skills. The third stage of the program, the "inner circle," focus­ es on challenging old beliefs that arose as a result of the trauma. For instance, the concept of "nonprotecting bystander" is used to repre­ sent the lack of support that the traumatized person experienced at the time of the trauma. This representation is replaced with the "pro­ tective 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 favora­ ble 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 describ­ ing the theory behind this model in greater depth, as well as how to implement it, is pub­ lished under the title *Addictions and Trauma Recovery: Healing the Body, Mind, and Spirit* (Miller & Guidry, 2001).

148

Part 1, Chapter 6-T rauma-Specific Services

###### Beyond Trauma: A Healing Journey for Women

Beyond Trauma (Covington, 2003) is a curric­ ulum for women's services based on theory, research, and clinical experience. It was devel­ oped for use in residential, outpatient, and correctional settings; domestic violence pro­ grams; 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 com­ ponent that defines trauma by way of its pro­ cess as well as its impact on the inner self (thoughts, feelings, beliefs, values) and the outer self (behavior and relationships, includ­ ing 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 expo­ sure therapy (in which the client becomes de­ sensitized 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. Ses­ sion six transitions into exposure therapy, which begins in earnest in session seven and is combined with CBT for the treatment of sub­ stance 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 de­ pressive 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 result­ ed in improvements in PTSD with no differ­ ence 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 sub­ stance use. It incorporates elements such as psychoeducation, cognitive restructuring, and breathing retraining (McGovern, Lamber­ Harris, Alterman, Xie, & Meier, 2011). A ran­ domized controlled trial showed that both integrated CBT and individual addiction treatment achieved improvements in substance use and other measures of psychiatric symp­ tom 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, 20026) offers clinician guide­ lines and client handouts and is available in

**149**

Trauma-Informed Care in Behavioral Health Services

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 indi­ viduals, 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 your­ self, 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 process­ es and offers concrete strategies that are thought to be essential for clients dealing with concurrent substance use disorders and histo­ ries of trauma.

More than 20 published studies (which include pilot studies, randomized controlled trials, and multisite trials representing various investiga­ tors and populations) provide the evidence base for this treatment model. For more infor­ mation, 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 peo­ ple with chronic, severe trauma symptoms and substance dependence who were diverse in ethnicity and were treated in a range of set­ tings (e.g., criminal justice, VA centers, adoles­ cent 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 satisfac­ tion 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 (address­

ing countertransference, self-care, and other issues).

#### Substance Dependence PTSD Therapy

Substance Dependence PTSD Therapy (Triffleman, 2000) was designed to help cli­ ents 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 en­ hancement techniques. Phase II, "Trauma­ Focused, Addictions-Informed Treatment," begins with psychoeducation about **PTSD** fol­ lowed by ''Anti-Avoidance I," in which a modi­ fied 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.

150

Part 1, Chapter 6-T rauma-Specific Services

#### Trauma Affect Regulation: Guide for Education and Therapy

Trauma Affect Regulation: Guide for Educa­ tion and Therapy (TARGET; Ford & Russo, 2006; Frisman, Ford, Lin, Mallon, & Chang, 2008) uses emotion and information pro-

cessing 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 par­ ticipants 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 posi­ tive feelings (e.g., happiness, love, comfort, compassion) and feelings that represent positive striv­ ings (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 cata­ strophic. 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.*

151

Trauma-Informed Care in Behavioral Health Services

normal stress response into an extreme survival-based alarm response that can lead to PTSD, and it teaches them a seven-step ap­ proach to making the PTSD alarm response less distressing and more adaptive (summa­ rized by the acronym FREEDOM: Focus, Recognize triggers, Emotion self-check, Eval­ uate 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).

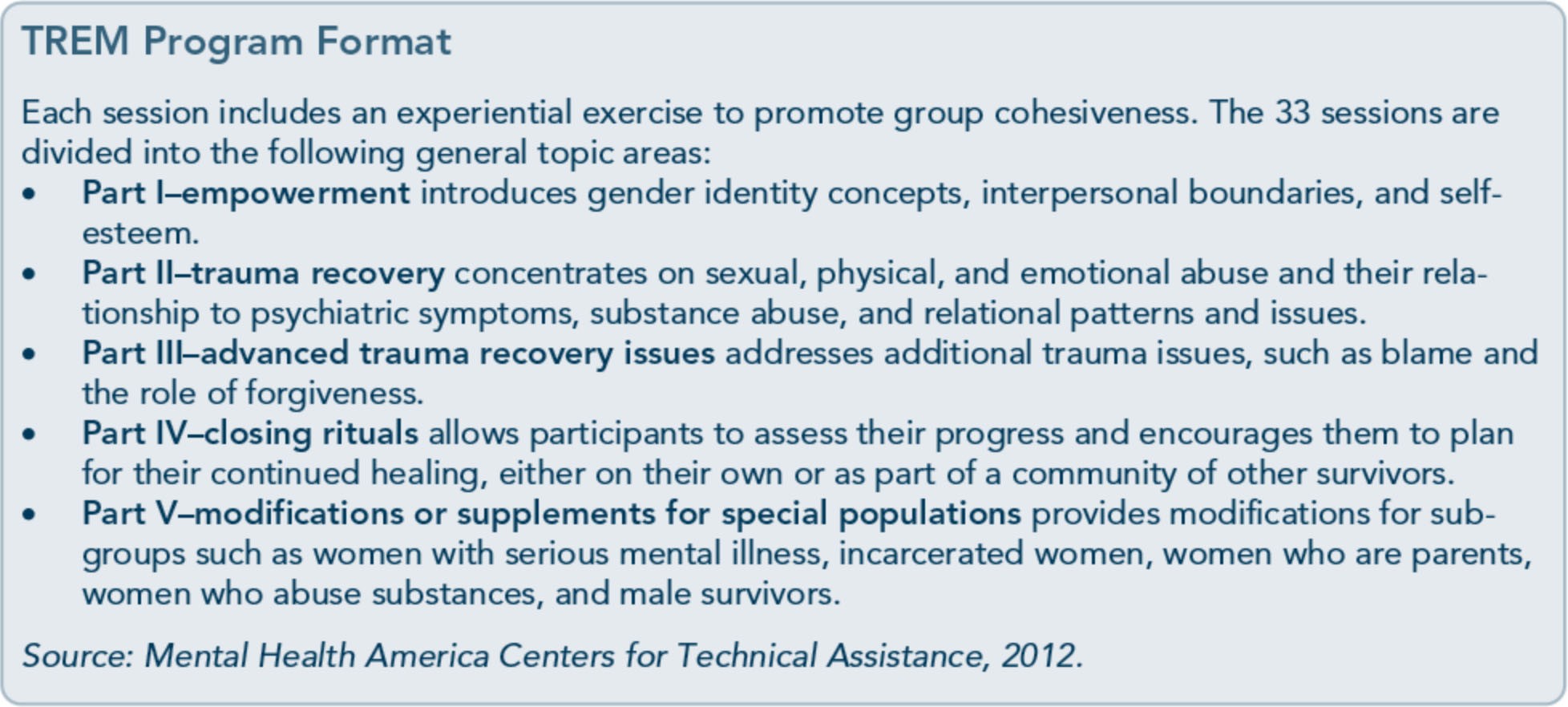
###### Trauma Recovery and Empowerment Model

The trauma recovery and empowerment mod­ el (TREM) of therapy (Fallot & Harris, 2002; Harris & Community Connections Trauma Work Group, 1998) is a manualized group intervention designed for female trauma survi-

vors with severe mental disorders. TREM addresses the complexity oflong-term adapta­ tion to trauma and attends to a range of diffi­ culties common among survivors of sexual and physical abuse. TREM focuses mainly on de­ veloping specific recovery skills and current functioning and uses techniques that are effec­ tive 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 resi­ dential 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 Vio­ lence Study for three of the nine study sites and in SAMHSA's Homeless Families pro­ gram, and it is listed in SAMHSA's NREPP. This model has been used with clients in sub­ stance abuse treatment; research by Toussaint,

VanDeMark, Bornemann, and Graeber (2007) shows that women in a residential sub­ stance abuse treatment program showed sig­ nificantly better trauma treatment outcomes using TREM than they did in treatment as usual, but no difference in substance use.



152

Part 1, Chapter 6-T rauma-Specific Services

###### 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 inte­ grated model designed for female trauma sur­ vivors 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 inte­ grated 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 interven­ tions 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 ac­ cessibility 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 rela­ tionships. Family and couples therapy may be key to recovery. Family members may experi­ ence secondary traumatization silently, lack

understanding of traumatic stress symptoms or treatment, and/or have their own histories of trauma that influence their willingness to sup­ port the client in the family or to talk about anything related to trauma and its effects.

Family members can engage in similar pat­ terns 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 treat­ ment, and lifestyle management courses (Riggs, Monson, Glynn, & Canterino, 2009).

**Mindfulness Interventions** Mindfulness is a process of learning to be pre­ sent 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.

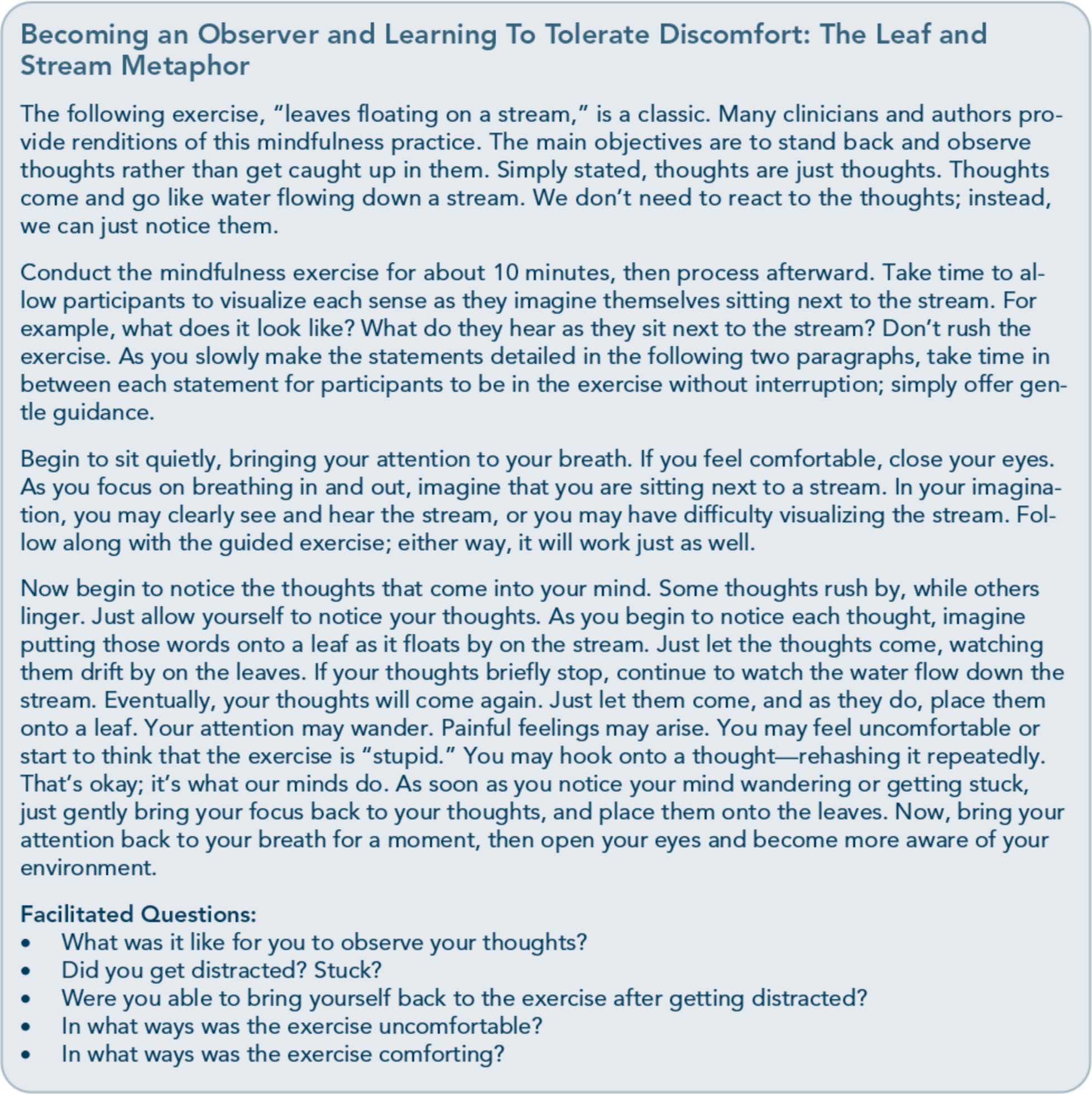
It plays a significant role in helping individuals

who have been traumatized observe their ex­ periences, increase awareness, and tolerate uncomfortable emotions and cognitions.

To date, mindfulness-based interventions ap­ pear to be valuable as an adjunct to trauma­ specific interventions and in decreasing arous­ al (Baer, 2003). It may also help individuals tolerate discomfort during exposure-oriented and trauma processing interventions. Overall, mindfulness practices can help clients in man­ aging traumatic stress, coping, and resilience. In a study of firefighters, mindfulness was associated with fewer PTSD symptoms, de­ pressive symptoms, physical symptoms, and alcohol problems when controlling for other variables (Smith et al., 2011).

153

Trauma-Informed Care in Behavioral Health Services



For clients and practitioners who want to de­ velop a greater capacity for mindfulness, see Kabat-Zinn's books *Wherever You Go, There You Are: Mincifulness Meditation In Everyday Life* (1994) and *Full Catastrophe Living: Using the Wisdom ofYour Body and Mind to Face Stress, Pain, and Illness* (1990). For clinical applications of mindfulness, see *Mincifulness­ Based Cognitive Therapy far Depression: A New Approach to Preventing Relapse* (Segal et al., 2002) and *Relapse Prevention: Maintenance*

*Strategies in the Treatment of Addictive Behav­ iors* (Marlatt & Donovan, 2005).

**Pharmacological Therapy** Pharmacotherapy for people with mental, sub­ stance 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

154

Part 1, Chapter 6-T rauma-Specific Services

are no specific "antitrauma" drugs; rather, cer­ tain drugs target specific trauma symptoms. Clients receiving pharmacotherapy need care­ ful assessment. Some clients with preexisting mental disorders may need further adjustment in medications due to the physiological effects of traumatic stress. In addition, sudden with­ drawal from a pattern of self-administered substances can not only lead to dangerous lev­ els 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 medica­ tions 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 symp­ toms 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 train­ ing, identified problems, the potential for pre­ vention, 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 tech­ niques might be successful in keeping clients engaged in recovery.

155

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222

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225

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226

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228

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230

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231

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232

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238

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239

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240

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241

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242

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243

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244

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246