Part 2: An Implementation Guide for Behavioral Health Program Administrators

1 Trauma-Informed Organizations

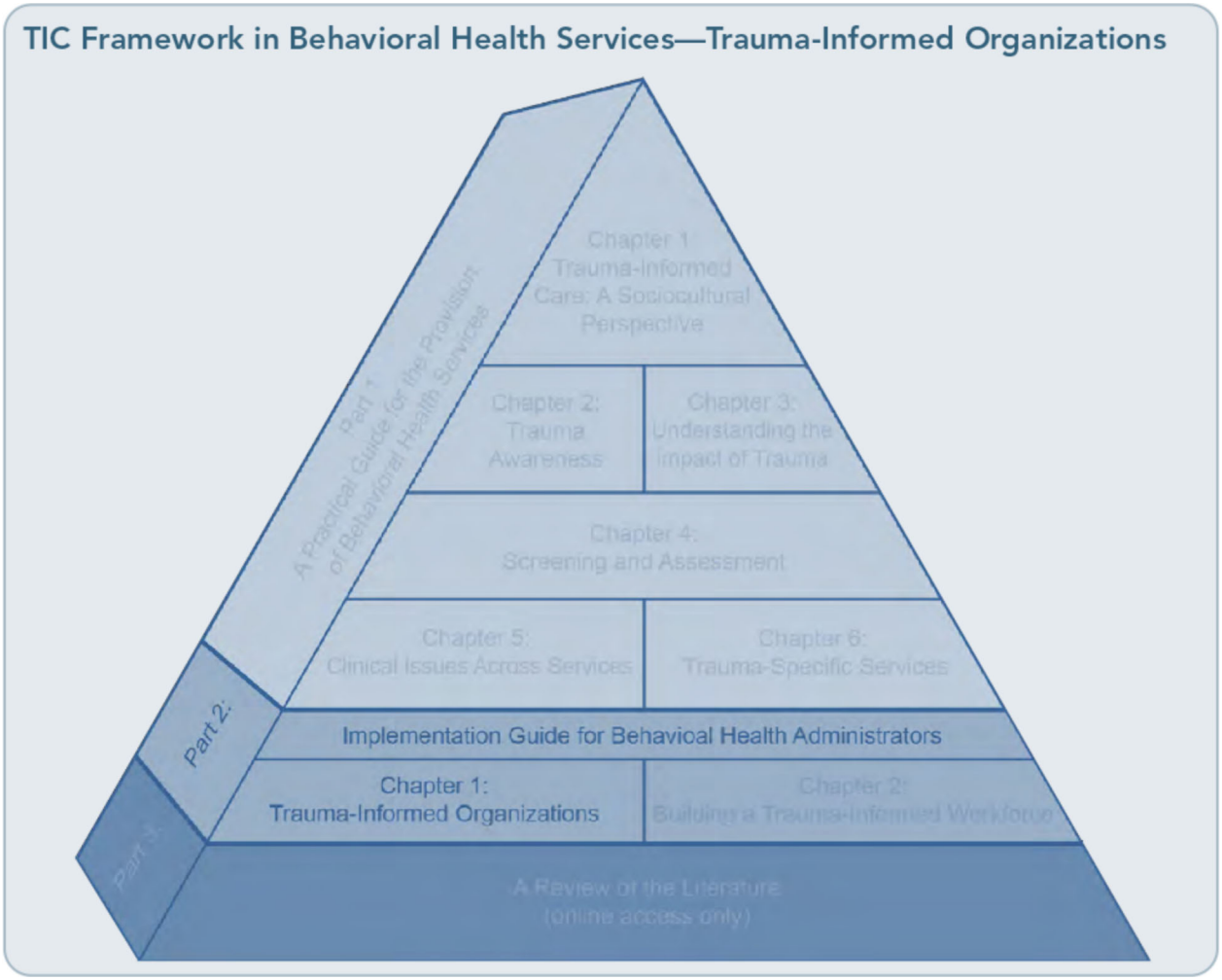
IN THIS CHAPTER

- Show Organizational and Administrative Commitment to TIC
- Use Trauma Informed Principles in Strategic Planning
- Review and Update Vision, Mission, and Value Statements
- Assign a Key Staff Member To Facilitate Change
- Create a Trauma Informed Oversight Committee
- Conduct an Organizational Self Assessment of Trauma Informed Services
- Develop an Implementation Plan
- Develop Policies and Procedures To Ensure Trauma Informed Practices and To Prevent Retraumatization
- Develop a Disaster Plan
- Incorporate Universal Routine Screenings
- Apply Culturally Responsive Principles
- Use Science Based Knowledge
- Create a Peer Support Environment
- Obtain Ongoing Feedback and Evaluations
- Change the Environment To Increase Safety
- Develop Trauma Informed Collaborations

Part 2 provides a broad overview of how to create and implement an institutional framework for trauma-informed services in program delivery and staff development, policies and procedures, administrative practices, and organizational infrastructure in behavioral health services. Chapter 1, "Trauma-Informed Organizations," focuses on specific organizational strategies that will help develop a trauma-informed culture in behavioral health settings. Numerous strategies are presented, including organizational commitment to trauma-informed care (TIC), trauma-informed organizational assessment, implementation of universal screening for trauma, and creation of a peer support environment.

Chapter 2, "Building a Trauma-Informed Workforce," focuses on organizational activities that foster the development of a trauma-informed workforce, including recruiting, hiring, and retaining trauma-informed staff; providing training on evidence-based and emerging trauma-informed best practices; developing competencies specific to TIC; addressing ethical considerations; providing trauma-informed supervision; and preventing and treating secondary trauma in behavioral health service providers.

The strategies described in the following sections can help supervisors and other administrative staff members create a trauma-informed behavioral health environment. As a starting point, the administration should identify key personnel and consumers to guide the organizational change process and the organizational assessment. Administrators and supervisors need to plan for and demonstrate an ongoing commitment to these strategies, or staff may perceive development activities as comprising yet another idea or demand from the agency that is short-lived beyond the initial thrust of training.



Creating a trauma-informed organization is a fluid, ongoing process; it has no completion date. Consumer demographics change across time, exposure to specific types of trauma may become more prevalent, and knowledge of best and evidence-based practices (EBPs) will continue to advance. A trauma-informed organization continues to demonstrate a commitment to compassionate and effective practices and organizational reassessments, and it changes to meet the needs of consumers with histories of trauma. It is encouraging that recent Substance Abuse and Mental Health Services Administration (SAMHSA) data indicates that the majority of over 10,000 programs they surveyed state that they provide trauma-related care (Capezza & Najavits, 2012). However, there remains a major need to make TIC consistently high-quality, routine, and pervasive across treatment systems.

The following stages form the basis of creating a trauma-informed organization:

1. Commit to creating a trauma-informed agency.
2. Create an initial infrastructure to initiate, support, and guide changes.
3. Involve key stakeholders, including consumers who have histories of trauma.
4. Assess whether and to what extent the organization's current policies, procedures, and operations either support TIC or interfere with the development of a trauma-informed approach.
5. Develop an organizational plan to implement and support the delivery of TIC within the agency.

Trauma-Informed Services and Service Systems

"A trauma-informed service system and/or organization is one in which all components of the system have been reconsidered and evaluated in the light of a basic understanding of the role that violence and trauma play in the lives of people seeking mental health and addiction services. A 'trauma-informed' organizational environment is capable of supporting and sustaining 'trauma-specific' services as they develop. A trauma-informed system recognizes that trauma results in multiple vulnerabilities and affects many aspects of a survivor's life over the lifespan, and therefore coordinates and integrates trauma-related activities and training with other systems of care serving trauma survivors. A basic understanding of trauma and trauma dynamics…should be held by all staff and should be used to design systems of services in a manner that accommodates the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid retraumatization and facilitate consumer participation in treatment. A trauma-informed service system is knowledgeable and competent to recognize and respond effectively to adults and children traumatically impacted by any of a range of overwhelming adverse experiences, both interpersonal in nature and caused by natural events and disasters. There should be written plans and procedures to develop a trauma-informed service system and/or trauma-informed organizations and facilities with methods to identify and monitor progress. Training programs for this purpose should be implemented."

Source: Jennings, 2009, pp. 111–112.

6. Create collaborations between providers and consumers and among service providers and various community agencies.
7. Put the organizational plan into action.
8. Reassess the implementation of the plan and its ability to meet the needs of consumers and to provide consistent TIC on an ongoing basis.
9. Implement quality improvement measures as needs and problem areas are identified.
10. Institute practices that support sustainability, such as ongoing training, clinical supervision, consumer participation and feedback, and resource allocation.

Strategy #1: Show Organizational and Administrative Commitment to TIC

Foremost, administrators need to understand the impact that trauma can have on people's lives. The consistent delivery of TIC is only as effective as the organization's commitment, which must extend to administrative practices with staff members, program policies and procedures, program design, staffing patterns, use of peer support, staff and peer training and supervision, organizational assessment and consumer feedback, and resources to uphold trauma-informed principles and practices. Even short-term change is not sustainable without the agency's continual commitment.

Typically, desirable organizational change doesn't occur by accident. It comes from steadfast leadership, a convincing message that change is necessary and beneficial for staff and consumers, and resources that support change. Many people naturally resist change; thus, an organization's commitment includes a willingness to discuss with staff members the impact and role of trauma in their service setting, patience in planning and implementation, and

Seminal Resource for Administrators

As you investigate how best to implement or improve trauma informed services within your organization or across systems, review the influential work, *Using Trauma Theory to Design Service Systems: New Directions for Mental Health Services.* (Harris & Fallot, 2001c)

Advice to Administrators: Managing Staff Reactions to Implementation of New Processes or Ideas

A common hurdle for administrators after introducing a new process or idea is the staff assumption that it will require more work. Frontline staff members are often inundated with many responsibilities beyond face-to-face time with clients. In addition, a common misperception is that if you begin to address trauma, you will have difficulty containing it.

In addition to administrative buy-in, administrators must promote rather than simply announce the implementation of trauma-informed services. Promotion includes educating staff about the rationale for trauma-informed services, offering opportunities for discussion and input from staff and consumers, providing training focused on trauma-informed skills, and so forth. For example, the San Diego Trauma-Informed Guide Team (2012) created a promotional brochure on how TIC can make staff jobs easier:

- Focuses on root problem
- Is preventative
- Increases support system
- Facilitates collaboration
- Shares workload
- Empowers client
- Provides consistency in agencies/systems
- Uses evidence-based best practices

TIC may be cost-effective, lead to less intensive services and less use of services, prevent undue stress for staff members and clients, and prevent client crises caused by old policies that could retraumatize trauma survivors.

the ability to tolerate the uncertainty that naturally accompanies transitions.

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

Strategic planning provides an opportunity to explore and develop short- and long-term goals. The planning process often begins with reevaluating the organizations' values, mission, and vision, yet agencies cannot adequately develop a trauma-informed strategic plan without obtaining specific information about internal (staff, resources, processes) and external environmental (referral constellation, changes in health care, funding sources, State and Federal standards, community needs, consumer demographics, etc.) factors and influences. Data gathered through staff, consumer, organizational, and community assessments shapes the direction of the plan, including projected demands, challenges, obstacles, strengths, weaknesses, and resources. At the conclusion of this planning process, the organization will have specific goals, objectives, and tasks to meet the needs of their stakeholders and to address any anticipated challenges. Ideally, strategic planning should define key steps in developing or refining trauma-informed services within the organization.

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

Vision, mission, and value statements provide a conceptual framework for TIC development and delivery. They should not be created in isolation; they should reflect voices from the community, populations, and other stakeholders that the organization serves. These statements develop through input, discussion, and assessment. They are not static; they evolve as needs, populations, or environments change.

Statement Example

As behavioral health service providers, we strive to be trauma aware—to understand the dynamics and impact of trauma on the lives of individuals, families, and communities. We strive to create a trauma-sensitive culture by demonstrating, through consumer empowerment, program design, and direct care, an understanding of the relationships among trauma, substance abuse, and mental illness.

Advice to Administrators: How To Create Vision, Value, and Mission Statements

Define the organization's vision, values, and mission to be compatible with TIC. Emphasize the organizational culture needed to provide TIC. An outgrowth of that cultural shift may include an enhanced working environment for employees and consumers that is noncoercive and reduces conflicts, restraint, and seclusion. Even if the current mission statement is appropriate, change it anyway to symbolize intended change within the organization. To define or redefine the vision, values, and mission:

- Involve consumers, all levels of staff, and leadership, including the director/CEO.
- Review:
  - Organizational priorities to identify and manage conflicting priorities.
  - Resources to assess whether reallocation is necessary for change (e.g., to hire peer support specialists, to furnish comfort rooms).
- Operationalize the vision, values, and mission at the level of individual departments
- Evaluate progress at regular staff meetings to ensure that changing the culture of care stays on the agenda.

Source: New Logic Organizational Learning, 2011.

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

Prior to the development of an oversight committee, a senior staff member with the authority to initiate and implement changes should be assigned to oversee the developmental process. By assigning a trauma-aware senior staff member who is committed to trauma-informed services, it is more likely that the organization's and committee's goals, objectives, and plans will remain in focus. This senior staff member is responsible for ongoing development and facilitation of the oversight committee; management of the initial organizational assessment, reassessments, and other evaluative and feedback processes; and facilitation and oversight of the implementation plan and subsequent changes, including policies and procedures to ensure delivery of TIC.

Strategy #5: Create a Trauma-Informed Oversight Committee

The role of the oversight committee includes providing ongoing input and direction in the initial organizational assessment, strategic plan, plan implementation, reevaluation and development of trauma-informed policies and procedures, and future reassessments. The committee monitors progress and uses real-time data to forge a clear pathway to new processes that support TIC. The committee should involve stakeholders from the community, consumers, specialists, staff members, and administrators. Leadership involvement is necessary. Stakeholders may be alumni, family members, community-based organizations, and other institutions that interact with the agency or would benefit from trauma-informed services.

Initially, the agency must educate the committee on the organization's mission, values, and vision as well as the task at hand—developing trauma-informed services. To ease potential conflicts or confusion about the organization's structure, the guidelines, expectations, and roles of the committee need to be communicated directly to committee members as well as the organization as a whole, including board members, support and professional staff, supervisors, and so forth. The committee also needs to know the extent of their power and the necessary lines of communication before, during, and after evaluating and implementing changes in the organization.

Including consumers and/or those who have lived through trauma is vital. They have unique knowledge, experiences, and perspectives on the impact of treatment design, delivery, policies, and procedures. They offer firsthand information on practices that can potentially retraumatize clients in behavioral health settings and can suggest preventive, alternative practices and solutions. Consumer committee members keep staff and administrators aware of the goal of achieving TIC.

Strategy #6: Conduct an Organizational Self-Assessment of Trauma-Informed Services

An organizational self-assessment evaluates the presence and/or the effectiveness of current trauma-informed practices across each service and level of the organization. This assessment allows an organization to see how it functions within the context of trauma-informed principles and provides feedback to inform the development or revision of the implementation plan for TIC. In essence, this assessment process can serve as a blueprint for change and as a benchmark of compliance with and progress in implementing trauma-informed practices across time. Overall, it is a process of identifying organizational strengths, weaknesses, opportunities, and threats related to the implementation and maintenance of TIC. Refer to Appendix F for sample organizational assessment tools for the organization and the consumer.

The self-assessment should obtain feedback from key stakeholders, particularly consumers, family members, referral sources, community organizations, and all levels of the organization's staff, including nonclinical and clinical staff, supervisors, and administrative personnel. Similar to the universal screening process, an organizational self-assessment is only as effective as the steps taken after data are gathered and analyzed. From this assessment, an implementation plan should be established that highlights the goals, objectives, steps, timeframe, and personnel responsible in overseeing the specific objective. Assessment shouldn't be a once-and-done project. Timely and regularly scheduled organizational assessments should follow to assist in quality improvement. For an explanation of more detailed steps to take in conducting an organizational self-assessment, see Chapter 4 of the planned Treatment Improvement Protocol (TIP), *Improving Cultural Competence* (SAMHSA, planned c).

Advice to Administrators: Ten Steps to Quality Improvement

1. Identify new goals or problems.
2. Gather input from each level of the organization, including consumers and other key stakeholders.
3. Analyze the feedback.
4. Explore improvement options and the potential barriers associated with each.
5. Select the overall approach and specific strategies to address barriers (anticipate barriers, and try to address them before they occur).
6. Develop an implementation plan, and then present the plan to staff members and other key stakeholders not directly involved in the quality improvement process.
7. Implement the plan.
8. Reassess the new plan.
9. Evaluate the results and determine if new goals or additional problems or issues need to be addressed.
10. Repeat the first nine steps.

Strategy #7: Develop an Implementation Plan

Implementation plans should evolve from consumer participation, demographic profiles

Advice to Administrators: Implementation Plan Content

1. **Introduction and overview:** This includes the organization's history, the demographics that characterize its client base, the rationale for the implementation plan, and the incorporation of TIC. Focus on identification of strengths, weaknesses, opportunities, and threats. Provide an overview of goals and objectives.
2. **Specific goals and objectives:** Goals and objectives should address:
   - Workforce development strategies for recruiting, hiring, retaining, training, supervising, and promoting wellness of clinical and nonclinical staff members to support TIC.
   - Consumer participation and peer support development and implementation strategies.
   - Policies, procedures, and practices to support TIC and culturally responsive services, to promote safety, and to prevent retraumatization.
   - Specific evidence-based or best practice adoptions to support TIC.
   - Strategies to amend facility design or environment (plant) operations to reinforce safety.
   - Fiscal planning to ensure sustainability of the steps initiated in the organization.
3. **Guidelines for implementation:** Guidelines should highlight the specific steps, roles, responsibilities, and timeframes for each activity to meet TIC objectives.

of populations served, data from organizational self-assessment, and research on promising and evidence-based trauma-informed practices. Using the framework proposed in this TIP, the oversight committee is responsible for designing a plan that outlines the purpose, goals, objectives, timeframes, and personnel responsible for each objective (Exhibit 2.1-1).

Exhibit 2.1-1: TIC Planning Guidelines

The following publications provide samples of organizational guidelines for implementing TIC.

- Fallot, R. D. & Harris, M. (2009). *Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol.* Washington, DC: Community Connections, 2009.
- Guarino, K., Soares, P., Konnath, K., Clervil, R., & Bassuk, E. (2009). *Trauma-informed organizational toolkit.* Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; the Daniels Fund; the National Child Traumatic Stress Network; and the W. K. Kellogg Foundation.
- Huckshorn, K. (2009). Transforming cultures of care toward recovery oriented services: Guidelines toward creating a trauma informed system of care. In *Trauma informed care (TIC) planning guidelines for use in developing an organizational action plan.* Alexandria, VA: National Association of State Mental Health Program Directors.
- Jennings, A. (2009). *Criteria for building a trauma-informed mental health service system.* Retrieved on May 21, 2013, from http://www.theannainstitute.org/CBTIMHSS.pdf
- Ohio Legal Rights Service (2007). *Trauma-informed treatment in behavioral health settings.* Columbus, OH: Ohio Legal Rights Service.
- Prescott, L., Soares, P., Konnath, K., & Bassuk, E. (2008). *A long journey home: A guide for creating trauma-informed services for mothers and children experiencing homelessness* [draft]. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; the Daniels Fund; the National Child Traumatic Stress Network; and the W.K. Kellogg Foundation.

The following resource is a systemwide set of guidelines for implementing TIC.

- U.S. Department of Health and Human Services, Health Resources and Services Administration (2006). *Model trauma system: Planning and evaluation.* Rockville, MD: Health Resources and Services Administration.

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

In the early stage of evaluating current services and planning for TIC, the committee needs to assess practices, procedures, and policies that may have been or could be retraumatizing to any individual, at any level of the organization, from consumers to administrators. Programs that are not trauma informed are as likely to be unaware of the impact of trauma on staff as they are to be unaware of its influence on consumers. In the initial review, careful scrutiny should be used to eliminate any practice that is potentially harmful, including seclusion and restraint practices, therapeutic activities that are shaming, treatment planning without collaboration, any medical inquiry without privacy, and so forth.

Program Curriculum: Roadmap to Seclusion-Free and Restraint-Free Mental Health Services

This curriculum, written from consumer perspectives, provides behavioral health staff with education, strategies, and hands-on tools to prevent and ultimately eliminate the use of seclusion and restraint. It includes many handouts for participants and consumers. This training package, available online (http://store.samhsa.gov/product/Roadmap-to-Seclusion-and-Restraint-Free-Mental-Health-Services-CD-/SMA06-4055), is divided into seven modules plus a resources section:

- Module 1: The Personal Experience of Seclusion and Restraint
- Module 2: Understanding the Impact of Trauma
- Module 3: Creating Cultural Change
- Module 4: Understanding Resilience and Recovery from the Consumer Perspective
- Module 5: Strategies to Prevent Seclusion and Restraint
- Module 6: Sustaining Change Through Consumer and Staff Involvement
- Module 7: Review and Action Plan
- Resource Section

Source: Center for Mental Health Services (CMHS), SAMHSA, 2005.

Policies and procedures are the building blocks of each agency. They guide the service process and, if followed, they provide an opportunity for the agency to deliver consistent responses and care. Policies and procedures must incorporate trauma-informed practices across all domains and standards, such as admissions, plant/environmental standards, screening and assessment processes, referrals (to other services, including hospitalization, or for further evaluations), treatment planning, confidentiality, discharge, and more. They also need to be updated periodically to incorporate new science and to meet the changing needs of consumers. By regularly reviewing and adapting administrative and clinical policies and procedures in response to ever-changing needs and evidence, the agency can provide staff members with good guidelines for providing trauma-informed services that are consistent yet flexible.

Strategy #9: Develop a Disaster Plan

Facilities are often required to develop disaster plans, but specific requirements vary from State to State. From the outset, developing a disaster plan in behavioral health services is essential. Many clients in behavioral health services have lived with trauma, so proactive steps that reduce the impact of a new trauma may prevent worsening of symptoms and decrease the risk for more pervasive effects. (See also Technical Assistance Publication 34, *Disaster Planning Handbook for Behavioral Health Treatment Programs* [SAMHSA, 2013].)

Most disaster events cannot be accurately anticipated. Even so, behavioral health organizations can take steps to reduce the impact of a disaster event on program functioning and on the lives of clients. Each service or program should develop a disaster response committee that meets regularly to develop, maintain, and adapt policies and procedures to respond to disasters affecting the program. Committee planning efforts may include:

1. Creating a disaster response team of program staff members tasked with coordinating program administration and services in a disaster event.
2. Establishing a communication process for informing staff and clients of the status of program functioning and for coordinating staff assignments during and shortly after the disaster event.
3. Outlining a process to inform clients and their families of available services, their location, and contact information for accessing services to meet clients' critical needs.
4. Developing plans for service provision during a disaster event and service implementation after the event.
5. Creating special plans for high-risk or special needs clients who need services during and shortly after the disaster. Examples of this are clients who are homeless, in detoxification services or methadone programs, on prescribed psychopharmaceuticals, or at risk for suicide.
6. Making plans for maintaining the security of client records, program records, and facilities during and shortly after the event.
7. Coordinating ahead with other community resources and services to ensure that clients at high risk or with special needs get the services they require as soon as possible.
8. Prioritizing how services will start back up after a disaster event.
9. Providing special services after the event to clients at high risk for trauma reactions and symptoms.
10. Establishing a postdisaster debriefing process to review disaster responses, services, and outcomes.

Some specific disaster events, such as hurricanes, may sometimes offer opportunities for planning and preparation in advance of the disaster event. This preparation time is usually just a few days, but it allows programs to make advance preparations and take advance action to establish lines of communication, stockpile resources, prepare for evacuation of clients, and protect client and program records.

Strategy #10: Incorporate Universal Routine Screenings

A key element of trauma-informed services is the institution of universal routine screening across all services, regardless of the individual's path in accessing services (e.g., primary care, hospitalization, outpatient). Considering the prevalence of trauma among individuals who seek services for mental and substance use disorders, the implementation of screening is paramount. Without screening, clients are not identified as trauma survivors. Subsequently, they miss recovery opportunities and treatment services that would be more likely to meet their needs, while also running a higher risk of being retraumatized by unexamined organizational policies, procedures, and practices. For more information on the rationale, processes, and instruments of universal screening for trauma, refer to Part 1, Chapter 4.

Strategy #11: Apply Culturally Responsive Principles

Providers must be culturally competent when incorporating evidence-based and best practices as well as trauma-informed treatment

models within the organization. Clients' views of behavioral health differ according to race, ethnicity, and culture (refer to the planned Treatment Improvement Protocol [TIP], *Improving Cultural Competence* [SAMHSA, planned c]). Likewise, cultures attach different meanings to trauma, and responses to trauma will vary considerable across cultures (see Part 3, the online literature review, for more information). For example, trauma survivors who come from a collective society or culture, in which the goals of the group take precedence over the goals of the individual, may be more focused on the well-being of their family or the family's response to the trauma survivors' experience. Often, this view runs in opposition to the individualistic perspective of many behavioral health services. Subsequently, treatment providers who are not culturally competent may interpret collective values as a sign of resistance or avoidance in dealing with traumatic stress. CMHS (2003) outlines principles of cultural competence in disaster work applicable across all forms of trauma:

1. ***Recognize the importance of culture and respect diversity.*** Those who value culture and diversity understand their own cultures, attitudes, values, and beliefs, and they work to understand the cultures of others. This includes being able to communicate effectively with those from other cultures, respecting others' feelings about personal space, knowing about others' social organization, understanding how time is viewed, and being aware of others' beliefs about the effects of their behaviors.
2. ***Maintain a current profile of the cultural composition of the community.*** This includes describing the community's population in terms of race and ethnicity, age, gender, religion, refugee and immigrant status, housing status, income levels, rural/urban balance, unemployment, languages spoken, literacy, schools, and businesses.
3. ***Recruit workers who are representative of the community or service area.*** If the workers who are available do not match the community, they should have the personal attributes, knowledge, and skills to develop cultural competence.
4. ***Provide ongoing cultural competence training to staff.*** Topics should include cultural values and traditions, family values, linguistics and literacy, immigration experiences and status, help-seeking behaviors, techniques and strategies for cross-cultural outreach, and the avoidance of stereotypes and labels (DeWolfe & Nordboe, 2000b).
5. ***Ensure that services are accessible, appropriate, and equitable.*** In planning disaster work or TIC, community associations and organizations are invaluable. Gaining their acceptance requires time and energy.
6. ***Recognize the role of help-seeking behaviors, traditions, and natural support networks.*** Culture includes traditions that dictate whom, or which groups, to seek in times of need; how to handle suffering and loss; and how healing takes place. These customs and traditions are respected by a culturally responsive disaster relief program.
7. ***Involve community leaders and organizations representing diverse cultural groups as "cultural brokers."*** Collaborating with community leaders is an effective means of learning about the community, establishing program credibility, and ensuring that services are culturally responsive.
8. ***Ensure that services and information are culturally and linguistically responsive.*** Communication with individuals who do not speak English, who are illiterate in all languages or have limited literacy, and who are deaf or hard of hearing is essential to service provision. Local radio stations, television outlets, and newspapers that are multicultural are an excellent venue for educational information after a disaster.

Using survivors' friends or relatives as interpreters is not recommended, as survivors may be uncomfortable discussing personal matters with family members or friends. Asking children to interpret can place too heavy a responsibility on them and reverses parents' and children's roles.

9. ***Assess and evaluate the program's level of cultural responsiveness.*** Self-assessment and process evaluation can help keep a program on track. A variety of strategies can be used for collecting data and communicating findings to stakeholders.

Strategy #12: Use Science-Based Knowledge

Along with culturally responsive services, trauma-informed organizations must use science-based knowledge to guide program development and the implementation of services, policies, procedures, and practices. This includes the adoption of EBPs (see Part 1, Chapter 6, and Part 3, Section 1, to review definition, treatments, and resources for EBPs). TIC research is quite new; interpret these limited studies and information cautiously. Chambless and Hollon's (1998) criteria, which are still the benchmark for EBPs, are valuable resources for administrators. Look closely at who was included—and excluded—from treatment studies. Often, the types of severe, chronic, and unstable cases seen in community settings are excluded from treatment studies. Evidence-based interventions should be a primary consideration in selecting appropriate treatment models for people with mental illness, substance use disorders, and co-occurring psychological trauma. Nonetheless, other variables must also be contemplated before adopting EBPs in an organization, including the cultural appropriateness of the practice; the strength of its clinical focus on strengths-based strategies; training and competence of clinical staff; the cost of training, materials, and implementation; and the ease of maintaining EBP fidelity amidst staff turnover.

For more detailed information on EBPs, visit the National Registry of Evidence Based Programs and Practices (NREPP) Web site (http://nrepp.samhsa.gov). For more specific research oriented information on trauma and trauma specific treatments, refer to the literature review in Part 3 of this TIP, available online.

Strategy #13: Create a Peer-Support Environment

The main purpose of peer support services is to provide consumer mentoring, support, and care coordination for clients with histories of mental illness or substance abuse. The goals are to help others deal with personal and environmental barriers that impede recovery and achieve wellness. Peer support accomplishes this through many activities, including advocacy, support during crises and recovery activities, modeling, education, and assistance in accessing available resources. Peer support programs send a powerful message to staff members, consumers, and the community—that recovery is possible through support, collaboration, and empowerment. These programs reinforce the trauma-informed premise that organizations need to reflect the populations that they serve and involve consumers in planning, implementing, monitoring, and delivering recovery services.

For an introduction to peer support services, see *What Are Peer Recovery Support Services?* (Center for Substance Abuse Treatment, 2009e).

Notably, peer support services have the potential to be considerably flexible to meet client needs at each stage of recovery. Specifically, peer support services can be incorporated

across the continuum of care, starting with outreach services and extending into long-term recovery services. Peer support specialists can enhance consumer motivation to change, to initiate services, and/or to engage in recovery activities. They can play powerful liaison roles by supporting clients entering treatment and explaining what to expect from services. They can ease the transition into treatment, from one service to the next, from one modality to another (e.g., inpatient group to outpatient group), and beyond formal treatment. Moreover, peer support services create an atmosphere focused on mutuality rather than pathology. They provide living models of resilience and promote hope—that recovery is possible and attainable.

Administrators should familiarize themselves with how other organizations have implemented peer support programs, current curricula, certifications and training processes, competencies and ethics, and peer support service State standards or recommendations, if applicable. The Carter Center's Summit in 2009, The Pillars of Peer Support Services, supported in part by SAMHSA and CMHS, highlighted the numerous elements necessary to develop a strong, vital peer workforce (Daniels et al., 2010). These elements include:

- Clear job and service descriptions.
- Job-related competencies and competence-based testing processes.
- Peer support certifications.
- Ongoing continuing education.
- Media and technology access for peer specialists.
- Sustainable funding.
- Research and evaluation components.
- Code of ethics and conduct.
- Competence-based training for supervisors.
- Multilevel support and program support teams.

> "Peer recovery support services are evidence based and have been demonstrated to promote positive health outcomes and control the cost of healthcare. These services are offered by a trained individual with lived experience and recovery from a mental illness, substance use and/or chronic health conditions. Peer recovery support services minimally include chronic illness self management, whole health and wellness promotion and engagement, relapse prevention, life skill coaching, and insurance and health systems navigation."
>
> (Daniels et al., 2012, p. 22)

Advice to Administrators: Sample Peer Support Staff Tasks

- Use active listening skills help peers identify areas of dissatisfaction and benefits of changing beliefs, thoughts, and behavior.
- Use problem-solving skills to help peers identify barriers to recovery and develop plans to meet peer-determined goals.
- Facilitate recovery support groups.
- Link clients with community resources.
- Work with the treatment team to advocate for clients and to remove recovery barriers.
- Participate in consumer panels to educate staff about the consumer perspective and about peer support.
- Participate in hospital-wide committees and workgroups

Source: New Logic Organizational Learning, 2011.

Strategy #14: Obtain Ongoing Feedback and Evaluations

Obtain feedback on and evaluations of organizational performance on a regular basis. Give consumers a clear avenue for offering feedback at any time, and make evaluations assessing the organization's progress toward providing trauma-informed services standard practice. Without feedback and further evaluation, organizations cannot assess whether they are

meeting trauma-informed objectives. A routine monitoring process for TIC implementation gives the organization additional information necessary to combat new obstacles and threats and to understand what works. Regular monitoring equips organizations with the ability to formulate different strategies to meet objectives as well as to respond to the changing needs of the population. Ongoing evaluation and consumer feedback are essential in improving the quality of services.

Strategy #15: Change the Environment To Increase Safety

Practices that generate emotional and physical safety are necessary. Another aspect of creating safety is reevaluating the physical facilities and environment to enhance safety and to circumvent preventable retraumatization. Think how traumatizing it would be if you were a female rape survivor and a night counselor was conducting a room check at 2:00 a.m., or a male security guard was walking the women's residential wing. What would it be like if you were sitting with your back to the door in a small office during an intake interview, if your history included a physical assault and robbery? For most, it would at least increase anxiety; for others it would be retraumatizing. Trauma-informed providers must carefully assess environmental safety. Although you are likely to identify some facility issues that could erode safety for trauma survivors, a safe environment will only be established if regular feedback is obtained from consumers about their experiences with the program.

Strategy #16: Develop Trauma-Informed Collaborations

TIC is about collaboration with consumers, staff members, key stakeholders, and other agencies. Collaborative relationships provide opportunities for consumers to access the most appropriate services as needs arise. Rather than waiting for a crisis or a dire need for a service to investigate available resources, it is far more efficient and compassionate to establish relationships within the agency and with other community resources before these needs arise. No agency can meet the needs of every client; referral agreements and/or collaborative arrangements that integrate the delivery of TIC, including support services (e.g., housing, legal, medical), are important.

Creating Sanctuary

The sanctuary model is a trauma-based therapeutic approach that has been used in inpatient, residential, therapeutic community, and outpatient settings with children, adolescents, and adults. It provides a template for changing social service delivery systems so that they are better equipped to respond to the complex needs of trauma survivors. Sanctuary is informed by four knowledge areas: "the psychobiology of trauma, the active creation of nonviolent environments, principles of social learning, and an understanding of the ways in which complex adaptive systems grow, change, and alter their course" (Bloom et al., 2003, p. 174).

The sanctuary model describes a stage-based approach to healing that is referred to as SAGE: safety, affect modulation, grieving, and emancipation. This model is nonlinear; an individual does not necessarily move from one stage to another in a straight path, but progress in one area does affect progress in other areas (Bloom, 1997; Bloom et al., 2003). SAGE is a cognitive–behavioral translation of the sanctuary model (Bills, 2003). Early in treatment, the focuses are typically on safety and affect management. Safety encompasses four domains: physical, psychological, social, and moral (Bloom, 1997; see http://www.sanctuaryweb.com for further details and a curriculum).

2 Building a Trauma-Informed Workforce

IN THIS CHAPTER

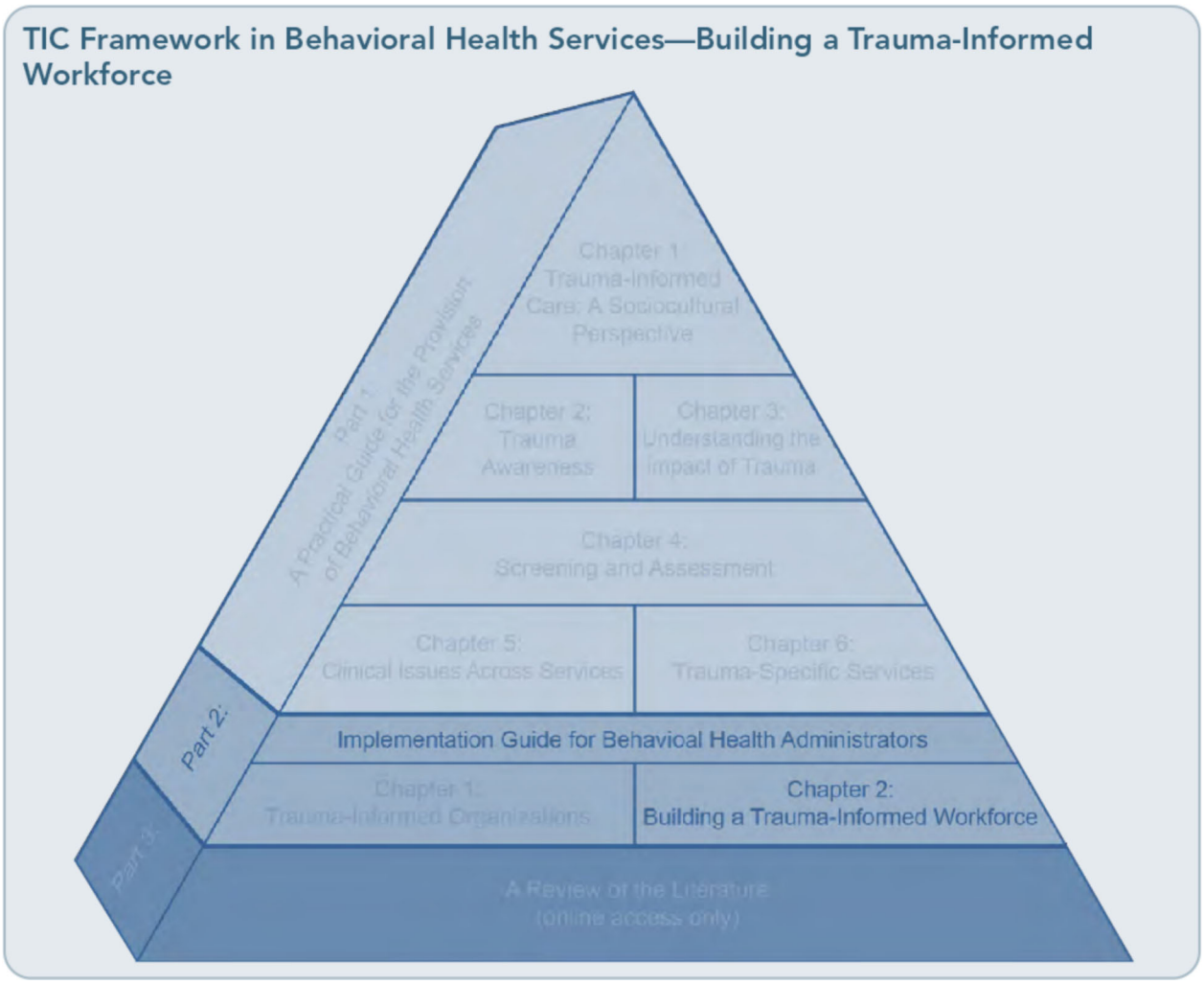
- Introduction
- Workforce Recruitment, Hiring, and Retention
- Training in TIC
- Trauma Informed Counselor Competencies
- Counselor Responsibilities and Ethics
- Clinical Supervision and Consultation
- Secondary Traumatization
- Counselor Self Care

Introduction

For an organization to embrace a trauma-informed care (TIC) model fully, it must adopt a trauma-informed organizational mission and commit resources to support it. This entails implementing an agency-wide strategy for workforce development that is in alignment with the values and principles of TIC and the organization's mission statement. Without a fully trained staff, an organization will not be able to implement the TIC model. However, simply training behavioral health professionals in TIC is not enough. Counselors will not be able to sustain the kind of focus required to adopt and implement a trauma-informed philosophy and services without the ongoing support of administrators and clinical supervisors.

An organizational environment of care for the health, well-being, and safety of, as well as respect for, its staff will enhance the ability of counselors to provide the best possible trauma-informed behavioral health services to clients. This culture of care must permeate the organization from top to bottom. Behavioral health program administrators should aim to strengthen their workforce; doing so "requires creating environments that support the health and well-being, not only of persons with mental and substance use conditions, but of the workforce as well" (Hoge, 2007, p. 58). An organizational culture of care, safety, and respect demands activities that foster the development of trauma-informed counselors. This chapter focuses on key workforce development activities, such as:

- Recruiting, hiring, and retaining trauma-informed staff.
- Training behavioral health service providers on the principles of, and evidence-based and emerging best practices relevant to, TIC.
- Developing and promoting a set of counselor competencies specific to TIC.



- Delineating the responsibilities of counselors and addressing ethical considerations specifically relevant to promoting TIC.
- Providing trauma-informed clinical supervision.
- Committing to prevention and treatment of secondary trauma of behavioral health professionals within the organization.

Addressing each of these areas is essential to building a trauma-informed workforce and an organizational culture that supports TIC.

Workforce Recruitment, Hiring, and Retention

An Action Plan for Behavioral Health Workforce Development (Hoge et al., 2007) emphasizes the importance of organization-wide support and active involvement in workforce recruitment, hiring, and retention in behavioral health systems. One of the key findings of this report is that the work environment itself in many behavioral health settings can be toxic to the workforce and may hinder the delivery of individualized, respectful, collaborative, and client-centered care to service recipients. Factors such as the downward pressure on organizations for higher productivity of counselors increase caseloads and decrease wages of behavioral health staff members and may create a high-stress environment that contributes to low morale and worker dissatisfaction. Other factors that often contribute to low retention of qualified counselors in behavioral health settings include the lack of professional career

ladders, fragile job security, the lack of clinical supervision, and an inability to influence the organization in which they are working (Hoge et al., 2007).

Added to this mix is the intensity of working with people with the co-occurring conditions of trauma-related mental and substance use disorders and the risk of secondary traumatization of counselors. In creating and sustaining a trauma-informed workforce, organizations need to foster a work environment that parallels the treatment philosophy of a trauma-informed system of care. Doing so allows counselors to count on a work environment that values safety, endorses collaboration in the making of decisions at all levels, and promotes counselor well-being.

Recruitment and Hiring in a Trauma-Informed System of Care

In a 2007 technical report (Jennings, 2007b), the National Center for Trauma-Informed Care identified several priorities for organizations with regard to recruitment and hiring trauma-informed staff, including:

- Active recruitment of and outreach to prospective employees who are trauma-informed or have formal education in providing trauma-informed or trauma-specific services in settings such as universities, professional organizations, professional training and conference sites, peer support groups, and consumer advocacy groups.
- Hiring counselors and peer support staff members with educational backgrounds and training in trauma-informed and/or trauma-specific services and/or lived experience of trauma and recovery.
- Providing incentives, bonuses, and promotions for staff members during recruitment and hiring that take into consideration prospective employees' trauma-related education, training, and job responsibilities.

In addition to hiring behavioral health professionals with formal professional education and training, organizations should also "routinely survey the demographics and other characteristics of the population served and recruit a workforce of similar composition" (Hoge et al., 2007, p. 297). Essentially, this means actively engaging in outreach to consumer advocacy groups, recovery-oriented programs, community and faith-based organizations, and former clients/consumers with the intention of recruiting potential employees whose knowledge and expertise comes from their lived experience of trauma, resilience, and recovery. Support staff members, peer support workers, counselors in training, and apprentices can be recruited from this population and offered incentives, such as tuition reimbursement, training stipends, and professional mentoring with the goal of developing a trauma-informed workforce from within the demographic served. Jennings (2007b) calls these staff members "trauma champions" who can provide needed expertise in a trauma-informed organization to promote trauma-informed policies, staff development, and trauma-based services consistent with the mission of the organization (p. 135).

Who Is a Trauma Champion?

"A champion understands the impact of violence and victimization on the lives of people seeking mental health or addiction services and is a front-line worker who thinks 'trauma first.' When trying to understand a person's behavior, the champion will ask, 'is this related to abuse and violence?' A champion will also think about whether his or her own behavior is hurtful or insensitive to the needs of a trauma survivor. The champion is there to do an identified job—he is a case manager or a counselor or a residential specialist—but in addition to his or her job, a champion is there to shine the spotlight on trauma issues."

Source: Harris & Fallot, 2001a, p. 8.

As with hiring behavioral health professionals who are in recovery from substance use disorders, the organization should be transparent and explicit in its recruitment and hiring practices of trauma survivors in recovery. The organization can be transparent by advertising the mission statement of the organization as part of the recruitment process and inviting applicants who are in recovery from trauma to apply. The needs of behavioral health staff members who are in recovery from both substance use and trauma-related conditions and working in a trauma-informed system of care should be addressed in the organization's ongoing training, clinical supervision, and staff development policies and practices.

Workforce Retention

Staff turnover is rampant in behavioral health settings. It is costly to the organization, and as a result, it is costly to clients. A strong therapeutic relationship with a counselor is one of the largest factors in an individual's ability to recover from the overwhelming effects of trauma. When behavioral health professionals leave an organization prematurely or in crisis as a result of chronic levels of high stress or secondary traumatization, clients must deal with disruptions in their relationships with counselors. Some of the organizational factors that contribute to chronic levels of high stress and often lead to high staff turnover include expecting counselors to maintain high caseloads of clients who have experienced trauma; not providing trauma-informed clinical supervision and training to counselors; and failing to provide adequate vacation, health insurance, and other reasonable benefits that support counselors' well-being. Other factors that may have a more profound impact on staff retention include failing to acknowledge the reality of secondary traumatization, promoting the view that counselors' stress reactions are a personal failure instead of a normal response to engaging with clients' traumatic material, and not supporting personal psychotherapy for counselors (Saakvitne, Pearlman, & Traumatic Stress Institute/Center for Adult & Adolescent Psychotherapy, 1996).

Research on promoting counselor retention in behavioral health settings demonstrates that

Advice to Administrators: Preventing Turnover and Increasing Workforce Retention

To prevent behavioral health staff turnover and increase retention of qualified, satisfied, and highly committed trauma-informed counselors, consider:

- Offering competitive wages, benefits, and performance incentives that take into account education, training, and levels of responsibility in providing trauma-informed or trauma-specific services.
- Creating a safe working environment that includes both the physical plant and policies and procedures to prevent harassment, stalking, and/or violence in the workplace and to promote respectful interactions amongst staff at all levels of the organization.
- Establishing an organizational policy that normalizes secondary trauma as an accepted part of working in behavioral health settings and views the problem as systemic—not the result of individual pathology or a deficit on the part of the counselor.
- Instituting reasonable, manageable caseloads that mix clients with and without trauma-related concerns.
- Letting staff offer input into clinical and administrative policies that directly affect their work experience.
- Providing vacation, health insurance (which includes coverage for psychotherapy/personal counseling), and other benefits that promote the well-being of the staff.
- Implementing regular, consistent clinical supervision for all clinical staff members.
- Providing ongoing training in trauma-informed services offered by the organization.

behavioral health staff members are interested in the same kind of work environment and benefits as employees in many other fields. They include a "living wage with healthcare benefits; opportunities to grow and advance; clarity in a job role; some autonomy and input into decisions; manageable workloads; administrative support without crushing administrative burden; basic orientation and training for assigned responsibilities; a decent and safe physical work environment; a competent and cohesive team of coworkers; the support of a supervisor; and rewards for exceptional performance" (Hoge et al., 2007, p. 18).

When an organization's administration values its staff by providing competitive salaries and benefits, a safe working environment, a reasonable and manageable workload, input into the making of clinical and administrative policy decisions, and performance incentives, it helps behavioral health workers feel connected to the mission of the organization and become dedicated to its sustainability and growth. This type of work environment demonstrates both a level of respect for counselors (similar to the level of respect a trauma-informed organization displays toward clients) and an appreciation for the complexity of their job responsibilities and the stress they face when working with people who have experienced trauma in their lives. To retain behavioral health professionals working in a trauma-informed setting, wages and performance incentives should be tied not only to education, training, and work experience, but also to levels of responsibility in working with clients who have experienced trauma.

Training in TIC

Training for all staff members is essential in creating a trauma-informed organization. It may seem that training should simply focus on new counselors or on enhancing the skill level of those who have no prior experience in working with trauma, but training should, in fact, be more systematic across the organization to develop fully sustainable trauma-informed services. All employees, including administrative staff members, should receive an orientation and basic education about the prevalence of trauma and its impact on the organization's clients. To ensure safety and reduction of harm, training should cover dynamics of retraumatization and how practice can mimic original sexual and physical abuse experiences, trigger trauma responses, and cause further harm to the person. Training for all employees must also educate them "about the impacts of culture, race, ethnicity, gender, age, sexual orientation, disability, and socioeconomic status on individuals' experiences of trauma" (Jennings, 2007a, p. 5).

All clinical and direct service staff members, regardless of level of experience, should receive more indepth training in screening and assessment of substance use and trauma-related disorders; the relationships among trauma, substance use disorders, and mental disorders; how to understand difficult client behaviors through a trauma-informed lens; how to avoid retraumatizing clients in a clinical setting; the development of personal and professional boundaries unique to clinical work with traumatized clients; how to identify the signs of secondary traumatization in themselves; and how to develop a comprehensive personal and professional self-care plan to prevent and/or ameliorate the effects of secondary traumatization in the workplace. All clinical staff members who work with traumatized clients should receive additional training in evidence-based and promising practices for the treatment of trauma (for information on locating training, see Appendix B.) This might include training done within the agency by experts in the field or training received by attending advanced trauma trainings. Administrators

should provide the time and financial resources to clinical staff members for this professional development activity. Jennings (2007a) suggests that, whenever possible, "trainings should be multi-system, inclusive of staff in mental health and substance abuse, health care, educational, criminal justice, social services systems and agencies, and promoting systems integration and coordination" (p. 5).

Moreover, criminal justice settings, schools, military/veteran programs, and other places in which behavioral health services are provided may benefit from approaches that are sensitive to the special circumstances and cultures of these environments. For example, in exploring trauma-informed correctional care, Miller and Najavits (2012, p. 1) observe:

> Prisons are challenging settings for trauma-informed care. Prisons are designed to house perpetrators, not victims. Inmates arrive shackled and are crammed into overcrowded housing units; lights are on all night, loud speakers blare without warning and privacy is severely limited. Security staff is focused on maintaining order and must assume each inmate is potentially violent. The correctional environment is full of unavoidable triggers, such as pat downs and strip searches, frequent discipline from authority figures, and restricted movement….This is likely to increase trauma-related behaviors and symptoms that can be difficult for prison staff to manage….Yet, if trauma-informed principles are introduced, all staff can play a major role in minimizing triggers, stabilizing offenders, reducing critical incidents, deescalating situations, and avoiding restraint, seclusion or other measures that may repeat aspects of past abuse.

The Need for Training

Behavioral health service providers working with clients who have mental, substance use, and trauma-related disorders need to have the best knowledge, skills, and abilities. Substance abuse counselors, in particular, require additional training and skill development to be able to extend trauma-informed services (within the

Case Illustration: Larry

Larry is a 28-year-old clinical social worker who just finished his master's program in social work and is working in a trauma-informed outpatient program for people with substance use disorders. He is recovering from alcohol use disorder and previously worked in a residential rehabilitation program as a recovery support counselor. There, his primary responsibilities were to take residents to Alcoholics Anonymous (AA) meetings, monitor their participation, and confront them about their substance use issues and noncompliance with the program's requirement of attendance at 12-Step meetings.

In Larry's new position as a counselor, he confronts a client in his group regarding her discomfort with attending AA meetings. The client reports that she feels uncomfortable with the idea that she has to admit that she is powerless over alcohol to be accepted by the group of mostly men. She was sexually abused by her stepfather when she was a child and began drinking heavily and smoking pot when she was 11 years old. The client reacts angrily to Larry's intervention.

In supervision, Larry discusses his concerns regarding the client's resistance to AA and the feedback that he provided to her in group. Beyond focusing supervision on Larry's new role as a counselor in a trauma-informed program, the clinical supervisor recommends that Larry take an interactive, multisession, computer-assisted training on the 12-Step facilitation (TSF) model. The TSF model introduces clients to and assists them with engaging in 12-Step recovery support groups. The agency has the computer-based training available in the office, and Larry agrees to use follow-up coaching sessions with his supervisor to work on implementation of the approach. The supervisor recognizes that Larry is falling back on his own recovery experience and the strategies he relied on in his previous counseling role. He will benefit from further training and coaching in an evidence-based practice that provides a nonaggressive, focused, and structured way to facilitate participation in recovery support groups with clients who have trauma histories.

limits of their professional licensure and scope of practice) to clients who have co-occurring substance use, trauma-related, or mental disorders. Many clinical practice issues in traditional substance abuse treatment are inconsistent with trauma-informed practice, which needs to be addressed with further training. Similarly, mental health clinicians often need training in substance abuse treatment, as they typically do not have backgrounds or experience in that domain. Moreover, several surveys indicate that clinicians consistently perceive the combination of trauma and substance abuse as harder to treat than either one alone (Najavits, Norman, Kivlahan, & Kosten, 2010). It is thus key to emphasize cross-training as part of TIC. Exhibit 2.2-1 addresses these issues and offers suggestions for additional training.

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

- Some substance abuse counseling strategies commonly used to work through clients' denial and minimization of their substance use issues may be inappropriate when working with trauma survivors (e.g., highly confrontational models can remind trauma survivors of emotional abuse).

  Training: The Stages of Change model of addiction treatment can help counselors shift from the traditional confrontation of denial to conceptualizing clients' ambivalence about changing substance use patterns as a normal part of the precontemplation stage of change. This method is a respectful cognitive–behavioral approach that helps counselors match counseling strategies to their assessment of where each client is in each stage of change, with the ultimate goal of helping clients make changes to health risk behaviors. (Connors, Donovan, & DiClemente, 2001).

- The 12-Step concept of powerlessness (Step 1) may seem unhelpful to trauma survivors for whom the emotional reaction to powerlessness is a major part of their trauma (particularly for victims of repetitive trauma, such as child abuse or intimate partner violence). It can be confusing and counterproductive to dwell on this concept of powerlessness regarding trauma when the therapeutic objective for trauma-informed counseling methods should be to help clients empower themselves. For people in recovery, powerlessness is a paradox, sometimes misunderstood by both counselors and clients, in that the acknowledgment of powerlessness often creates a sense of empowerment. Most clients, with support and respectful guidance from a counselor, will come to understand that powerlessness (as used in 12-Step programs) is not an inability to stand up for oneself or express a need, and it does not mean for one to be powerless in the face of abuse. With this understanding, clients may become more open to participating in 12-Step groups as a resource for their recovery from substance use disorders. When clients continue to struggle with this concept and decline to participate in 12-Step recovery efforts, they may benefit from referral to other forms of mutual-help programs or recovery support groups in which the concept of powerlessness over the substance of abuse is not such a significant issue.

  Training: The TSF model can help counselors develop a more supportive and understanding approach to facilitating clients' involvement in 12-Step recovery groups (if this is a client-generated recovery goal). "Although based on standard counseling models, TSF differs from them in several ways. These differences include TSF's strong emphasis on therapist support, discouragement of aggressive 'confrontation of denial' and therapist self-disclosure, and highly focused and structured format" (Sholomskas & Carroll, 2006, p. 939).

  Another well-intentioned, but often misguided, approach by counselors who have not had formal or extensive training is "digging" for trauma memories without a clear therapeutic rationale or understanding of client readiness. In doing so, the counselor may unintentionally retraumatize the client or produce other harmful effects. In early intervention, it is sufficient simply to acknowledge and validate the pain and suffering of the client without uncovering or exploring specific trauma memories. The counselor who is insufficiently trained in trauma-informed clinical

(Continued on the next page.)

Exhibit 2.2-1: Clinical Practice Issues Relevant to Counselor Training in Trauma-Informed Treatment Settings (continued)

practice may also press agendas that are ultimately unhelpful, such as insisting that the client forgive an abuser, pursue a legal case against a perpetrator, or engage in trauma treatment, even when the client may not be ready for such steps. These efforts are particularly inappropriate for clients in early recovery from substance use disorders. The first goal in treatment is stabilization

Training: The Seeking Safety model of treating substance abuse and posttraumatic stress disorder (PTSD) can help counselors focus on the primary goal of stabilization and safety in TIC. This model emphasizes safety as the target goal, humanistic themes such as honesty and compassion, and making cognitive–behavioral therapy accessible and interesting to clients who may otherwise be difficult to engage (Najavits, 2002a).

- Treatment should be client-centered; it should acknowledge the client's right to refuse counseling for trauma-related issues. It is important to discuss the advantages and disadvantages of exploring trauma-related concerns, and then, following an open discussion, to allow clients the right to choose their path. This discussion should be part of the informed consent process at the start of treatment. Clients also have the right to change their minds.

  Training: Motivational interviewing, a client-centered, nonpathologizing counseling method, can aid clients in resolving ambivalence about and committing to changing health risk behaviors including substance use, eating disorders, self-injury, avoidant and aggressive behaviors associated with PTSD, suicidality, and medication compliance (Arkowitz, Miller, Westra, & Rollnick, 2008; Kress & Hoffman, 2008). Training in MI can help counselors remain focused on the client's agenda for change, discuss the pros and cons of treatment options, and emphasize the personal choice and autonomy of clients.

In addition to the training needs of substance abuse counselors, all direct care workers in mental health settings, community-based programs, crisis intervention settings, and criminal justice environments should receive training in TIC. Guidelines for training in assisting trauma-exposed populations are presented in Exhibit 2.2-2.

Continuing Education

Research on the effectiveness of single-session didactic and/or skill-building workshops

Exhibit 2.2-2: Guidelines for Training in Mental Health Interventions for Trauma-Exposed Populations

After a year of collaboration in 2002, the Task Force on International Trauma Training of the International Society for Traumatic Stress Studies published a consensus-based set of recommendations for training. Core curricular elements of the recommended training include:

- Competence in listening.
- Recognition of psychosocial and mental problems to promote appropriate assessment.
- Familiarity with established interventions in the client population.
- Full understanding of the local context, including help-seeking expectations, duration of treatment, attitudes toward intervention, cost-effectiveness of intervention, and family attitudes and involvement.
- Strategies for solving problems on the individual, family, and community levels.
- Treatment approaches for medically unexplained somatic pain.
- Collaboration with existing local resources and change agents (e.g., clergy, traditional healers, informal leaders).
- Self-care components.

Source: Weine et al., 2002.

Advice to Administrators: Trauma-Informed Staff Training

- Establish training standards for the evidence-based and promising trauma-informed practice models (such as Seeking Safety) adopted by your organization.
- Bring expert trainers with well-developed curricula in TIC and trauma-specific practices into your organization.
- Select a core group of clinical supervisors and senior counselors to attend multisession training or certification programs. These clinicians can then train the rest of the staff.
- Use sequenced, longitudinal training experiences instead of single-session seminars or workshops.
- Emphasize interactive and experiential learning activities over purely didactic training.
- Provide ongoing mentoring/coaching to behavioral health professionals in addition to regular clinical supervision to enhance compliance with the principles and practices of TIC and to foster counselor mastery of trauma-specific practice models.
- Build organization-wide support for the ongoing integration of new attitudes and counselor skills to sustain constructive, TIC-consistent changes in practice patterns.
- Provide adequate and ongoing training for clinical supervisors in the theory and practice of clinical supervision and the principles and practices of TIC.
- Include information and interactive exercises on how counselors can identify, prevent, and ameliorate secondary traumatic stress (STS) reactions in staff trainings.
- Offer cross-training opportunities to enhance knowledge of trauma-informed processes throughout the system.

demonstrates that immediate gains in counselor knowledge and skills diminish quickly after the training event (Martino, Canning-Ball, Carroll, & Rounsaville, 2011). Consequently, organizations may be spending their scarce financial resources on sending counselors to this kind of training but may not be reaping adequate returns with regard to long-lasting changes in counselor skills and the development of trauma-informed and trauma-specific counselor competencies. Hoge et al. (2007) suggest the implementation of training strategies for behavioral health professionals that have proven to be effective in improving counselor skills, attitudes, and practice approaches. These strategies include: "interactive approaches; sequenced, longitudinal learning experiences; outreach visits, known as academic detailing; auditing of practice with feedback to the learner; reminders; the use of opinion leaders to influence practice; and patient-mediated interventions, such as providing information on treatment options to persons in recovery, which in turn influences the practice patterns of their providers" (p. 124).

Trauma-Informed Counselor Competencies

Hoge et al. (2007) identified a number of counselor competencies in behavioral health practices that are consistent with the skills needed to be effective in a trauma-informed system of care. They include person-centered planning, culturally competent care, development of therapeutic alliances, shared responsibility for decisions, collaboratively developed recovery plans, evidence-based practices, recovery- and resilience-oriented care, interdisciplinary- and team-based practice, and consumer/client advocacy. In addition, counselor competencies critical to the effective delivery of services to clients with trauma-related disorders include:

- Screening for and assessment of trauma history and trauma-related disorders, such as mood and anxiety disorders.
- Awareness of differences between trauma-informed and trauma-specific services.

- Understanding the bidirectional relationships among substance use and mental disorders and trauma.
- Engagement in person-centered counseling.
- Competence in delivering trauma-informed and trauma-specific evidence-based interventions that lessen the symptoms associated with trauma and improve quality of life for clients.
- Awareness of and commitment to counselor self-care practices that prevent or lessen the impact of secondary traumatization on behavioral health workers.

Exhibit 2.2-3 provides a checklist of competencies for counselors working in trauma-informed behavioral health settings. Administrators and clinical supervisors can use this checklist to assess behavioral health professionals' understanding of trauma awareness and counseling skills and determine the need for additional training and clinical supervision.

Counselor Responsibilities and Ethics

Treating all clients in an ethical manner is an expectation of all healthcare providers. It is of special importance when working with clients who have trauma-related disorders, as their trust in others may have been severely shaken. Counselors who work with traumatized individuals on a regular basis have special responsibilities to their clients because of the nature of this work. Administrators and clinical supervisors in trauma-informed organizations should develop policies that clearly define the counselors' job and should provide education about the role of counselors in the organization and their responsibilities to clients.

General Principles Regarding Counselor Responsibilities

The following are some general principles governing the responsibilities of counselors who provide behavioral health services for clients with histories of trauma:

- Counselors are responsible for routinely screening clients for traumatic experiences and trauma-related symptoms (Ouimette & Brown, 2003; see also Treatment Improvement Protocol [TIP] 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders*, Center for Substance Abuse Treatment [CSAT], 2005c).
- Counselors should offer clients with substance use and trauma-related disorders continuing mental health services if it is within their professional license and scope of practice to do so.
- Counselors are responsible for referring clients with substance use disorders and co-occurring trauma-related disorders to treatment that addresses both disorders when the treatment falls outside of the counselor's professional license and scope of practice (Ouimette & Brown, 2003).
- Counselors should refer clients with substance use disorders and co-occurring trauma-related disorders to concurrent participation in mutual-help groups if appropriate (Ouimette & Brown, 2003).
- Counselors have a responsibility to practice the principles of confidentiality in all interactions with clients and to respect clients' wishes not to give up their right to privileged communication.
- Counselors are responsible for educating clients about the limits of confidentiality and what happens to protected health information, along with the client's privilege, when the client signs a release of information or agrees to assign insurance benefits to the provider.
- Counselors must inform clients that treatment for trauma-related disorders is always voluntary.
- Counselors are responsible for being aware of their own secondary trauma and

Exhibit 2.2-3: Trauma-Informed Counselor Competencies Checklist

Trauma Awareness

___ Understands the difference between trauma-informed and trauma-specific services

___ Understands the differences among various kinds of abuse and trauma, including: physical, emotional, and sexual abuse; domestic violence; experiences of war for both combat veterans and survivors of war; natural disasters; and community violence

___ Understands the different effects that various kinds of trauma have on human development and the development of psychological and substance use issues

___ Understands how protective factors, such as strong emotional connections to safe and nonjudgmental people and individual resilience, can prevent and ameliorate the negative impact trauma has on both human development and the development of psychological and substance use issues

___ Understands the importance of ensuring the physical and emotional safety of clients

___ Understands the importance of not engaging in behaviors, such as confrontation of substance use or other seemingly unhealthy client behaviors, that might activate trauma symptoms or acute stress reactions

___ Demonstrates knowledge of how trauma affects diverse people throughout their lifespans and with different mental health problems, cognitive and physical disabilities, and substance use issues

___ Demonstrates knowledge of the impact of trauma on diverse cultures with regard to the meanings various cultures attach to trauma and the attitudes they have regarding behavioral health treatment

___ Demonstrates knowledge of the variety of ways clients express stress reactions both behaviorally (e.g., avoidance, aggression, passivity) and psychologically/emotionally (e.g., hyperarousal, avoidance, intrusive memories)

Counseling Skills

___ Expedites client-directed choice and demonstrates a willingness to work within a mutually empowering (as opposed to a hierarchical) power structure in the therapeutic relationship

___ Maintains clarity of roles and boundaries in the therapeutic relationship

___ Demonstrates competence in screening and assessment of trauma history (within the bounds of his or her licensing and scope of practice), including knowledge of and practice with specific screening tools

___ Shows competence in screening and assessment of substance use disorders (within the bounds of his or her licensing and scope of practice), including knowledge of and practice with specific screening tools

___ Demonstrates an ability to identify clients' strengths, coping resources, and resilience

___ Facilitates collaborative treatment and recovery planning with an emphasis on personal choice and a focus on clients' goals and knowledge of what has previously worked for them

___ Respects clients' ways of managing stress reactions while supporting and facilitating taking risks to acquire different coping skills that are consistent with clients' values and preferred identity and way of being in the world

___ Demonstrates knowledge and skill in general trauma-informed counseling strategies, including, but not limited to, grounding techniques that manage dissociative experiences, cognitive–behavioral tools that focus on both anxiety reduction and distress tolerance, and stress management and relaxation tools that reduce hyperarousal

(Continued on the next page.)

Exhibit 2.2-3: Trauma-Informed Counselor Competencies Checklist (continued)

___ Identifies signs of STS reactions and takes steps to engage in appropriate self-care activities that lessen the impact of these reactions on clinical work with clients

___ Recognizes when the needs of clients are beyond his or her scope of practice and/or when clients' trauma material activates persistent secondary trauma or countertransference reactions that cannot be resolved in clinical supervision; makes appropriate referrals to other behavioral health professionals

Source: Abrahams et al., 2010.

countertransference reactions and seeking appropriate help in responding to these reactions so that they do not interfere with the best possible treatment for clients.

TIC organizations have responsibilities to clients in their care, including:

- Protecting client confidentiality, particularly in relation to clients' trauma histories. Organizations should comply with the State and Federal laws that protect the confidentiality of clients being treated for mental and substance use disorders.
- Providing clients with an easy-to-read statement of their rights as consumers of mental health and substance abuse services, including the right to confidentiality (Exhibit 2.2-4).
- Providing quality clinical supervision to all counselors and direct-service workers, with an emphasis on TIC. Organizations should, at minimum, comply with State licensing requirements for the provision of clinical supervision to behavioral health workers.
- Establishing and maintaining appropriate guidelines and boundaries for client and counselor behavior in the program setting.
- Creating and maintaining a trauma-informed treatment environment that respects the clients' right to self-determination and need to be treated with dignity and respect.
- Maintaining a work environment that reinforces and supports counselor self-care.

All behavioral health professionals are responsible for abiding by professional standards of care that protect the client. Breaches of confidentiality, inappropriate conduct, and other violations of trust can do further harm to clients who already have histories of trauma. Many treatment facilities have a Client Bill of Rights (or a similar document) that describes the rights and responsibilities of both the counselors and the participants; it often is part of the orientation and informed consent process when a client enters treatment. However, simply reading and acknowledging the receipt of a piece of paper is not a substitute for the dialog that needs to happen in a collaborative therapeutic partnership. Administrators are responsible for providing clients with easy-to-read information describing counselor responsibilities and client rights. Clinical supervisors are responsible for helping counselors engage in a respectful dialog with clients about those rights and responsibilities as part of a comprehensive informed consent process.

Exhibit 2.2-4 is an excerpt from a Client Bill of Rights that outlines clients' right to confidentiality in plain language that is readable and easily understood.

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

Tri-County Mental Health Services is a trauma-informed mental health and substance abuse treatment agency in Maine. Below is a statement regarding clients' right to confidentiality and staff responsibility to protect that privilege; this statement is provided in a brochure outlining consumer rights that is easily accessible to service recipients at the agency and online.

Confidentiality

We will not give out information about you to anyone without your knowledge and permission. This includes written information from your record and verbal information from your providers. Additionally, we will not request any information about you without your knowledge and permission. A Release of Information Form allows you to say what information can be shared and with whom. You determine the length of time this is valid, up to one year.

Tri-County policies prevent any employee of the agency who does not have a direct need to know from having access to any information about you. The penalty for violation can include immediate dismissal.

Exceptions to this rule of confidentiality include times when a client is at immediate risk of harm to self or others, or when ordered by the court. We will make every effort to notify you in these instances.

Source: Tri-County Mental Health Services, 2008, pp. 6-7.

Ethics in Treating Traumatized Clients

All behavioral health professionals must conform to the ethical guidelines established by their profession's State licensing boards and/or certifying organizations. State licensing boards for substance abuse counseling, psychiatry, social work, psychology, professional counseling, and other behavioral health professions provide regulatory standards for ethical practice in these professions. These boards also have specific procedures for responding to complaints regarding the actions of professional caregivers. Additionally, national professional societies have standards for ethical practices. Members of these organizations are expected to practice within the boundaries and scope of these standards. Some of these standards are quite explicit, whereas others are more general; most approach professional ethics not as a rigid set of rules, but rather, as a process of making ethical decisions.

Clinical supervisors are responsible for informing counselors of their ethical responsibilities with regard to their own organization's policies and procedures, monitoring supervisees' reading and understanding the codes of ethics of professional organizations and State licensing boards, and promoting counselor understanding of ethics and how to make decisions ethically as a regular part of clinical supervision, team meetings, and counselor training. Administrators can support high ethical standards by creating an organization-wide ethics task group consisting of counselors, supervisors, and administrators who meet regularly to review and revise clinical policies in line with State and Federal law and professional codes of ethics. Administrators may also act as a support mechanism for counselors who need additional consultation regarding potential ethical dilemmas with clients. The Green Cross Academy of Traumatology provides ethical guidelines for the treatment of clients who have experienced trauma; these guidelines are adapted in Exhibit 2.2-5.

Exhibit 2.2-5: Green Cross Academy of Traumatology Ethical Guidelines for the Treatment of Clients Who Have Been Traumatized

Respect for the dignity of clients

- Recognize and value the personal, social, spiritual, and cultural diversity present in society, without judgment. As a primary ethical commitment, make every effort to provide interventions with respect for the dignity of those served.

Responsible caring

- Take the utmost care to ensure that interventions do no harm.
- Have a commitment to the care of those served until the need for care ends or the responsibility for care is accepted by another qualified service provider.
- Support colleagues in their work and respond promptly to their requests for help.
- Recognize that service to survivors of trauma can exact a toll in stress on providers. Maintain vigilance for signs in self and colleagues of such stress effects, and accept that dedication to the service of others imposes an obligation to sufficient self-care to prevent impaired functioning.
- Engage in continuing education in the appropriate areas of trauma response. Remain current in the field and ensure that interventions meet current standards of care.

Integrity in relationships

- Clearly and accurately represent your training, competence, and credentials. Limit your practice to methods and problems for which you are appropriately trained and qualified. Readily refer to or consult with colleagues who have appropriate expertise; support requests for such referrals or consultations from clients.
- Maintain a commitment to confidentiality, ensuring that the rights of confidentiality and privacy are maintained for all clients.
- Do not provide professional services to people with whom you already have either emotional ties or extraneous relationships of responsibility. The one exception is in the event of an emergency in which no other qualified person is available.
- Refrain from entering other relationships with present or former clients, especially sexual relationships or relationships that normally entail accountability.
- Within agencies, ensure that confidentiality is consistent with organizational policies; explicitly inform individuals of the legal limits of confidentiality.

Responsibility to society

- Be committed to responding to the needs generated by traumatic events, not only at the individual level, but also at the level of community and community organizations in ways that are consistent with your qualifications, training, and competence.
- Recognize that professions exist by virtue of societal charters in expectation of their functioning as socially valuable resources. Seek to educate government agencies and consumer groups about your expertise, services, and standards; support efforts by these agencies and groups to ensure social benefit and consumer protection.
- If you become aware of activities of colleagues that may indicate ethical violations or impairment of functioning, seek first to resolve the matter through direct expression of concern and offers of help to those colleagues. Failing a satisfactory resolution in this manner, bring the matter to the attention of the officers of professional societies and of governments with jurisdiction over professional misconduct.

Clients' universal rights

All clients have the right to:

- Not be judged for any behaviors they used to cope, either at the time of the trauma or after the trauma.
- Be treated at all times with respect, dignity, and concern for their well-being.
- Refuse treatment, unless failure to receive treatment places them at risk of harm to self or others.

(Continued on the next page.)

Exhibit 2.2-5: Academy of Traumatology Ethical Guidelines for the Treatment of Clients Who Have Been Traumatized (continued)

- Be regarded as collaborators in their own treatment plans.
- Provide their informed consent before receiving any treatment.
- Not be discriminated against based on race, culture, sex, religion, sexual orientation, socioeconomic status, disability, or age.
- Have promises kept, particularly regarding issues related to the treatment contract, role of counselor, and program rules and expectations.

Procedures for introducing clients to treatment

Obtain informed consent, providing clients with information on what they can expect while receiving professional services. In addition to general information provided to all new clients, clients presenting for treatment who have histories of trauma should also receive information on:

- The possible short-term and long-term effects of trauma treatment on the client and the client's relationships with others.
- The amount of distress typically experienced with any particular trauma treatment.
- Possible negative effects of a particular trauma treatment.
- The possibility of lapses and relapses when doing trauma work, and the fact that these are a normal and expected part of healing.

Reaching counseling goals through consensus

Collaborate with clients in the design of a clearly defined contract that articulates a specific goal in a specific time period or a contract that allows for a more open-ended process with periodic evaluations of progress and goals.

Informing clients about the healing process

- Clearly explain to clients the nature of the healing process, making sure clients understand.
- Encourage clients to ask questions about any and all aspects of treatment and the therapeutic relationship. Provide clients with answers in a manner they can understand.
- Encourage clients to inform you if the material discussed becomes overwhelming or intolerable.
- Inform clients of the necessity of contacting you or emergency services if they feel suicidal or homicidal, are at risk of self-injury, or have a sense of being out of touch with reality.
- Give clients written contact information about available crisis or emergency services.
- Inform clients about what constitutes growth and recovery and about the fact that some trauma symptoms may not be fully treatable.
- Address unrealistic expectations clients may have about counseling and/or the recovery process.

Level of functioning

- Inform clients that they may not be able to function at the highest level of their ability—or even at their usual level—when working with traumatic material.
- Prepare clients to experience trauma-related symptoms, such as intrusive memories, dissociative reactions, reexperiencing, avoidance behaviors, hypervigilance, or unusual emotional reactivity.

Source: Green Cross Academy of Traumatology, 2007. Adapted with permission.

Boundaries in therapeutic relationships

Maintaining appropriate therapeutic boundaries is a primary ethical concern for behavioral health professionals. Counselors working with clients who have substance use, trauma-related, and other mental disorders may feel challenged at times to maintain boundaries that create a safe therapeutic container. Some clients, especially those with longstanding disorders, bring a history of client–counselor relationships to counseling. Clients who have been traumatized may need help understanding the roles and responsibilities of both the counselor and the client. Clients with trauma-related conditions may also have special needs

Advice to Clinical Supervisors: Recognizing Boundary Confusion

Clinical supervisors should be aware of the following counselor behaviors that can indicate boundary confusion with clients:

- The counselor feels reluctant or embarrassed to discuss specific interactions with a client or details of the client's treatment in supervision or team meetings.
- The counselor feels possessive of the client, advocates with unusual and excessive vehemence for the client, or expresses an unreasonable sense of overresponsibility for the client.
- The counselor becomes defensive and closed to hearing ideas from the supervisor or the treatment team members about approaches to working with a client and/or exploring his or her own emotional reactions to a client.
- The clinician begins or increases personal self-disclosure to the client and is not able to identify legitimate clinical reasons for the self-disclosure.

in establishing appropriate boundaries in the counseling setting; they may be particularly vulnerable and not understand or appreciate the need for professional boundaries, including not engaging in dual relationships. For example, some clients might experience a counselor's boundary around not giving the client his or her personal phone number for emergency calls as a rejection or abandonment. Cultural considerations also influence therapeutic boundaries.

Administrators, in collaboration with clinical supervisors, are responsible for creating policies regarding counselor and client boundaries for various issues (e.g., giving and receiving gifts, counselor personal disclosure, and counselor roles and responsibilities when attending the same 12-Step meetings as clients); policies should be specific to their organization and conform to State and Federal law and behavioral health professional codes of ethics. Clinical supervisors are responsible for training counselors in the informed consent process and effective ways to discuss boundaries with clients when they enter treatment.

Guidelines for establishing and maintaining boundaries in therapeutic relationships, adapted from the Green Cross Academy of Traumatology, are given in Exhibit 2.2-6.

Clients with trauma histories may be especially vulnerable to counselor behaviors that are inconsistent or that are experienced by the client as boundary violations. Examples of such behavior include: being late for appointments, ending counseling sessions early, repeatedly and excessively extending the session time, canceling or "forgetting" appointments multiple times, spending time in the session talking about their own needs and life experiences, exploring opportunities for contact outside the therapeutic relationship (including making arrangements to meet at AA or other 12-Step recovery group meetings), and enforcing rules differently for one client than for another.

Due to the complex dynamics that can arise in the treatment of clients with trauma histories, regularly scheduled clinical supervision, where issues of ethics and boundaries can be discussed, is recommended for counselors. For more information on how clinical supervision can be effectively used, see TIP 52, *Clinical Supervision and the Professional Development of the Substance Abuse Counselor* (CSAT, 2009b).

Boundary crossing and boundary violation

Although guidelines and codes of ethics are useful tools in helping clinical supervisors and counselors understand the boundaries between counselors and clients, they are open to interpretation and are context-bound. Given these limitations, it is crucial to educate counselors

Exhibit 2.2-6: Boundaries in Therapeutic Relationships

Procedures for Establishing Safety

Roles and boundaries
Counselor roles and boundaries should be established at the start of the counseling relationship and reinforced periodically, particularly at times when the client is experiencing high stress.

Ongoing Relationships and the Issue of Boundaries

Dual relationships
Dual relationships and inappropriate interactions with clients are to be avoided. It is important to tell clients at the beginning of counseling that contact between the counselor and the client can only occur within the boundaries of the professional relationship. This information is part of the informed consent process. Relationships outside these boundaries include sexual or romantic relationships, a counselor also serving as a client's sponsor in 12-Step programs, and any kind of relationship in which the counselor exploits the client for financial gain.

Sexual contact
- Never engage in any form of sexual contact with clients.
- Do not reward sexualized behaviors with attention or reactivity.
- Directly clarify the boundaries of the therapeutic relationship, and address the underlying motivations of persisting sexualized behavior.
- Set limits on a client's inappropriate behaviors while maintaining an ethos of care. Maintain respect for the dignity and worth of the client at all times.
- Understand that a client's attempt to sexualize a therapeutic relationship may reflect an early history of abuse, difficulty understanding social norms, or a variety of psychological problems.
- Readdress the absolute inappropriateness of sexual and/or romantic behavior in a nonlecturing, nonpunitive manner.
- If sexual behavior between clients occurs in a treatment program, counselors should consult with a clinical supervisor. Document the nature of the contact and how the issue is addressed.
- If a counselor has sexual contact with a client, he or she should take responsibility by ceasing counseling practice, referring clients to other treatment providers, and notifying legal and professional authorities. If a counselor is at risk for engaging with a client sexually but has not acted on it, the counselor should immediately consult with a supervisor, colleague, or psychotherapist.

Boundaries
Counselors should use care with self-disclosure or any behaviors that may be experienced as intrusive by the client, including:
- Personal disclosures made for the counselor's own gratification.
- Sexualized behavior with the client.
- Excessively intrusive questions or statements.
- Interrupting the client frequently.
- Violating the client's personal space.
- Interpersonal touch, which might activate intrusive memories or dissociative reactions or be experienced as a boundary violation by the client.
- Being consistently late for appointments or allowing outside influences (such as telephone calls) to interrupt the client's time in a counseling session.

Source: Green Cross Academy of Traumatology, 2007. Adapted with permission.

in TIC settings regarding the boundary issues that may arise for clients who have been traumatized and to give counselors a conceptual framework for understanding the contextual nature of boundaries. For example, it would be useful for clinical supervisors to discuss with

counselors the distinction between boundary crossings and boundary violations in clinical practice. Gutheil and Brodsky (2008) define boundary crossing as a departure from the customary norms of counseling practice in relation to psychological, physical, or social space "that are harmless, are nonexploitative, and may even support or advance the therapy" (p. 20). Examples of boundary crossings include taking phone calls from a client between sessions if the client is in crisis or telling a client a story about the counselor's recovery from trauma (without offering specific personal information or graphic/detailed description of the trauma) with the intention of offering hope that it is possible to recover.

Gutheil and Brodsky (2008) define boundary violations as boundary crossings that are unwanted and dangerous and which exploit the client, stating that "some boundary crossings are inadvisable because of their intent (i.e., they are not done in the service of the patient's well-being and growth, involve extra therapeutic gratification for the therapist) and/or their effect (i.e., they are not likely to benefit the patient and entail a significant risk of harming the patient)" (pp. 20–21). An example of a boundary violation would be when a counselor invites a client to attend the same AA meetings the counselor attends or shares drinking and drugging "war stories" for the counselor's own gratification. Two key elements in understanding when a boundary crossing becomes a boundary violation are the intent of the counselor and the damaging effect on the client. Maintaining a standard of practice of nonexploitation of the client is the primary focus for clinical supervisors and counselors in determining when boundary crossings become boundary violations.

Context is also an important consideration in determining the acceptability of boundary crossings. For example, it may be acceptable for a counselor in a partial hospitalization program for serious mental illness to have a cup of coffee at the kitchen table with a resident, whereas for a counselor in an outpatient mental health program, having a cup of coffee with a client at the local coffee shop would be a much more questionable boundary crossing.

Case Illustration: Denise

Denise is a 40-year-old licensed professional counselor working in an inpatient eating disorder program. She has had extensive training in trauma and eating disorder counseling approaches and has been working as a clinician in mental health settings for 15 years. Denise is usually open to suggestions from her supervisor and other treatment team members about specific strategies to use with clients who have trauma histories and eating disorders. However, in the past week, her supervisor has noticed that she has become defensive in team meetings and individual supervision when discussing a recently admitted young adult who was beaten and raped by her boyfriend; subsequently, the client was diagnosed with PTSD and anorexia. When the clinical supervisor makes note of the change in Denise's attitude and behavior in team meetings since this young woman was admitted, initially Denise becomes defensive, saying that the team just doesn't understand this young woman and that the client has repeatedly told Denise, "You're the only counselor I trust."

The clinical supervisor recognizes that Denise may be experiencing secondary traumatization and boundary confusion due to working with this young woman and to the recent increase in the number of clients with co-occurring trauma-related disorders on her caseload. After further exploration, Denise reveals that her own daughter was raped at the same age as the young woman and that hearing her story has activated an STS reaction in Denise. Her way of coping has been to become overly responsible for and overprotective of the young woman. With the nonjudgmental support of her supervisor, Denise is able to gain perspective, recognize that this young woman is not her daughter, and reestablish boundaries with her that are appropriate to the inpatient treatment setting.

Clinical Supervision and Consultation

Organizational change toward a TIC model doesn't happen in isolation. Ongoing support, supervision, and consultation are key ingredients that reinforce behavioral health professionals' training in trauma-informed and trauma-specific counseling methods and ensure compliance with practice standards and consistency over time. Often, considerable energy and resources are spent on the transition to new clinical and programmatic approaches, but without long-range planning to support those changes over time. The new treatment approach fades quickly, making it hard to recognize and lessening its reliability.

Advice to Clinical Supervisors and Administrators: Adopting an Evidence-Based Model of Clinical Supervision and Training

Just as adopting evidence-based clinical practices in a trauma-informed organization is important in providing cost-effective and outcome-relevant services to clients, adopting an evidence-based model of clinical supervision and training clinical supervisors in that model can enhance the quality and effectiveness of clinical supervision for counselors. This will ultimately enhance client care.

One of the most commonly used and researched integrative models of supervision is the discrimination model, originally published by Janine Bernard in 1979 and since updated (Bernard & Goodyear, 2009). This model is considered a competence-based and social role model of supervision; it includes three areas of focus on counselor competencies (intervention, conceptualization, and personalization) and three possible supervisor roles (teacher, counselor, and consultant).

Counselor competencies:

- Intervention: The supervisor focuses on the supervisee's intervention skills and counseling strategies used with a particular client in a given session.
- Conceptualization: The supervisor focuses on how the supervisee understands what is happening in a session with the client.
- Personalization: The supervisor focuses on the personal style of the counselor and countertransference responses (i.e., personal reactions) of the counselor to the client.

Supervisor roles:

- Teacher: The supervisor teaches the supervisee specific counseling theory and skills and guides the supervisee in the use of specific counseling strategies in sessions with clients. The supervisor as teacher is generally task-oriented. The supervisor is more likely to act as a teacher with beginning counselors.
- Counselor: The supervisor does not act as the counselor's therapist, but helps the counselor reflect on his or her counseling style and personal reactions to specific clients. The supervisor as counselor is interpersonally sensitive and focuses on the process and relational aspects of counseling.
- Consultant: The supervisor is more of a guide, offering the supervisee advice on specific clinical situations. The supervisor as consultant invites the counselor to identify topics and set the agenda for the supervision. The supervisor is more likely to act as a consultant with more advanced counselors.

This model of supervision may be particularly useful in working with counselors in TIC settings, because the supervisor's response to the supervisee is flexible and specific to the supervisee's needs. In essence, it is a counselor-centered model of supervision in which the supervisor can meet the most relevant needs of the supervisee in any given moment.

For a review of other theories and methods of clinical supervision, refer to TIP 52, *Clinical Supervision and Professional Development of the Substance Abuse Counselor* (CSAT, 2009b).

Ongoing supervision and consultation supports the organizational message that TIC is the standard of practice. It normalizes secondary traumatization as a systemic issue (not the individual pathology of the counselor) and reinforces the need for counselor self-care to prevent and lessen the impact of secondary traumatization. Quality clinical supervision for direct care staff demonstrates the organization's commitment to implementing a fully integrated, trauma-informed system of care.

Supervision and Consultation

Historically, there was an administrative belief that counselors who had extensive clinical experience and training would naturally be the best clinical supervisors. However, research does not support this idea (Falender & Shafranske, 2004). Although a competent clinical supervisor needs to have an extensive clinical background in the treatment of substance use, trauma-related, and other mental disorders, it is also essential for any counselor moving into a supervisory role to have extensive training in the theory and practice of clinical supervision before taking on this role. In particular, clinical supervisors in trauma-informed behavioral health settings should be educated in how to perform clinical supervision (not just administrative supervision) of direct service staff and in the importance of providing continuous clinical supervision and support for staff members working with individuals affected by trauma. Clinical

Case Illustration: Arlene

Arlene is a 50-year-old licensed substance abuse counselor who has a personal history of trauma, and she is actively engaged in her own recovery from trauma. She is an experienced counselor who has several years of training in trauma-informed and trauma-specific counseling practices. Her clinical supervisor, acting in the role of consultant, begins the supervision session by inviting her to set the agenda. Arlene brings up a clinical situation in which she feels stuck with a client who is acting out in her Seeking Safety group (for more information on Seeking Safety, see Najavits, 2002a).

Arlene reports that her client gets up suddenly and storms out of the group room two or three times during the session. The supervisor, acting in the role of the counselor and focusing on personalization, asks Arlene to reflect on the client's behavior and what feelings are activated in her in response to the client's anger. Arlene is able to identify her own experience of hyperarousal and then paralysis as a stress reaction related to her prior experience of domestic violence in her first marriage. The supervisor, acting in the role of teacher and focusing on conceptualization, reminds Arlene that her client is experiencing a "fight-or-flight" response to some experience in the group that reminds her of her own trauma experience. The supervisor then suggests to Arlene that her own reactions are normal responses to her previous history of trauma, and that when her client is angry, Arlene is not reexperiencing her own trauma but is being activated by the client's traumatic stress reaction to being in group. In this way, the supervisor highlights the parallel process of the client–counselor's stress reactions to a perceived threat based on prior trauma experiences.

The supervisor, acting again as a consultant and focusing on personalization this time, invites Arlene to reflect on the internal and external resources she might be able to bring to this situation that will help remind her to ground herself so she can lessen the impact of her stress reactions on her counseling strategy with this client. Arlene states that she can create a list of safe people in her life and place this list in her pocket before group. She can use this list as a touchstone to remind her that she is safe and has learned many recovery skills that can help her stay grounded, maintain her boundaries, and deal with her client's behavior. The clinical supervisor, acting as a consultant and now focusing on intervention, asks Arlene if she has some specific ideas about how she can address the client's behavior in group. Arlene and the clinical supervisor spend the remainder of the session discussing different options for addressing the client's behavior and helping her feel safer in group.

supervision in a TIC organization should focus on the following priorities:

- General case consultation
- Specialized consultation in specific and unusual cases
- Opportunities to process clients' traumatic material
- Boundaries in the therapeutic and supervisory relationship
- Assessment of secondary traumatization
- Counselor self-care and stress management
- Personal growth and professional development of the counselor

Supervision of counselors working with traumatized clients should be regularly scheduled, with identified goals and with a supervisor who is trained and experienced in working with trauma survivors. The styles and types of supervision and consultation may vary according to the kind of trauma work and its context. For instance, trauma counseling in a major natural disaster would require a different approach to supervision and consultation than would counseling adults who experienced childhood developmental trauma or counseling clients in an intensive early recovery treatment program using a manualized trauma-specific counseling protocol.

Competence-based clinical supervision is recommended for trauma-informed organizations. Competence-based clinical supervision models identify the knowledge and clinical skills each counselor needs to master, and they use targeted learning strategies and evaluation procedures, such as direct observation of counselor sessions with clients, individualized coaching, and performance-based feedback. Studies on competence-based supervision approaches have demonstrated that these models improve counselor treatment skills and proficiency (Martino et al., 2011).

Whichever model of clinical supervision an organization adopts, the key to successful trauma-informed clinical supervision is the recognition that interactions between the supervisor and the counselor may parallel those between the counselor and the client. Clinical supervisors need to recognize counselors' trauma reactions (whether they are primary or secondary to the work with survivors of trauma) and understand that a confrontational or punitive approach will be ineffective and likely retraumatize counselors.

Clinical supervisors should adopt a respectful and collaborative working relationship with counselors in which role expectations are clearly defined in an informed consent process similar to that used in the beginning of the counselor–client relationship and in which exploring the nature of boundaries in both client–counselor and counselor–supervisor relationships is standard practice. Clear role boundaries, performance expectations, open dialog, and supervisor transparency can go a long way toward creating a safe and respectful relationship container for the supervisor and supervisee and set the stage for a mutually enhancing, collaborative relationship. This respectful, collaborative supervisory relationship is the main source of training and professional growth for the counselor and for the provision of quality care to people with behavioral health disorders.

Secondary Traumatization

The demands of caregiving exact a price from behavioral health professionals that cannot be ignored; otherwise, they may become ineffective in their jobs or, worse, emotionally or psychologically impaired. In a study of Master's level licensed social workers, 15.2 percent of respondents to a survey reported STS as a result of indirect exposure to trauma material at a level that meets the diagnostic criteria for PTSD. This rate is almost twice the rate of PTSD in the general population. The author

STS is a trauma related stress reaction and set of symptoms resulting from exposure to another individual's traumatic experiences rather than from exposure directly to a traumatic event.

concluded that behavioral health professionals' experience of STS is a contributing factor in staff turnover and one reason why many behavioral health service professionals leave the field (Bride, 2007). Secondary traumatization of behavioral health workers is a significant organizational issue for clinical supervisors and administrators in substance abuse and mental health treatment programs to address.

To prevent or lessen the impact of secondary traumatization on behavioral health professionals, clinical supervisors and administrators need to understand secondary trauma from the ecological perspective described in Part 1, Chapter 1 of this TIP. The organization itself creates a social context with risk factors that can increase the likelihood of counselors experiencing STS reactions, but it also contains protective factors that can lessen the risk and impact of STS reactions on staff members. Organizations can lessen the impact of the risk factors associated with working in trauma-informed organizations by mixing caseloads to contain clients both with and without trauma-related issues, supporting ongoing counselor training, providing regular clinical supervision, recognizing counselors' efforts, and offering an empowering work environment in which counselors share in the responsibility of making decisions and can offer input into clinical and program policies that affect their work lives.

When organizations support their counselors in their work with clients who are traumatized, counselors can be more effective, more productive, and feel greater personal and professional satisfaction. In addition, counselors develop a sense of allegiance toward the organization, thus decreasing staff turnover. If organizations do not provide this support, counselors can become demoralized and have fewer emotional and psychological resources to manage the impact of clients' traumatic material and outward behavioral expressions of trauma on their own well-being. Providing counselors with the resources to help them build resilience and prevent feeling overwhelmed should be a high priority for administrators and clinical supervisors in TIC organizations.

Risk and Protective Factors Associated With Secondary Traumatization

Clinical and research literature on trauma describes a number of factors related to the development of secondary trauma reactions and psychological distress in behavioral health professionals across a wide range of practice settings, as well as individual and organizational factors that can prevent or lessen the impact of STS on staff. The risk and protective factors model of understanding secondary trauma is based on the ecological perspective

Advice to Clinical Supervisors: Recognizing Secondary Traumatization

Some counselor behaviors that demonstrate inconsistency to clients may be outward manifestations of secondary traumatization, and they should be discussed with counselors through a trauma-informed lens. It is imperative that clinical supervisors provide a nonjudgmental, safe context in which counselors can discuss these behaviors without fear of reprisal or reprimand. Clinical supervisors should work collaboratively with supervisees to help them understand their behavior and engage in self-care activities that lessen the stress that may be contributing to these behaviors.

outlined in Part 1, Chapter 1 of this TIP. The terms "compassion fatigue," "vicarious traumatization," "secondary traumatization," and "burnout" are used in the literature, sometimes interchangeably and sometimes as distinct constructs. As stated in the terminology portion of the "How This TIP Is Organized" section that precedes Part 1, Chapter 1, of this TIP, the term "secondary traumatization" refers to traumatic stress reactions and psychological distress from exposure to another individual's traumatic experiences; this term will be used throughout this section, although the studies cited may use other terms.

Risk factors

Individual risk factors that may contribute to the development of STS in behavioral health professionals include preexisting anxiety or mood disorders; a prior history of personal trauma; high caseloads of clients with trauma-related disorders; being younger in age and new to the field with little clinical experience or training in treating trauma-related conditions; unhealthy coping styles, including distancing and detachment from clients and co-workers; and a lack of tolerance for strong emotions (Newall & MacNeil, 2010). Other negative coping strategies include substance abuse, other addictive behaviors, a lack of recreational activities not related to work, and a lack of engagement with social support. A recent study of trauma nurses found that low use of support systems, use of substances, and a lack of hobbies were among the coping strategies that differed between nurses with and without STS (Von Rueden et al., 2010). Other researchers found that clinicians who engaged in negative coping strategies, such as alcohol and illicit drug use, were more likely to experience intrusive trauma symptoms (Way, Van Deusen, Martin, Applegate, & Janle, 2004).

Numerous organizational factors can contribute to the development of STS in counselors who work with clients with trauma-related disorders. These risk factors include organizational constraints, such as lack of resources for clients, lack of clinical supervision for counselors, lack of support from colleagues, and lack of acknowledgment by the organizational culture that secondary traumatization exists and is a normal reaction of counselors to client trauma (Newall & MacNeil, 2010). In a study of 259 individuals providing mental health counseling services, counselors who spent more time in session with clients with trauma-related disorders reported higher levels of traumatic stress symptoms (Bober & Regehr, 2006). Counselors may be more at risk for developing secondary traumatization if the organization does not allow for balancing the distribution of trauma and nontrauma cases amongst staff members.

Protective factors

Much of the clinical and research literature focuses on individual factors that may lessen the impact of STS on behavioral health professionals, including male gender, being older, having more years of professional experience,

Advice to Clinical Supervisors: Recognizing STS in Counselors Who Are In Recovery

For counselors who are in recovery from a substance use or mental disorder, the development of STS may be a potential relapse concern. As Burke, Carruth, and Prichard (2006) point out, "a return to drinking or illicit drug use as a strategy for dealing with secondary trauma reactions would have a profoundly detrimental effect on the recovering counselor" (p. 292). So too, secondary trauma may ignite the reappearance of depressive or anxiety symptoms associated with a previous mental disorder. Clinical supervisors can address these risk factors with counselors and support them in engaging with their own recovery support network (which might include a peer support group or an individual counselor) to develop a relapse prevention plan.

having specialized training in trauma-informed and trauma-specific counseling practices, lacking a personal trauma history, exhibiting personal autonomy in the workplace, using positive personal coping styles, and possessing resilience or the ability to find meaning in stressful life events and to rebound from adversity (Sprang, Clark, & Whitt-Woosley, 2007). Some of these factors, like positive personal coping styles and the ability to find meaning in adversity, can be developed and enhanced through personal growth work, psychotherapy, engagement with spiritual practices and involvement in the spiritual community, and stress reduction strategies like mindfulness meditation. A recent multimethod study of an 8-week workplace mindfulness training group for social workers and other social service workers found that mindfulness meditation increased coping strategies, reduced stress, and enhanced self-care of the participants; findings suggested that workers were more likely to practice stress management techniques like mindfulness at their place of work than at home (McGarrigle & Walsh, 2011). Organizations can support counselors' individual efforts to enhance positive personal coping styles, find meaning in adversity, and reduce stress by providing time for workers during the workday for personal self-care activities, like mindfulness meditation and other stress reduction practices.

One of the organizational protective factors identified in the literature that may lessen the negative impact of secondary traumatization on behavioral health professionals is providing adequate training in trauma-specific counseling strategies, which increases providers' sense of efficacy in helping clients with trauma-related disorders and reduces the sense of hopelessness that is often a part of the work (Bober & Regehr 2006). One study found that specialized trauma training enhanced job satisfaction and reduced levels of compassion fatigue, suggesting that "knowledge and training might provide some protection against the deleterious effects of trauma exposure" (Sprang et al., 2007, p. 272). Another protective factor that may lessen the chances of developing secondary traumatization is having a diverse caseload of clients. Organizations "must determine ways of distributing workload in order to limit the traumatic exposure of any one worker. This may not only serve to reduce the impact of immediate symptoms but may also address the potential longitudinal effects" (Bober & Regehr, 2006, p. 8).

Emotional support from professional colleagues can be a protective factor. A study of substance abuse counselors working with clients who were HIV positive found that workplace support from colleagues and supervisors most effectively prevented burnout (Shoptaw, Stein, & Rawson, 2000). This support was associated with less emotional fatigue and depersonalization, along with a sense of greater personal accomplishment. In a study of domestic violence advocates, workers who received more support from professional peers were less likely to experience secondary traumatization (Slattery & Goodman, 2009).

In addition, counselor engagement in relationally based clinical supervision with a trauma-informed supervisor acts as a protective agent. Slattery and Goodman (2009) note that "for the trauma worker, good supervision can normalize the feelings and experiences, provide support and information about the nature and course of the traumatic reaction, help in the identification of transference and countertransference issues, and reveal feelings or symptoms associated with the trauma" (p. 1362). Workers who reported "engaging, authentic, and empowering relationships with their supervisors" were less likely to experience STS (p. 1369). Thus, it is not simply the frequency and regularity of clinical supervision,

but also the quality of the supervision and the quality of the supervisor–counselor relationship that can lessen the impact of STS on behavioral health professionals.

Engagement with a personal practice of spirituality that provides a sense of connection to a larger perspective and meaning in life is another protective factor that can lessen the impact of STS on counselors (Trippany, Kress, & Wilcoxon, 2004). Although recovering counselors may look to support groups for connection to a spiritual community, other behavioral health professionals might find support for enhancing spiritual meaning and connection in church, a meditation group, creative endeavors, or even volunteer work. The key is for counselors to develop their own unique resources and practices to enhance a sense of meaningful spirituality in their lives. Clinical supervisors should be aware of spiritual engagement as a protective factor in preventing and lessening the impact of STS and should support clinicians in including it in their self-care plans, but they should take care not to promote or reject any particular religious belief system or spiritual practice.

Another protective factor that may lessen the impact of workers' STS is a culture of empowerment in the organization that offers counselors a sense of autonomy, a greater ability to participate in making decisions about clinical and organizational policies, and obtaining support and resources that further their professional development. Slattery & Goodman (2009) surveyed 148 domestic violence advocates working in a range of settings. The authors found that those workers "who reported a high level of shared power were less likely to report posttraumatic stress symptoms, despite their own personal abuse history or degree of exposure to trauma" (p. 1370). To the degree that organizations can provide a cultural context within which behavioral health professionals have autonomy and feel empowered, they will be able to lessen the impact of STS on their professional and personal lives. Self-efficacy and empowerment are antidotes to the experience of powerlessness that often accompanies trauma.

Strategies for Preventing Secondary Traumatization

The key to prevention of secondary traumatization for behavioral health professionals in a trauma-informed organization is to reduce risk and enhance protective factors. Organizational strategies to prevent secondary traumatization include:

- Normalize STS throughout all levels of the organization as a way to help counselors feel safe and respected, enhancing the likelihood that they will talk openly about their experiences in team meetings, peer supervision, and clinical supervision.
- Implement clinical workload policies and practices that maintain reasonable standards for direct-care hours and emphasize balancing trauma-related and nontrauma-related counselor caseloads.
- Increase the availability of opportunities for supportive professional relationships by promoting activities such as team meetings, peer supervision groups, staff retreats, and counselor training that focuses on understanding secondary traumatization and self-care. Administrators and clinical supervisors should provide time at work for counselors to engage in these activities.
- Provide regular trauma-informed clinical supervision that is relationally based. Supervisors should be experienced and trained in trauma-informed and trauma-specific practices and provide a competence-based model of clinical supervision that promotes counselors' professional and personal development. Supervision limited to case consultation or case management is insufficient to

reduce the risk for secondary traumatization and promote counselor resilience.

- Provide opportunities for behavioral health professionals to enhance their sense of autonomy and feel empowered within the organization. Some of these activities include soliciting input from counselors on clinical and administrative policies that affect their work lives, including how to best balance caseloads of clients with and without histories of trauma; inviting representatives of the counseling staff to attend selected agency board of directors and/or management team meetings to offer input on workforce development; and inviting counselors to participate in organizational task forces that develop trauma-informed services, plan staff retreats, or create mechanisms to discuss self-care in team meetings. Administrators and clinical supervisors should assess the organization's unique culture and develop avenues for counselor participation in activities that will enhance their sense of empowerment and efficacy within the organization.

Exhibit 2.2-7 highlights some specific strategies that individual counselors can engage in to prevent secondary traumatization.

Assessment of Secondary Traumatization

Counselors with unacknowledged STS can harm clients, self, and family and friends by becoming unable to focus on and attend to their needs or those of others. They may feel helpless or cynical and withdraw from support systems. Exhibit 2.2-8 describes some emotional, cognitive, and behavioral signs that may indicate that a counselor is experiencing secondary traumatization. Clinical supervisors should be familiar with the manifestations of STS in their counselors and should address signs of STS immediately.

Stamm (2009–2012) has developed and revised a self-assessment tool, the Professional Quality of Life Scale (ProQOL), that measures indicators of counselor compassion fatigue and compassion satisfaction. Compassion fatigue "is best defined as a syndrome consisting of a combination of the symptoms

Exhibit 2.2-7: Counselor Strategies To Prevent Secondary Traumatization

Strategies that counselors can use (with the support and encouragement of supervisors and administrators) to prevent secondary traumatization include:

- ***Peer support***: Maintaining adequate social support, both personally and professionally, helps prevent isolation and helps counselors share the emotional distress of working with traumatized individuals.
- ***Supervision and consultation***: Professional consultation will help counselors understand secondary traumatization, their own personal risks, the protective factors that can help them prevent or lessen its impact, and their countertransference reactions to specific clients.
- ***Training***: Ongoing professional training can improve counselors' understanding of trauma and enhance a sense of mastery and self-efficacy in their work.
- ***Personal psychotherapy or counseling***: Being in counseling can help counselors become more self-aware and assist them in managing the psychological and emotional distress that often accompanies working with clients who have trauma histories in a number of behavioral health settings.
- ***Maintaining balance in one's life***: Balancing work and personal life, developing positive coping styles, and maintaining a healthy lifestyle can enhance resilience and the ability to manage stress.
- ***Engaging in spiritual activities that provide meaning and perspective***: Connection to a spiritual community and spiritual practices (such as meditation) can help counselors gain a larger perspective on trauma and enhance resilience.

Exhibit 2.2-8: Secondary Traumatization Signs

The following are some indicators that counselors may be experiencing secondary traumatization.

Psychological distress

- Distressing emotions: grief, depression, anxiety, dread, fear, rage, shame
- Intrusive imagery of client's traumatic material: nightmares, flooding, flashbacks of client disclosures
- Numbing or avoidance: avoidance of working with client's traumatic material
- Somatic issues: sleep disturbances, headaches, gastrointestinal distress, heart palpitations, chronic physiological arousal
- Addictive/compulsive behaviors: substance abuse, compulsive eating, compulsive working
- Impaired functioning: missed or canceled appointments, decreased use of supervision, decreased ability to engage in self-care, isolation and alienation

Cognitive shifts

- Chronic suspicion about others
- Heightened sense of vulnerability
- Extreme sense of helplessness or exaggerated sense of control over others or situations
- Loss of personal control or freedom
- Bitterness or cynicism
- Blaming the victim or seeing everyone as a victim
- Witness or clinician guilt if client reexperiences trauma or reenacts trauma in counseling
- Feeling victimized by client

Relational disturbances

- Decreased intimacy and trust in personal/professional relationships
- Distancing or detachment from client, which may include labeling clients, pathologizing them, judging them, canceling appointments, or avoiding exploring traumatic material
- Overidentification with the client, which may include a sense of being paralyzed by one's own responses to the client's traumatic material or becoming overly responsible for the client's life

Frame of reference

- Disconnection from one's sense of identity
- Dramatic change in fundamental beliefs about the world
- Loss or distortion of values or principles
- A previous sense of spirituality as comfort or resource decreases or becomes nonexistent
- Loss of faith in something greater
- Existential despair and loneliness

Sources: Figley, 1995; Newall & MacNeil, 2010; Saakvitne et al., 1996.

of secondary traumatic stress and professional burnout" (Newall & MacNeil, 2010, p. 61). Although secondary traumatization as a reaction to exposure to clients' trauma material is similar to PTSD, burnout is a more general type of psychological distress related to the pressures of working in high-stress environments over time. Burnout may be a result of secondary traumatization and/or a contributing factor in the development of secondary traumatization. The ProQOL includes STS and burnout scales that have been validated in research studies (Adams, Figley, & Boscarino, 2008; Newall & MacNeil, 2010).

This tool can be used in individual and group clinical supervision, trainings on self-care, and team meetings as a way for counselors to check in with themselves on their levels of stress and potential signs of secondary traumatization.

Case Illustration: Gui

Gui is a 48-year-old licensed substance abuse counselor who has worked in a methadone maintenance clinic for 12 years. He originally decided to get his degree and become a counselor because he wanted to help people and make a difference in the world. Over the past 6 months, he has felt fatigued a great deal, gets annoyed easily with both clients and coworkers, and has developed a cynical attitude about the world and the people who come to the clinic for help. During this time, the clinic has been forced to lay off a number of counselors due to funding cutbacks. As a result, Gui and the remaining counselors have had a 20 percent increase in the number of weekly client contact hours required as part of their job duties. In addition, the level and severity of clients' trauma-related and other co-occurring disorders, poverty, joblessness, and homelessness has increased.

Gui is a valued employee, and when Gui discusses his thoughts that he might want to leave the clinic with his clinical supervisor, the supervisor listens to Gui's concerns and explores the possibility of having him fill out the ProQOL to get a pulse on his stress level. Gui agrees and is willing to discuss the results with his supervisor. He is not surprised to see that he scores above average on the burnout scale of the instrument but is very surprised to see that he scores below average on the secondary traumatic stress scale and above average on the compassion satisfaction scale. He begins to feel more hopeful that he still finds satisfaction in his job and sees that he is resilient in many ways that he did not acknowledge before.

Gui and the clinical supervisor discuss ways that the supervisor and the organization can lessen the impact of the stress of the work environment on Gui and support the development of a self-care plan that emphasizes his own ability to rebound from adversity and take charge of his self-care.

The compassion satisfaction scale allows counselors to reflect on their resilience and reminds them of why they choose to work with people with substance use and trauma-related disorders, despite the fact that this work can lead to secondary traumatization. The compassion satisfaction subscale reminds counselors that they are compassionate, that one of the reasons they are in a helping profession is that they value service to others, and that helping brings meaning and fulfillment to their lives. Exhibits 2.2-9 through 2.2-11 present the most recent version of the ProQOL.

Addressing Secondary Traumatization

If a counselor is experiencing STS, the organization should address it immediately. Clinical supervisors can collaborate with counselors to devise an individualized plan that is accessible, acceptable, and appropriate for each counselor and that addresses the secondary stress reactions the counselor is experiencing, providing specific self-care strategies to counteract the stress. Decisions about strategies for addressing secondary traumatization should be based on the personal preferences of the counselor, the opportunity for an immediate intervention following a critical incident, and the counselor's level of awareness regarding his or her experience of STS. Counselors may need to talk about what they are experiencing, feeling, and thinking. These experiences can be processed in teams, in consultations with colleagues, and in debriefing meetings to integrate them effectively (Myers & Wee, 2002).

If a critical incident evokes secondary traumatization among staff—such as a client suicide, a violent assault in the treatment program, or another serious event—crisis intervention should be available for workers who would like to participate. Any intervention should be voluntary and tailored to each worker's individual needs (e.g., peer, group, or individual sessions); if possible, these services should be offered continuously instead of just one time.

Exhibit 2.2-9: PRoQOL Scale

COMPASSION SATISFACTION AND COMPASSION FATIGUE (PRoQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *past 30 days*.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

___ 1. I am happy.
___ 2. I am preoccupied with more than one person I *[help]*.
___ 3. I get satisfaction from being able to *[help]* people.
___ 4. I feel connected to others.
___ 5. I jump or am startled by unexpected sounds.
___ 6. I feel invigorated after working with those I *[help]*.
___ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
___ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
___ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
___ 10. I feel trapped by my job as a *[helper]*.
___ 11. Because of my *[helping]*, I have felt "on edge" about various things.
___ 12. I like my work as a *[helper]*.
___ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
___ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
___ 15. I have beliefs that sustain me.
___ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
___ 17. I am the person I always wanted to be.
___ 18. My work makes me feel satisfied.
___ 19. I feel worn out because of my work as a *[helper]*.
___ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
___ 21. I feel overwhelmed because my case [work] load seems endless.
___ 22. I believe I can make a difference through my work.
___ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
___ 24. I am proud of what I can do to *[help]*.
___ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
___ 26. I feel "bogged down" by the system.
___ 27. I have thoughts that I am a "success" as a *[helper]*.
___ 28. I can't recall important parts of my work with trauma victims.
___ 29. I am a very caring person.
___ 30. I am happy that I chose to do this work.

Source: Stamm, 2012. Used with permission.

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

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental healthcare professional.

Compassion Satisfaction _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout_____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress_____

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a healthcare professional.

Source: Stamm, 2012. Used with permission.

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

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section,** total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

*You Wrote	Change to
1	5
2	4
3	3
4	2
5	1

3. ____
6. ____
12. ____
16. ____
18. ____
20. ____
22. ____
24. ____
27. ____
30. ____
Total : ____

The sum of my Compassion Satisfaction questions is	So my score equals	And my Compassion Satisfaction level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are *not* happy so you reverse the score.

*1. ____ = ____
*4. ____ = ____
8. ____
10. ____
*15. ____ = ____
*17. ____ = ____
19. ____
21. ____
26. ____
*29. ____ = ____
Total : ____

The sum of my Burnout questions is	So my score equals	And my Burnout level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Secondary Traumatic Stress Scale

Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add the[m] up. When you have added them up you can find your score on the table to the right.

2. ____
5. ____
7. ____
9. ____
11. ____
13. ____
14. ____
23. ____
25. ____
28. ____
Total : ____

The sum of my Secondary Trauma questions is	So my score equals	And my Secondary Traumatic Stress level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Source: *Stamm, 2012. Used with permission.*

The objective of debriefing a critical incident that evokes STS reactions in counselors is to help them dissipate the hyperarousal associated with traumatic stress and prevent long-term aftereffects that might eventually lead to counselor impairment. Because clinical supervisors may also be experiencing secondary traumatization, it is advisable for administrators to invite an outside trauma consultant into the organization to provide a safe space for all staff members (including clinical supervisors) to address and process the critical stress incident. For noncrisis situations, secondary traumatization should be addressed in clinical supervision. Clinical supervisors and counselors should work collaboratively to incorporate regular screening and self-assessment of STS into supervision sessions.

Advice to Clinical Supervisors: Advantages and Disadvantages of Using Psychometric Measures

Using a psychometric measure such as the ProQOL has advantages and disadvantages. It is important to understand that all tests measure averages and ranges but do not account for individual circumstances.

If you use the ProQOL in clinical supervision, present it as a self-assessment tool. Let counselors opt out of sharing their specific results with you and/or your team if it is administered in a group. If counselors choose to share scores on specific items or scales with you, work collaboratively and respectfully with them to explore their own understanding of and meanings attached to their scores. If this tool is not presented to supervisees in a nonjudgmental, mindful way, counselors may feel as if they have failed if their scores on the secondary traumatization scale are above average or if their scores on the compassion satisfaction scale are below average. High scores on the compassion fatigue and burnout scales do not mean that counselors don't care about their clients or that they aren't competent clinicians. The scores are simply one way for you and your supervisees to get a sense of whether they might be at risk for secondary traumatization, what they can do to prevent it, how to address it, and how you can support them.

The potential benefits of using a self-assessment tool like the ProQOL in clinical supervision are that it can help counselors:

- Reflect on their emotional reactions and behaviors and identify possible triggers for secondary traumatization.
- Assess their risk levels.
- Examine alternative coping strategies that may prevent secondary traumatization.
- Understand their own perceptions of themselves and their job satisfaction, affirming what they already know about their risk of secondary traumatization and their compassion satisfaction.
- Reflect on different factors that might contribute to unexpected low or high scores, such as the day of the week, the intensity of the workload, whether they have just come back from the weekend or a vacation, and so forth.
- Increase self-awareness and self-knowledge, because scores on specific items or scales bring to consciousness what is often outside of awareness.
- Realize how resilient they are emotionally, mentally, physically, and spiritually.
- Become aware of and open up conversations about self-care and self-care activities and resources, such as supportive coworkers, team members, and social networks outside of work.

If used regularly, self-assessment tools can help counselors and clinical supervisors monitor STS levels, indicate significant positive and negative changes, and suggest action toward self-care in specific areas. Clinical supervisors should fill out the ProQOL and review results with their own supervisors, a peer supervisor, or a colleague before administering it to supervisees. Doing so enables supervisors to gauge their own reactions to the self-assessment and anticipate potential reactions from supervisees.

Advice to Clinical Supervisors: Is it Supervision or Psychotherapy?

Although there are some aspects of clinical supervision that can be therapeutic and parallel the therapeutic and emotional support that occurs between the counselor and the client, clinical supervision is not therapy. As a result, it is important for clinical supervisors to maintain appropriate boundaries with supervisees when addressing their STS reactions at work.

When does the process in supervision cross over into the realm of practicing therapy with a supervisee? One clear indicator is if the supervisor begins to explore the personal history of the counselor and reflects directly on that history instead of bringing it back to how the counselor's history influences his or her work with a particular client or with clients with trauma histories in general. Clinical supervisors should focus only on counselor issues that may be directly affecting their clinical functioning with clients. If personal issues arise in clinical supervision, counselors should be encouraged to address them in their own counseling or psychotherapy.

Exhibit 2.2-12: Clinical Supervisor Guidelines for Addressing Secondary Traumatization

1. Engage counselors in regular screening/self-assessment of counselors' experience of STS.
2. Address signs of STS with counselors in clinical supervision.
3. Work collaboratively with counselors to develop a comprehensive self-care plan and evaluate its effectiveness on a regular basis.
4. Provide counselors a safe and nonjudgmental environment within which to process STS in individual and group supervision or team meetings.
5. Provide counselors with a safe and nonjudgmental place within which to debrief critical stress incidents at work; bring in an outside consultant if needed.
6. Support and encourage counselors to engage in individual counseling or psychotherapy, when needed, to explore personal issues that may be contributing to secondary traumatization at work.

When STS issues arise, the clinical supervisor should work with counselors to review and revise their self-care plans to determine what strategies are working and whether additional support, like individual psychotherapy or counseling, may be warranted.

Exhibit 2.2-12 outlines some guidelines for clinical supervisors in addressing secondary trauma in behavioral health professionals working with clients who have substance use, mental, and trauma-related disorders.

Counselor Self-Care

In light of the intensity of therapeutic work with clients with co-occurring substance use, mental, and trauma-related disorders and the vulnerability of counselors to secondary traumatization, a comprehensive, individualized self-care plan is highly recommended. Balance is the key to the development of a self-care plan—a balance between home and work, a balance between focusing on self and others, and a balance between rest and activity (Saakvitne, Perlman, & Traumatic Stress Institute/ Center for Adult & Adolescent Psychotherapy 1996). Counselor self-care is also about balancing vulnerability, which allows counselors to be present and available when clients address intensely painful content, with reasonable efforts to preserve their sense of integrity in situations that may threaten the counselors' faith or worldview (Burke et al., 2006). A comprehensive self-care plan should include activities that nourish the physical, psychological/mental, emotional/relational, and spiritual aspects of counselors' lives.

The literature on counselor self-care advocates for individual, team, and organizational strategies that support behavioral health professionals working with clients who have

Case Illustration: Carla

Carla is a 38-year-old case manager working in an integrated mental health and substance abuse agency. She provides in-home case management services to home-bound clients with chronic health and/or severe mental health and substance abuse problems. Many of her clients have PTSD and chronic, debilitating pain.

Both her parents had alcohol use disorders, and as a result, Carla became the caretaker in her family. She loves her job; however, she often works 50 to 60 hours per week and has difficulty leaving her work at work. She often dreams about her clients and wakes up early, feeling anxious. She sometimes has traumatic nightmares, even though she was never physically or sexually abused, and she has never experienced the trauma of violence or a natural disaster. She drinks five cups of coffee and three to four diet sodas every day and grabs burgers and sweets for snacks while she drives from one client to the next. She has gained 20 pounds in the past year and has few friends outside of her coworkers. She has not taken a vacation in more than 2 years. She belongs to the Catholic church down the street, but she has stopped going because she says she is too busy and exhausted by the time Sunday rolls around.

The agency brings in a trainer who meets with the case management department and guides the staff through a self-assessment of their current self-care practices and the development of a comprehensive self-care plan. During the training, Carla acknowledges that she has let her work take over the rest of her life and needs to make some changes to bring her back into balance. She writes out her self-care plan, which includes cutting back on the caffeine, calling a friend she knows from church to go to a movie, going to Mass on Sunday, dusting off her treadmill, and planning a short vacation to the beach. She also decides that she will discuss her plan with her supervisor and begin to ask around for a counselor for herself to talk about her anxiety and her nightmares. In the next supervision session, Carla's supervisor reviews her self-care plan with her and helps Carla evaluate the effectiveness of her self-care strategies. Her supervisor also begins to make plans for how to cover Carla's cases when she takes her vacation.

substance use and trauma-related disorders. Counselors are responsible for developing comprehensive self-care plans and committing to their plans, but clinical supervisors and administrators are responsible for promoting counselor self-care, supporting implementation of counselor self-care plans, and modeling self-care. Counselor self-care is an ethical imperative; just as the entire trauma-informed organization must commit to other ethical issues with regard to the delivery of services to clients with substance use, mental, and trauma-related disorders, it must also commit to the self-care of staff members who are at risk for secondary traumatization as an ethical concern. Saakvitne and colleagues (1996) suggest that when administrators support counselor-self-care, it is not only cost-effective in that it reduces the negative effects of secondary traumatization on counselors (and their clients), but also promotes "hope-sustaining behaviors" in counselors, making them more motivated and open to learning, and thereby improving job performance and client care.

A Comprehensive Self-Care Plan

A self-care plan should include a self-assessment of current coping skills and strategies and the development of a holistic, comprehensive self-care plan that addresses the following four domains:

1. Physical self-care
2. Psychological self-care (includes cognitive/mental aspects)
3. Emotional self-care (includes relational aspects)
4. Spiritual self-care

Activities that may help behavioral health workers find balance and cope with the stress

Advice to Clinical Supervisors: Spirituality

The word "spiritual" in this context is used broadly to denote finding a sense of meaning and purpose in life and/or a connection to something greater than the self. Spiritual meanings and faith experiences are highly individual and can be found within and outside of specific religious contexts.

Engaging in spiritual practices, creative endeavors, and group/community activities can foster a sense of meaning and connection that can counteract the harmful effects of loss of meaning, loss of faith in life, and cognitive shifts in worldview that can be part of secondary traumatization. Counselors whose clients have trauma-related disorders experience fewer disturbances in cognitive schemas regarding worldview and less hopelessness when they engage in spiritually oriented activities, such as meditation, mindfulness practices, being in nature, journaling, volunteer work, attending church, and finding a spiritual community (Burke et al., 2006). Clinical supervisors can encourage counselors to explore their own spirituality and spiritual resources by staying open and attuned to the multidimensional nature of spiritual meaning of supervisees and refraining from imposing any particular set of religious or spiritual beliefs on them. A strong sense of spiritual connection can enhance counselors' resilience and ability to cope with the sometimes overwhelming effects of clients' trauma material and trauma-related behavior (including suicidality) on counselors' faith in life and sense of meaning and purpose.

Modeling Self-Care

"Implementing interventions was not always easy, and one of the more difficult coping strategies to apply had to do with staff working long hours. Many of the staff working at the support center also had full-time jobs working for the Army. In addition, many staff chose to volunteer at the Family Assistance Center and worked 16- to 18-hour days. When we spoke with them about the importance of their own self-care, many barriers emerged: guilt over not working, worries about others being disappointed in them, fear of failure with respect to being unable to provide what the families might need, and a 'strong need to be there.' Talking with people about taking a break or time off proved problematic in that many of them insisted that time off was not needed, despite signs of fatigue, difficulty concentrating, and decreased productivity. Additionally, time off was not modeled. Management, not wanting to fail the families, continued to work long hours, despite our requests to do otherwise. Generally, individuals could see and understand the reasoning behind such endeavors. Actually making the commitment to do so, however, appeared to be an entirely different matter. In fact, our own team, although we kept reasonable hours (8 to 10 per day), did not take a day off in 27 days. Requiring time off as part of membership of a Disaster Response Team might be one way to solve this problem."

—Member of a Disaster Response Team at the Pentagon after September 11

Source: Walser, 2004, pp. 4–5.

of working with clients with trauma-related disorders include talking with colleagues about difficult clinical situations, attending workshops, participating in social activities with family and friends, exercising, limiting client sessions, balancing caseloads to include clients with and without trauma histories, making sure to take vacations, taking breaks during the workday, listening to music, walking in nature, and seeking emotional support in both their personal and professional lives (Saakvitne et al., 1996). In addition, regular clinical supervision and personal psychotherapy or counseling can be positive coping strategies for lessening the impact of STS on counselors. Still, each counselor is unique, and a self-care approach that is helpful to one counselor may not be helpful to another. Exhibits 2.2-13 and 2.2-14 offer tools for self-reflection to help counselors discover which specific self-care activities might best suit them. The worksheet can be used privately by counselors or by clinical supervisors as an exercise in individual supervision, group supervision, team meetings, or trainings on counselor self-care.

Exhibit 2.2-13: Comprehensive Self-Care Plan Worksheet

Name: Date:	Personal	Professional/Workspace
Physical		
Psychological/Mental		
Emotional/Relational		
Spiritual		

Source: Burke, 2006. Used with permission.

Review the questions in Exhibit 2.2-14, and then write down specific self-care strategies in the form (given in Exhibit 2.2-13) that you're confident you will practice in both personal and professional realms.

The *Comprehensive Self-Care Worksheet* is a tool to help counselors (and clinical supervisors) develop awareness of their current coping strategies and where in the four domains they need to increase their engagement in self-care activities. Once completed, clinical supervisors should periodically review the plan with their supervisees for effectiveness in preventing and/or ameliorating secondary traumatization and then make adjustments as needed.

Essential Components of Self-Care

Saakvitne and colleagues (1996) describe three essential components, the "ABCs," of self-care that effectively address the negative impact of secondary traumatization on counselors:

1. **Awareness** of one's needs, limits, feelings, and internal/external resources. Awareness involves mindful/nonjudgmental attention to one's physical, psychological, emotional, and spiritual needs. Such attention requires quiet time and space that supports self-reflection.
2. **Balance** of activities at work, between work and play, between activity and rest, and between focusing on self and focusing on others. Balance provides stability and helps counselors be more grounded when stress levels are high.
3. **Connection** to oneself, to others, and to something greater than the self. Connection decreases isolation, increases hope, diffuses stress, and helps counselors share the burden of responsibility for client care. It provides an anchor that enhances counselors' ability to witness tremendous suffering without getting caught up in it.

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

Use the following questions to help you engage in a self-reflective process and develop your comprehensive self-care plan. Be specific and include strategies that are accessible, acceptable, and appropriate to your unique circumstances. Remember to evaluate and revise your plan regularly.

Physical
What are non-chemical things that help my body relax?
What supports my body to be healthy?

Psychological/Mental
What helps my mind relax?
What helps me see a bigger perspective?
What helps me break down big tasks into smaller steps?
What helps me counteract negative self-talk?
What helps me challenge negative beliefs?
What helps me build my theoretical understanding of trauma and addictions?
What helps me enhance my counseling/helping skills in working with traumatized clients?
What helps me become more self-reflective?

Emotional/Relational
What helps me feel grounded and able to tolerate strong feelings?
What helps me express my feelings in a healthy way?
Who helps me cope in positive ways and how do they help?
What helps me feel connected to others?
Who are at least three people I feel safe talking with about my reactions/feelings about clients?
How can I connect with those people on a regular basis?

Spiritual
What helps me find meaning in life?
What helps me feel hopeful?
What sustains me during difficult times?
What connects me to something greater?

Source: Burke, 2006. Used with permission.

Clinical supervisors can help counselors review their self-care plans through the ABCs by reflecting on these questions:

1. Has the counselor accurately identified his or her needs, limits, feelings, and internal and external resources in the four domains (physical, psychological/mental, emotional/relational, spiritual)?
2. Has the counselor described self-care activities that provide a balance between work and leisure, activity and rest, and a focus on self and others?
3. Has the counselor identified self-care activities that enhance connection to self, others, and something greater than self (or a larger perspective on life)?

Supervisors should make their own self-care plans and review them periodically with their clinical supervisors, a peer supervisor, or a colleague.

Commitment to Self-Care

One of the major obstacles to self-care is giving in to the endless demands of others, both at work and at home. It is therefore essential for counselors with the support of clinical supervisors to become "guardians of [their] boundaries and limits" (Saakvitne et al., 1996, p 136). Creating a daily schedule that includes breaks for rest, exercise, connection with coworkers, and other self-care activities can support counselors in recognizing that they are valuable individuals who are worthy of taking the time to nourish and nurture themselves, thus increasing commitment to self-care. Another way to support counselors in committing to self-care is for supervisors and administrators to model self-care in their own professional and personal lives.

Understanding that counselor self-care is not simply a luxury or a selfish activity, but rather, an ethical imperative (Exhibit 2.2-15) can foster counselors' sense of connection to their own values and accountability to the people they serve as competent and compassionate caregivers. Clinical supervisors and administrators can reinforce this sense of accountability while supporting counselors by providing a caring, trauma-informed work environment

Exhibit 2.2-15: The Ethics of Self-Care

The Green Cross Academy of Traumatology was originally established to serve a need in Oklahoma City following the April 19, 1995, bombing of the Alfred P. Murrah Federal Building. Below are adapted examples of the Academy's code of ethics with regard to worker self-care.

Ethical Principles of Self-Care in Practice
These principles declare that it is unethical not to attend to your self-care as a practitioner, because sufficient self-care prevents harming those we serve.

Standards of self-care guidelines:
- Respect for the dignity and worth of self: A violation lowers your integrity and trust.
- Responsibility of self-care: Ultimately it is your responsibility to take care of yourself—and no situation or person can justify neglecting this duty.
- Self-care and duty to perform: There must be a recognition that the duty to perform as a helper cannot be fulfilled if there is not, at the same time, a duty to self-care.

Standards of humane practice of self-care:
- Universal right to wellness: Every helper, regardless of her or his role or employer, has a right to wellness associated with self-care.
- Physical rest and nourishment: Every helper deserves restful sleep and physical separation from work that sustains them in their work role.
- Emotional rest and nourishment: Every helper deserves emotional and spiritual renewal both in and outside the work context.
- Sustenance modulation: Every helper must utilize self-restraint with regard to what and how much they consume (e.g., food, drink, drugs, stimulation) since improper consumption can compromise their competence as a helper.

Commitment to self-care:
- Make a formal, tangible commitment: Written, public, specific, measurable promises of self-care.
- Set deadlines and goals: The self-care plan should set deadlines and goals connected to specific activities of self-care.
- Generate strategies that work and follow them: Such a plan must be attainable and followed with great commitment and monitored by advocates of your self-care.

Source: Green Cross Academy of Traumatology, 2010. Adapted with permission.

that acknowledges and normalizes secondary traumatization and by offering reasonable resources that make it possible for counselors to do their work and take care of themselves at the same time. Preventing secondary traumatization and lessening its impact on counselors once it occurs is not only cost-effective with regard to decreasing staff turnover and potential discontinuity of services to clients; it is also the ethical responsibility of a trauma-informed organization.

Appendices

Appendix A—Bibliography

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Substance Abuse and Mental Health Services Administration. (planned f). *Reintegration-related behavioral health issues in veterans and military families.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration.

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Appendix B—Trauma Resource List

Introduction

As it would be difficult to include every organization focused on trauma, the list of resources in this appendix is not exhaustive; consequently, this list does not include books or other materials concerning the vast nature of this topic, but rather, it concentrates solely on online resources accessible to the public for free or as part of an organization membership. The inclusion of selected resources does not necessarily signify endorsement by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). Following these resources for adults is a list of resources focused on children and adolescents and a list of training opportunities.

Technology and Trauma: Using the Web To Treat PTSD

The role of the Internet in helping those who are experiencing posttraumatic stress disorder (PTSD) has expanded rapidly; there are numerous Web sites with toolkits and research publications for clinicians who treat clients with PTSD, as well as Web sites aimed at providing information and support for these individuals. The U.S. military has contributed to the field in developing these avenues—specifically, with interactive Web applications for use on home computers and smartphones.

- PTSD Coach is a smartphone application from the U.S. Department of Veterans Affairs (VA) to help people experiencing PTSD learn about and manage their symptoms (http://www.ptsd.va.gov/public/pages/ptsdcoach.asp).
- Afterdeployment.org is a Web site developed by the Defense Centers of Excellence project led by the National Center for Telehealth & Technology, with interactive workshops about PTSD, traumatic brain injury (TBI), anxiety, and depression, aimed at returning veterans (http://www.afterdeployment.org).
- T2 Virtual PTSD Experience, also developed by the National Center for Telehealth & Technology, is an application to be used within the popular online game Second Life as an interactive way of simulating how PTSD can be acquired within a combat environment, how PTSD may present itself to the person experiencing it, and how to seek effective treatment (http://www.t2health.org/vwproj).

Resources for Adults

Academy of Cognitive Therapy

http://www.academyofct.org
260 South Broad Street
18th Floor
Philadelphia, PA 19102
Phone: 267-350-7683
Email: info@academyofct.org

The Academy of Cognitive Therapy, a nonprofit organization, supports continuing education and research in cognitive therapy, provides a valuable resource in cognitive therapy for professionals and the public at large,

and actively works toward the identification and certification of clinicians skilled in cognitive therapy. Certification is awarded to those individuals who, based on an objective evaluation, have demonstrated an advanced level of expertise in cognitive therapy. The Academy includes physicians, psychologists, social workers, and other mental health professionals from around the world. The Academy formed a Trauma Task Force after September 11, 2001, to disseminate information (available on their Web site) to help people around the world receive the best help possible following trauma.

Addiction Technology Transfer Center Network

http://www.attcnetwork.org/index.asp
5100 Rockhill Road
Kansas City, MO 64110
Phone: 816-235-6888
Email: networkoffice@attcnetwork.org

The Addiction Technology Transfer Center (ATTC) Network serves as a resource for students and professionals to identify international distance education opportunities for the substance abuse treatment field and as a free marketing venue for ATTC-approved sponsors of distance education courses. The ATTC Web site provides trauma-related resources that include case studies, information on working with returning veterans who have been exposed to trauma, and links to various publications on PTSD and secondary traumatic stress.

Agency for Healthcare Research and Quality

http://www.innovations.ahrq.gov/index.aspx
540 Gaither Road
Suite 2000
Rockville, MD 20850
Phone: 301-427-1104

The Agency for Healthcare Research and Quality (AHRQ) is the research arm of HHS, specializing in patient safety and quality improvement, outcomes and effectiveness of care, clinical practice and technology assessment, and healthcare organization and delivery systems. AHRQ also provides funding and technical assistance to health research and research training programs at many universities and institutions. AHRQ's Web site provides links to research publications on PTSD and to other government publications and toolkits dealing with trauma-informed care.

The American Academy of Experts in Traumatic Stress

http://www.aaets.org
203 Deer Road
Ronkonkoma, NY 11779
Phone: 631-543-2217
Email: info@aaets.org

The American Academy of Experts in Traumatic Stress is a multidisciplinary network of professionals who are committed to the advancement of intervention for survivors of trauma. The Academy aims to identify expertise among professionals and across disciplines and to provide meaningful standards for those who work regularly with survivors. The Academy is committed to fostering a greater appreciation of the effects of common traumatic experiences (e.g., chronic illness, accidents, domestic violence, loss) in addition to large-scale disasters and catastrophes. The group's aim is to help all victims to become survivors and, ultimately, to thrive.

American Red Cross Disaster Services

http://www.redcross.org/what-we-do/disaster-relief
American Red Cross National Headquarters
2025 E Street, NW

Washington, DC 20006
Phone: 202-303-4498

Red Cross disaster relief focuses on meeting people's immediate emergency disaster-caused needs. When a disaster threatens or strikes, the Red Cross provides shelter, food, and health and mental health services to address basic human needs. In addition to these services, the core of Red Cross disaster relief is the assistance given to individuals and families affected by disaster to enable them to resume their normal daily activities independently. Training opportunities are also provided.

Anxiety and Depression Association of America

http://www.adaa.org
8701 Georgia Avenue #412
Silver Spring, MD 20910
Phone: 240-485-1001

The Anxiety and Depression Association of America (ADAA) is the only national, nonprofit membership organization dedicated to informing the public, healthcare professionals, and legislators that anxiety disorders are real, serious, and treatable. ADAA promotes the early diagnosis, treatment, and cure of anxiety disorders and is committed to improving the lives of the people who have them. The ADAA Web site provides information about the symptoms of PTSD and how it can be treated, in addition to offering a PTSD self-screening tool.

Association for Behavioral and Cognitive Therapies

http://www.abct.org
305 7th Avenue
16th Floor
New York, NY 10001
Phone: 212-647-1890
Fax: 212-647-1865

The Association for Behavioral and Cognitive Therapies is a professional, interdisciplinary organization concerned with the application of behavioral and cognitive science to understanding human behavior, developing interventions to enhance the human condition, and promoting the appropriate use of these interventions. The association's Web site includes resources for the public and for professionals on trauma and disaster-related problems, a clinical referral directory, and other resources and training opportunities in behavioral therapy.

Association of Traumatic Stress Specialists

http://www.atss.info
88 Pompton Avenue
Verona, NJ 07044
Phone: 973-559-9200
Email: Admin@atss.info

The Association of Traumatic Stress Specialists is an international membership organization that offers three distinct board certifications to qualified individuals who provide services, intervention, response, and/or treatment in the field of traumatic stress. The Association is dedicated to improving the quality of life of all individuals throughout the world who have been affected by traumatic events. Membership represents those who serve survivors of natural disasters, terrorist attacks, injuries and deaths related to serving in the line of duty or to school and workplace violence; veterans; refugees; victims of crime; Holocaust survivors; those affected and exploited by political persecution; and others who have experienced traumatic stress injuries.

Center for Anxiety and Related Disorders

http://www.bu.edu/card
648 Beacon Street
6th Floor

Boston, MA 02215
Phone: 617-353-9610

The Center for Anxiety and Related Disorders (CARD) at Boston University is a clinical and research center dedicated to advancing knowledge and providing care for anxiety, mood, eating, sleep, and related disorders. CARD's Web site offers information regarding PTSD and research publications on trauma and anxiety, in addition to linking to toolkits from the National Child Traumatic Stress Network's Adolescent Traumatic Stress and Substance Abuse Program.

Center for the Study of Traumatic Stress

http://www.cstsonline.org
Uniformed Services University of the Health Sciences
Department of Psychiatry
4301 Jones Bridge Road
Bethesda, MD 20814-4799
Phone: 301-295-2470
Fax: 301-319-6965

The Center for the Study of Traumatic Stress (CSTS) is a federally funded organization established by the Military Health System in 1987 to address Department of Defense concerns regarding health risks and concerns resulting from the traumatic impact of the use of weapons of mass destruction in combat, acts of terrorism and hostage events, combat and peacekeeping operations, natural disasters, and assaults or accidents occurring in both uniformed and civilian communities. CSTS primarily serves members of the armed forces, along with their children and families.

Center for Culture, Trauma and Mental Health Disparities

http://www.semel.ucla.edu/cctmhd
UCLA Semel Institute of Neuroscience & Biobehavioral Sciences
760 Westwood Plaza
Los Angeles, CA 90024
Phone: 310-794-9929

The Collaborative Center for Trauma and Mental Health Disparities at the University of California Los Angeles is a multiethnic and multidisciplinary group that focuses on conducting research and providing training that pertains to trauma in minority populations.

Council of State Governments Justice Center—Mental Health

http://csgjusticecenter.org/jc/category/mental-health
100 Wall Street
20th Floor
New York, NY 10005
Phone: 212-482-2320
Fax: 212-482-2344
Email: consensusproject@csg.org

The Consensus Project is part of the Council of State Governments Justice Center and partners with other organizations, such as SAMHSA's GAINS Center, working to improve outcomes for people, including juveniles, with mental illnesses involved with the criminal justice system. The Consensus Project offers a webinar on trauma services in the criminal justice system and on child trauma and juvenile justice, as well as a local programs database.

Dart Center for Journalism and Trauma

http://www.dartcenter.org
Columbia University
Graduate School of Journalism
2950 Broadway
New York, NY 10027
Phone: 212-854-8056

The Dart Center is dedicated to improving media coverage of trauma, conflict, and

tragedy. The Center also addresses the consequences of such coverage for those working in journalism and provides training and education via seminars, newsroom briefings and consultation on trauma issues, in addition to training for journalism educators and other trainers. The Dart Center Web site offers fact sheets, publications, and DVDs on request for use by journalists, educators, and clinicians.

David Baldwin's Trauma Information Pages

http://www.trauma-pages.com
Phone: 541-686-2598
Email: dvb@trauma-pages.com

This Web site focuses primarily on emotional trauma and traumatic stress, including PTSD and dissociation, whether following individual traumatic experience(s) or a large-scale disaster. The site's purpose is to provide information for clinicians and researchers in the traumatic stress field. Specifically, the focus is on both clinical and research aspects of trauma responses and their resolution.

Disaster Technical Assistance Center

http://www.samhsa.gov/dtac
9300 Lee Highway
Fairfax, VA 22031
Phone: 800-308-3515
Fax: 703-225-2338

SAMHSA has created the Disaster Technical Assistance Center (DTAC) to help States prepare for and respond to a wide range of potential catastrophes—both natural and human-caused disasters. DTAC primarily serves individuals and communities who are recovering from natural and human-caused disasters. It works in conjunction with the Federal Emergency Management Agency (FEMA) and SAMHSA's Emergency Mental Health and Traumatic Stress Services Branch, using strengths-based, outreach-oriented principles conducted in nontraditional settings, as a supplement to programs already in place on a local level.

EMDR Institute, Inc.

http://www.emdr.com
P.O. Box 750
Watsonville, CA 9507
Phone: 831-761-1040
Fax: 831-761-1204
Email: inst@emdr.com

Eye Movement Desensitization and Reprocessing (EMDR) is an information-processing therapy that uses an eight-phase approach. (See the description in Part 1, Chapter 6.) The Web site presents background and descriptive information about this approach to treatment and lists training opportunities, references, and networking groups.

The Federal Emergency Management Agency

http://www.fema.gov
500 C Street SW
Washington, DC 20472
Phone: 202-646-2500

The Federal Emergency Management Agency, a formerly independent agency that became part of the Department of Homeland Security in March 2003, is tasked with responding to, planning for, recovering from, and mitigating against disasters. FEMA can trace its beginnings to the Congressional Act of 1803. This Act, generally considered the first piece of disaster legislation, provided assistance to a New Hampshire town following an extensive fire. In the century that followed, ad hoc legislation was passed more than 100 times in response to hurricanes, earthquakes, floods, and other natural disasters.

The International Critical Incident Stress Foundation, Inc.

http://www.icisf.org
3290 Pine Orchard Lane
Suite 106
Ellicott City, MD 21042
Phone: 410-750-9600
Fax: 410-750-9601
Email: info@icisf.org

The International Critical Incident Stress Foundation, Inc., is a nonprofit, open-membership foundation dedicated to the prevention and mitigation of disabling stress through the provision of education, training, and support services for all emergency services professions; continuing education and training in emergency mental health services for psychologists, psychiatrists, social workers, and licensed professional counselors; and consultation in the establishment of crisis and disaster response programs for varied organizations and communities worldwide.

International Society for the Study of Trauma and Dissociation

http://www.issd.org
8400 Westpark Drive
Second Floor
McLean, VA 22102
Phone: 703-610-9037
Fax: 703-610-0234
Email: info@isst-d.org

The Society is a nonprofit professional association organized for the purposes of information sharing and international networking of clinicians and researchers; providing professional and public education; promoting research and theory about dissociation; and promoting research and training in the identification, treatment, and prevention of dissociative disorders. The Society offers courses in its Dissociative Disorders Psychotherapy Training Program.

The International Society for Traumatic Stress Studies

http://www.istss.org
111 Deer Lake Road
Suite 100
Deerfield, IL 60015
Phone: 847-480-9028
Fax: 847-480-9282

The International Society for Traumatic Stress Studies (ISTSS) was founded in 1985 for professionals to share information about the effects of trauma. ISTSS is dedicated to the discovery and dissemination of knowledge about policy, program, and service initiatives that seek to reduce traumatic stressors and their immediate and long-term consequences. ISTSS provides a forum for the sharing of research, clinical strategies, public policy concerns, and theoretical formulations on trauma in the United States and around the world.

National Alliance on Mental Illness

http://www.nami.org
3803 N. Fairfax Dr.
Suite 100
Arlington, VA 22203
Phone: 703-524-7600
Fax: 703-524-9094

The National Alliance on Mental Illness (NAMI) is a nonprofit advocacy group founded in 1979 to raise awareness and provide essential and free education, advocacy, and support group programs for people living with mental illness and their loved ones. NAMI operates at the local, State, and national levels, with each level of the organizations providing education, information, support, and advocacy for those with mental illness and their support system. NAMI has developed a Trauma Toolkit and includes a series of lectures for mental health professionals about trauma.

National Association of State Alcohol and Drug Abuse Directors, Inc.

http://www.nasadad.org
1025 Connecticut Ave NW
Suite 605
Washington, DC 20036
Phone: 202-293-0090
Fax: 202-293-1250
Email: dcoffice@nasadad.org

The National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD) is a private, not-for-profit educational, scientific, and informational organization. NASADAD's basic purpose is to foster and support the development of effective alcohol and drug abuse prevention and treatment programs throughout every State. NASADAD offers a policy brief with regards to trauma and substance use/abuse in the wake of natural or human-made disasters.

National Association of State Mental Health Program Directors

http://www.nasmhpd.org
66 Canal Center Plaza
Suite 302
Alexandria, VA 22314
Phone: 703-739-9333
Fax: 703-548-9517

The National Association of State Mental Health Program Directors (NASMHPD; pronounced "NASH-pid") is a nonprofit organization dedicated to serving the needs of the Nation's public mental health system through policy development, information dissemination, and technical assistance. NASMHPD represents the $23 billion public mental health service delivery system. As a private, not-for-profit 501(c)(3) membership organization, NASMHPD helps set the agenda and determine the direction of State mental health agency interests across the country, historically including State mental health planning, service delivery, and evaluation. The principal programs operated, funded, and/or regulated by NASMHPD members serve people who have serious mental illnesses, developmental disabilities, and/or substance use disorders. NASMPHD has launched a Technical Assistance Coordinating Center in response to the Alternatives to Restraint and Seclusion State Infrastructure Grant Project, an initiative of SAMHSA's Center for Mental Health Services, designed to promote the implementation and evaluation of best practice approaches to preventing and reducing the use of seclusion and restraint in mental health settings.

National Center for Injury Prevention and Control

http://www.cdc.gov/injury
1600 Clifton Road
Atlanta, GA 30333
Phone: 800-232-4636
Email: cdcinfo@cdc.gov

The National Center for Injury Prevention and Control (NCIPC) was established by the Centers for Disease Control and Prevention in 1992. Through research, surveillance, implementation of evidence-based strategies, capacity building, and communication activities, NCIPC works to reduce morbidity, disability, mortality, and costs associated with injuries and violence. NCIPC is the lead U.S. Federal agency for nonoccupational injury prevention.

National Center for PTSD

http://www.ptsd.va.gov
810 Vermont Avenue NW
Washington, DC 20420
Phone: 802-296-6300
Email: ncptsd@va.gov

The National Center for PTSD (NCPTSD) was created within the Department of

Veterans Affairs in 1989 in response to a Congressional mandate to address the needs of veterans with military-related PTSD. Its mission is to advance the clinical care and social welfare of America's veterans through research, education, and training in the science, diagnosis, and treatment of PTSD and stress-related disorders. Its Web site is provided as an educational resource concerning PTSD and other enduring consequences of traumatic stress. The NCPTSD Web site has information about instruments to measure trauma exposure, risk and resilience factors for PTSD, self-report instruments, and interview schedules. Training opportunities are listed at http://www.ptsd.va.gov/about/training/training-programs.asp.

National Center for Telehealth and Technology

http://www.t2health.org
9933C West Hayes Street
Joint Base Lewis-McChord, WA 98431
Phone: 253-968-1914
Fax: 253-968-4192
Email: AskUs@t2health.org

The National Center for Telehealth and Technology is a Federal agency founded by the Department of Defense as part of the Military Health System. It primarily serves veterans and active-duty military personnel who are experiencing adverse health effects due to TBI and PTSD, as well as military children who are coping with their parents' deployment, through the use of technology (e.g., mobile phone applications, deployable telehealth centers).

National Center for Trauma-Informed Care

http://www.samhsa.gov/nctic
66 Canal Center Plaza
Suite 302
Alexandria, VA 22314
Phone: 866-254-4819
Fax: 703-548-9517
Email: NCTIC@NASMHPD.org

The National Center for Trauma-Informed Care (NCTIC) is a Federal center established by SAMHSA in 2005 to offer consultation, technical assistance, education, outreach, and resources to support trauma-informed care in publicly-funded systems and programs. NCTIC primarily serves those who are already receiving services from the behavioral health system and is focused on helping behavioral health services and programs to become more aware of the impact of trauma among consumers, to adapt services to incorporate trauma-informed practices, and to help raise awareness of practices or processes that are more likely to retraumatize consumers.

National Center for Victims of Crime

http://www.victimsofcrime.org
2000 M Street NW
Suite 480
Washington, DC 20036
Phone: 202-467-8700
Fax: 202-467-8701
Email: webmaster@ncvc.org

The National Center for Victims of Crime (NCVC) is a nonprofit organization funded partially by Federal grants from the Department of Justice. It was founded in 1985 and originally known as the Sunny Von Bulow National Victim Advocacy Center. NCVC is a resource center for those affected by violent crimes and also provides training and education for behavioral health service providers.

National Center on Domestic Violence, Trauma & Mental Health

http://www.nationalcenterdvtraumamh.org/
Phone: 312-726-7020
Fax: 312-726-7022

The National Center on Domestic Violence, Trauma & Mental Health was established in 2005 through a grant from the Family Violence Prevention and Services Program, HHS. The Center's mission is to promote accessible, culturally relevant, and trauma-informed responses to domestic violence and other lifetime trauma so that survivors and their children can access the resources that are essential to their safety and well-being; this is achieved by providing training and online resources to mental health and substance abuse treatment providers and developing policies to improve system responses to domestic violence survivors and their children.

National Center on Elder Abuse

http://www.ncea.aoa.gov
University of California–Irvine
Program in Geriatric Medicine
101 The City Drive South, 200 Building
Orange, CA 92868
Phone: 855-500-3537
Email: ncea-info@aoa.hhs.gov

The National Center on Elder Abuse (NCEA), part of the U.S. Administration on Aging, serves as a national resource center dedicated to the prevention of elder mistreatment. NCEA provides information to both mental health professionals and the general public and also provides technical assistance and training to States and community-based organizations.

National Center on Family Homelessness

http://www.familyhomelessness.org
200 Reservoir Street
Suite 200
Needham, MA 02494
Phone: 617-964-3834
Fax: 617-244-1758
Email: info@familyhomelessness.org

The National Center on Family Homelessness (NCFH) was founded in 1988 and is a nonprofit organization that conducts research and creates public awareness about the special needs of families experiencing homelessness. NCFH primarily serves veterans who are homeless and their families and young mothers who are homeless with their children. NCFH has developed a Trauma-Informed Organizational Toolkit for Homeless Services.

National Coalition Against Domestic Violence

http://www.ncadv.org
1 Broadway
Suite B210
Denver, CO 80203
Phone: 303-839-1852
Fax: 303-831-9251
Email: mainoffice@ncadv.org

The National Coalition Against Domestic Violence (NCADV) is an advocacy group founded in 1978 and acts as a national information and referral center for the general public, media, survivors of domestic violence and their children, and allied and member agencies and organizations. NCADV also works to influence legislation that would provide protection for survivors of domestic violence and their families and provide funding to shelters, healthcare centers, and other organizations.

National Council for Behavioral Health

http://www.thenationalcouncil.org
1701 K Street NW
Suite 400
Washington, DC 20006
Phone: 202-684-7457
Email: communications@thenationalcouncil.org

The National Council for Behavioral Health is a national community behavioral health

advocacy organization, formed in 1970, to conduct Federal advocacy activities, representing the industry on Capitol Hill and before Federal agencies. It also offers a national consulting service program, various publications, and an annual training conference. The National Council Magazine, 2011, Issue 2, focuses on trauma-informed behavioral health services. The National Council has offered a Learning Community for Adoption of Trauma-Informed Practices, funded by SAMHSA.

National Institute on Drug Abuse

http://drugabuse.gov
National Institute on Drug Abuse
National Institutes of Health
6001 Executive Boulevard
Room 5213, MSC 9561
Bethesda, MD 20892-9561
Phone: 301-443-1124
Email: information@nida.nih.gov

The National Institute on Drug Abuse's (NIDA) mission is to lead the Nation in bringing the power of science to bear on drug abuse and addiction. NIDA's goal is to ensure that science, not ideology or anecdote, forms the foundation for all of the Nation's drug abuse reduction efforts. NIDA was established in 1974, and in October 1992 it became part of the National Institutes of Health (NIH), HHS. The Institute is organized into divisions and offices, each of which plays an important role in programs of drug abuse research. NIDA has an ongoing research program on women's health and sex/gender differences, including the gathering of information on trauma and substance abuse.

National Institute of Mental Health

http://www.nimh.nih.gov
National Institute of Mental Health
Science Writing, Press, and Dissemination Branch
6001 Executive Boulevard
Room 8184, MSC 9663
Bethesda, MD 20892-9663
Phone: 301-443-4513
Fax: 301-443-4279
Email: nimhinfo@mail.nih.gov

The National Institute of Mental Health (NIMH) is one of the 27 component institutes of NIH, the Federal Government's principal biomedical and behavioral research agency that is part of HHS. NIMH's mission is to reduce the burden of mental illness and behavioral disorders through research on mind, brain, and behavior. This public health mandate demands that NIMH use science to achieve better understanding, treatment, and eventually, prevention of these disabling conditions that affect millions of Americans. NIMH offers publications and podcasts related to traumatic events and PTSD.

National Registry for Evidence-Based Programs and Practices

http://www.nrepp.samhsa.gov
Phone: 866-436-7377
Email: nrepp@samhsa.hhs.gov

SAMHSA's National Registry for Evidence-Based Programs and Practices (NREPP) is a searchable online registry of more than 300 interventions supporting mental health promotion, substance abuse prevention, and mental health and substance abuse treatment. NREPP offers several interventions that address trauma and PTSD.

National Sexual Violence Resource Center

http://www.nsvrc.org
123 North Enola Drive
Enola, PA 17025
Phone: 717-909-0710
Fax: 717-909-0714

The National Sexual Violence Resource Center (NSVRC) was founded by the Pennsylvania Coalition Against Rape in 2000 and is partially federally funded by grants from the Centers for Disease Control and Prevention. NSVRC advocates for changes in Federal and State legislation to further the goal of ending sexual violence in all communities, in addition to collecting and disseminating a wide range of resources on sexual violence, including statistics, research, position statements, statutes, training curricula, prevention initiatives and program information. NSVRC does not provide direct services to survivors of sexual violence but acts as a resource to support these services.

National Voluntary Organizations Active in Disasters

http://www.nvoad.org
1501 Lee Highway
Suite 170
Arlington, VA 22209-1109
Phone: 703-778-5088
Fax: 703-778-5091
Email: info@nvoad.org

National Voluntary Organizations Active in Disasters (NVOAD) coordinates planning efforts by many voluntary organizations responding to disaster. Member organizations provide more effective service and less duplication by getting together before disasters strike. Once disasters occur, NVOAD or an affiliated State VOAD encourages members and other voluntary agencies to convene on site. This cooperative effort has proven to be the most effective way for a wide variety of volunteers and organizations to work together in a crisis. NVOAD's principles are cooperation, coordination, communication, education, mitigation, convening mechanisms, and outreach.

Office for Victims of Crime Training and Technical Assistance Center

https://www.ovcttac.gov/
9300 Lee Highway
Fairfax, VA 22031-6050
Phone: 866-682-8822
TTY: 866-682-8880
Fax: 703-279-4673
Email: TTAC@ovcttac.org

The Office for Victims of Crime Training and Technical Assistance Center provides comprehensive, quality technical assistance and training resources to victims' service providers and allied professionals. Its mission is to support the development of the field by increasing the Nation's capacity to provide crime victims with skilled, capable, and sensitive assistance. Its core functions are needs assessment, capacity building, evaluation, and reporting.

Rape, Abuse & Incest National Network

http://www.rainn.org
1220 L Street NW
Suite 505
Washington, DC 20005
Phone: 202-544-1034
Email: info@rainn.org

The Rape, Abuse & Incest National Network (RAINN) is a nonprofit organization, founded in 1994, that is partially funded by a grant from the Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice. RAINN provides support for survivors of sexual assault via a telephone hotline and an online hotline and works with the Department of Defense (DoD) to provide a hotline for members of the DoD community who have experienced sexual assault.

SAMHSA's Tribal Training and Technical Assistance Center

http://beta.samhsa.gov/tribal-ttac
201 Corporate Drive
Suite 800
Landover, MD 20785
Phone: 240-650-0257
Email: TA-Request@tribaltechllc.com

SAMHSA's Tribal Training and Technical Assistance Center (Tribal TTAC) is committed to providing comprehensive broad, focused, and/or intensive training and technical assistance to federally recognized Tribes and other American Indian and Alaska Native communities seeking to address and prevent mental and substance use disorders and suicide while promoting mental health. The goal of the Tribal TTAC is to use a culturally relevant, evidence-based, holistic approach to support Native communities in their self-determination efforts through infrastructure development, capacity building, and program planning and implementation.

Sanctuary Model

http://www.sanctuaryweb.com
Phone: 888-538-3124

The goals of the Sanctuary Model include increasing the perceived sense of community/cohesiveness; the degree of social immunity to the spread of violence; the capacity for social learning; the making of decisions democratically and the sharing of responsibility in solving problems and resolving conflicts; the ability to deal with complexity; opportunities for all clients and staff members to experience a truly safe and connected community; opportunities for troubled clients to have corrective emotional, relational, and environmental experiences; and recovery, healing, and growth.

Seeking Safety

http://www.seekingsafety.org
Treatment Innovations
28 Westbourne Road
Newton Centre, MA 02459
Phone: 617-299-1610
Fax: 617-701-1295
Email: info@seekingsafety.org

This Web site provides information about Seeking Safety, a psychotherapeutic intervention for treating trauma, PTSD, and substance abuse. Seeking Safety is a present-focused therapy to help people attain safety from both PTSD and substance abuse. The treatment is also available as a book, which provides both client handouts and guidance for clinicians. The site includes topics included in the treatment program, sample materials, relevant empirical studies, and supplementary articles.

Sidran Institute

http://www.sidran.org
P.O. Box 436
Brooklandville, MD 21022-0436
Phone: 410-825-8888
Fax: 410-560-0134
Email: info@sidran.org

The Sidran Institute is a nationally focused nonprofit organization devoted to helping people who have experienced traumatic life events through education and advocacy. The Institute's education and advocacy focuses on:

- The early recognition and treatment of trauma-related stress in children.
- The understanding of trauma and its long-term effect on adults.
- The strategies in engaging in mutual-help recovery for trauma survivors.
- The clinical methods and practices leading in aiding trauma victims.
- The development of public policy initiatives responsive to the needs of adult and child survivors of traumatic events.

Substance Abuse and Mental Health Services Administration

http://www.samhsa.gov
1 Choke Cherry Lane
Rockville, MD 20857
Phone: 877-726-4727
Fax: 240-221-4292
Email: SAMHSAInfo@samhsa.hhs.gov

SAMHSA is the Federal agency within HHS charged with improving the quality and availability of prevention, treatment, and rehabilitative services to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illness. The Emergency Mental Health and Traumatic Stress Services Branch, a branch of SAMHSA's Center for Mental Health Services, works with FEMA to provide crisis counseling training and technical assistance to State and local mental health professionals. SAMHSA offers several publications regarding trauma and PTSD, as well as a publication focusing on creating a seclusion-free and restraint-free environment.

Traumatic Stress Institute

http://www.traumaticstressinstitute.org
Klingberg Family Centers
370 Linwood Street
New Britain, CT 06052
Phone: 860-224-9113

The Traumatic Stress Institute (TSI) works to increase understanding of the psychological impact of trauma and to help victims of violence restore meaning and wholeness to their lives. In meeting these goals, TSI is involved in clinical service, professional training, community education, and research. TSI offers forensic assessment and expert testimony, professional education, training opportunities, and publications. TSI developed the "Risking Connections" trauma treatment program and provides training in the use of this model.

Tulane University Traumatology Institute

http://sites.google.com/site/charlesfigley/Home/traumatologyinstitute
Tulane School of Social Work
6823 St. Charles Ave., Building 9
New Orleans, LA 70118
Phone: 800-631-8234
Email: figley@tulane.edu

The Traumatology Institute, founded in 1996, brings together health and mental health professionals from a wide array of disciplines from throughout the United States and around the world to develop cutting-edge research, treatment approaches, and training programs in the field of traumatology. The Institute facilitates the development of knowledge about the traumatization experience of victims, survivors, and the professionals who serve them. The Traumatology Institute conducts research, education, and service activities toward reducing the deleterious effects of trauma on individuals, families, communities, and entire societies.

Veterans Affairs PTSD Support Services

http://www.ptsdsupport.net/va.html
P.O. Box 5574
Woodland Park, CO 80866
Email: russ@ptsdsupport.net

The Department of Veterans Affairs Medical Centers provide a network of more than 100 specialized programs for veterans with PTSD, working closely in conjunction with the Veterans Web Site (http://www.vetcenter.va.gov) operated by VA's Readjustment Counseling Service. Each specialized PTSD program offers veterans education, evaluation, and treatment conducted by mental health professionals from a variety of disciplines (such as psychiatry, psychology, social work, counseling, and nursing). See also: National Center for PTSD.

White Bison Wellbriety Training Institute

http://www.whitebison.org
701 N. 20th Street
Colorado Springs, CO 80904
Phone: 877-871-1495
Email: info@whitebison.org

White Bison is an American Indian nonprofit charitable organization that focuses on offering sobriety, recovery, addictions prevention, and wellness/Wellbriety learning resources to the Native American community nationwide. White Bison's Wellbriety Training Institute provides training, tools, and resources for historical and intergenerational trauma to trainers and mental health professionals.

Resources for Children and Adolescents

The following section provides resources that address the needs of children and adolescents who are affected by traumatic stress.

American Academy of Child & Adolescent Psychiatry

http://www.aacap.org
3615 Wisconsin Avenue NW
Washington, DC 20016-3007
Phone: 202-966-7300
Fax: 202-966-2891

The American Academy of Child & Adolescent Psychiatry (AACAP) is a national professional medical association dedicated to treating and improving the quality of life for children, adolescents, and families affected by mental, behavioral, and developmental disorders. AACAP distributes information to promote an understanding of mental illnesses and remove the shame associated with them, to advance efforts in prevention of mental illnesses, and to ensure proper treatment and access to services for children and adolescents.

American Professional Society on the Abuse of Children

http://www.apsac.org
350 Poplar Avenue
Elmhurst, IL 60126
Phone: 630-941-1235
Fax: 630-359-4274
E-mail: apsac@apsac.org

The mission of the American Professional Society on the Abuse of Children (APSAC) is to enhance the ability of professionals to respond to children and families affected by abuse and violence. Among other initiatives, APSAC provides education and other sources of information to professionals who work in the child maltreatment and related fields.

Anna Institute

http://www.theannainstitute.org
21 Ocean Street
Rockland, ME 04841
Email: afj@gwi.net

The Anna Institute was founded in memory of artist Anna Caroline Jennings; it focuses on educating both the public and mental health professionals about the effects of sexual abuse and trauma on children. The Anna Institute's Web site provides articles on incorporating

trauma-informed care into existing behavioral health models, presentations on childhood trauma and retraumatization, and handouts for teachers at primary and secondary schools.

Caring for Every Child's Mental Health Campaign

http://www.samhsa.gov/children
P.O. Box 2345
Rockville, MD 20847-2345
Email: nmhic-info@samhsa.hhs.gov

SAMHSA's Caring for Every Child's Mental Health communications campaign is a national public information and education operation. Its goals are to increase public awareness about the importance of protecting the mental health of young people; foster the recognition that many children have mental health problems; and encourage caregivers to seek early, appropriate treatment and services. It also strives to reduce discrimination associated with mental health problems. The campaign is a technical assistance program that is part of the Comprehensive Community Mental Health Services Program for Children and Their Families.

Child Study Center

http://www.aboutourkids.org
One Park Avenue
7th Floor
New York, NY 10016
Phone: 212-263-6622
Email: webmaster@aboutourkids.org

The New York University Child Study Center Web site offers information to parents of children and adolescents with learning, behavioral, and emotional disorders, including PTSD and substance use disorders. An online newsletter is available. Its research initiatives advance understanding of the causes and treatments of child mental disorders, and these findings are integrated into clinical care to provide state-of-the-art service.

Child Trauma Academy

http://www.childtrauma.org
5161 San Felipe
Suite 320
Houston, TX 77056
Phone: 866-943-9779
Email: cta@childtrauma.org

The mission of the Child Trauma Academy is to help improve the lives of traumatized and maltreated children. Through education, service delivery, and program consultation, the academy seeks to advance systems that educate, nurture, protect, and enrich these children.

Child Trauma Institute

http://www.childtrauma.com
P.O. Box 544
Greenfield, MA 01302-0544
Phone: 413-774-2340
Email: cti@childtrauma.com

The Child Trauma Institute provides training, consultation, information, and resources for those who work with trauma-exposed children, adolescents, and adults. The Web site has information for parents, publications for parents and professionals, and links to other child trauma Web sites.

Child Welfare Information Gateway

http://www.childwelfare.gov
Children's Bureau/ACYF
1250 Maryland Avenue SW
Eighth Floor
Washington, DC 20024
Phone: 800-394-3366
Email: info@childwelfare.gov

The Child Welfare Information Gateway (CWIG) is a service of the Children's Bureau in the Administration for Children and Families, part of HHS, which provides information

to child welfare and mental health professionals about programs, research, laws and policies, training approaches, and statistics regarding child welfare, child abuse and neglect, and adoption. CWIG offers educators' toolkits for preventing and responding to child abuse and neglect, a function to search State statutes about child abuse and neglect, and logic model builder toolkits for program administrators.

Child Welfare League of America

http://www.cwla.org
1726 M Street NW
Suite 500
Washington DC, 20036
Phone: 202-688-4200
Fax: 202-833-1689

Through its member child welfare agencies, the Child Welfare League of America develops and disseminates practice standards as benchmarks for high-quality services that protect children and youth; promotes high-quality services through training, consultation, conferences, and publications; formulates and promotes public policies that contribute to the well-being of children and youth; ensures that all child welfare services are provided in a manner that demonstrates respect for cultural and ethnic diversity; and promotes open exchange of data, resources, and ideas within and across systems that serve children, youth, and families.

Eunice Kennedy Shriver National Institute of Child Health and Human Development

http://www.nichd.nih.gov/Pages/index.aspx
31 Center Drive
Building 31, Room 2A32
Bethesda, MD 20892-2425
Phone: 800-370-2943

Established in 1962, NIH's National Institute of Child Health and Human Development (NICHD) focuses on human development processes from conception to later years. The Institute implements, conducts, and supports laboratory research, clinical trials, epidemiological research, and other studies that explore health processes and the impact of disabilities, diseases, and variations on the lives of individuals. NICHD sponsors training for scientists and healthcare providers to promote the goals of the Institute.

National Center for Children Exposed to Violence

http://www.nccev.org
Yale Child Study Center
230 South Frontage Road
P.O. Box 207900
New Haven, CT 06520-7900
Phone: 877-496-2238
Email: colleen.vadala@yale.edu

The National Center for Children Exposed to Violence (NCCEV) seeks to increase the capacity of individuals and communities to reduce the incidence and impact of violence on children and families; to train and support the professionals who provide intervention and treatment; and to increase professional and public awareness of the effects of violence on children, families, communities, and society. The Center's Web site is a rich source of information. NCCEV is supported by grants from the Office of Juvenile Justice and Delinquency Prevention, the Department of Justice, SAMHSA, and the Department of Education.

National Center on Substance Abuse and Child Welfare

http://www.ncsacw.samhsa.gov
P.O. Box 2345
Rockville, MD 20847-2345
Phone: 866-493-2758
Email: ncsacw@cffutures.org

The National Center on Substance Abuse and Child Welfare (NCSACW) is an initiative of HHS and is jointly funded by SAMHSA's Center for Substance Abuse Treatment and the Administration on Children, Youth and Families, Children's Bureau's Office on Child Abuse and Neglect. NCSACW seeks to develop and implement a comprehensive program of information gathering and dissemination, to provide technical assistance, and to develop knowledge that promotes effective practical, organizational, and systemic changes at the local, State, and national levels. Its Web site includes PowerPoint presentations, online tutorials and training, technical assistance presentations, and additional print resources.

National Child Traumatic Stress Network

http://www.nctsnet.org
NCTSN—University of California, Los Angeles
11150 W. Olympic Boulevard
Suite 650
Los Angeles, CA 90064
Phone: 310-235-2633
Fax: 310-235-2612

The National Child Traumatic Stress Network (NCTSN), currently comprising 54 treatment centers nationwide, is funded by SAMHSA's Center for Mental Health Services through the Donald J. Cohen National Child Traumatic Stress Initiative and coordinated by Duke University and the University of California, Los Angeles. The purpose of this congressionally mandated initiative is to improve the quality, effectiveness, provision, and availability of therapeutic services delivered to all children and adolescents experiencing traumatic events. NCTSN works with SAMHSA to raise public awareness of the effects of traumatic stress on children and families, and with other systems of care (including the health, mental health, education, law enforcement, child welfare, juvenile justice, and military family service systems) to ensure that there is a comprehensive trauma-informed continuum of accessible care. Additionally, NCTSN offers a list of evidence-based and promising practices.

National Institute for Trauma and Loss in Children

http://www.starrtraining.org/trauma-and-children
42855 Garfield Road
Suite 111
Clinton Township, MI 48038
Phone: 877-306-5256
Fax: 586-263-4915
Email: TLC@starrtraining.org

The National Institute for Trauma and Loss in Children provides school professionals, crisis intervention teams, medical and mental health professionals, child care professionals, and clinicians with trauma education, training, consultation, referral services, and trauma-specific intervention programs and resource materials needed to help those traumatized by violent or nonviolent trauma-inducing incidents.

National Native Children's Trauma Center

http://iers.umt.edu/National_Native_Childrens_Trauma_Center
Institute for Educational Research and Service
McGill Hall 026
The University of Montana
Missoula, MT 59812-6376
Phone: 406-243-5344
Fax: 406-243-2197
Email: iers@mso.umt.edu

The National Native Children's Trauma Center (NNCTC) is a federally funded organization created by SAMHSA and affiliated with the National Child Traumatic Stress Network. It

is run by the University of Montana. NNCTC offers trauma interventions and trainings to address trauma in American Indian/Alaska Native children, primarily through clinicians, Tribal programs, school systems, and community agencies.

Training Opportunities

The following resources highlight various training and credentialing opportunities for behavioral health professionals interested in gaining more education in treating and providing services to those affected by trauma. It is not an exhaustive list, but provides a starting place for service providers looking for further training.

The Web site of the ISTSS has posted a directory of trauma-related academic and training opportunities (http://www.istss.org/LearningAboutTrauma.htm). It includes links to the institutions providing the programs. The Association for Traumatic Stress Specialists (http://www.atss.info) offers three levels of recognition for education and experience:

- Certified Trauma Specialist (CTS)—designed for counselors, clinicians, and treatment specialists who provide intervention services or individual, group, and/or family counseling. This certification requires 240 hours of education and training in trauma treatment, plus 2,000 hours of trauma counseling and intervention experience.
- Certified Trauma Responder (CTR)—designed for those who provide immediate trauma interventions. It requires a minimum of 40 hours of experience on a crisis or critical incident response team, an associate degree or a high school diploma with successful completion of disaster or critical incident stress debriefing training, and 72 hours of crisis response training.
- Certified Trauma Services Specialist (CTSS)—designed for those who provide immediate trauma intervention, crisis support, advocacy, or victim assistance. It requires 1 year of experience in a trauma-related field, plus specific training.

Some colleges and universities, such as the International Trauma Studies Program at New York University and the Center for Anxiety and Related Disorders at Boston University, provide specialty trauma training for mental health practitioners. The University of Missouri at St. Louis offers specialized training in trauma therapy or research at its Center for Trauma Recovery to students in its Clinical Psychology graduate program. The Center for the Treatment and Study of Anxiety at the University of Pennsylvania provides training for health professionals. The Department of Counseling at the University of Nevada, Las Vegas offers a graduate and undergraduate course on Trauma and Addiction; graduate students can receive training in trauma and addictions as part of the Advanced Graduate Certificate in Addiction Studies. The Medical University of South Carolina offers Web-based courses in trauma-focused cognitive–behavioral therapy (TF-CBT) and in using TF-CBT for childhood traumatic grief. Many universities have faculty members with expertise in trauma and trauma-related subjects, so that training can be accessed through many graduate programs.

The Addiction Technology Transfer Center (ATTC) Network, a resource established in 1993 by the SAMHSA's Center for Substance Abuse Treatment, is a network of 14 independent regional centers with a national office. One of its programs provides long-distance education for clinicians on various topics. Among hundreds of self-paced, self-directed, and supervised courses available online (http://www.attcnetwork.org/learn/education/

dasp.asp) are Substance Abuse Treatment for Trauma Survivors, Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues, Chemical Dependency and Posttraumatic Stress Disorder, Clinical Self-Care for Addiction Counselors and Clinical Supervisors, Eye Movement Desensitization and Reprocessing, Battered Women and Addictions, and Posttraumatic Stress Disorder. ATTC training and educational opportunities are based on empirical research and are intended to bring science to service. Undoubtedly, more distance-learning courses in this specialized area of interest will be developed as professional attention to co-occurring disorders increases.

SAMHSA's Center for Mental Health Services provides training for FEMA-approved crisis counseling programs using Stafford Act funding. These funding resources are available to select agencies designated to provide crisis counseling in the wake of a Presidential Disaster Declaration. Other funding for trauma training may be found through special programs of funding for target groups, such as those who provide mental health services and case management for victims of crime (e.g., Office for Victims of Crime in the U.S. Department of Justice; see p. 257).

The American Red Cross provides limited disaster mental health training. The focus of this training is to orient licensed mental health professionals to the Red Cross Disaster services system and their roles as volunteers.

The National Center for Post-Traumatic Stress Disorder was originally created in 1989 within the U.S. Department of Veterans Affairs (VA) to address the needs of veterans with military-connected PTSD. Its focus has since broadened to include trauma in general. The Center provides a variety of training opportunities for both VA and non-VA mental health personnel, including a PTSD 101 course developed specifically for clinicians who provide services to clients who have experienced trauma (see http://www.ptsd.va.gov/professional/index.asp).

Seeking Safety offers training in trauma, PTSD, and co-occurring disorders to mental health professionals on all levels, from counselors to nurses to administrators. The EMDR International Association (EMDRIA) provides training to clinicians for certification in EMDR via a curriculum including instruction, supervised practicum, and consultation; EMDRIA additionally provides basic training in the field, separate from the certification process. EMDR training is also provided by the EMDR Humanitarian Assistance Program, a nonprofit organization with a training-focused model to assist clinicians in treating trauma.

ISTSS was founded in 1985 to bring attention to the study, assessment, and treatment of traumatized people (http://www.istss.org). ISTSS is a professional society and provides face-to-face training during its annual meeting, especially through the preconference institutes. The ISTSS Web site offers numerous video and audio trainings for continuing education credits. ISTSS and the Figley Institute (http://www.figleyinstitute.com) have established best practice standards. The American Academy of Experts in Traumatic Stress provides training and certification in several different areas (http://www.aaets.org). Similarly, the International Society for the Study of Dissociation (http://www.issd.org) specializes in promoting therapies for dissociative disorders. In 2002, the Green Cross Academy of Traumatology (http://www.greencross.org) established a Commission on Accreditation of Traumatology Education Programs to increase and maintain the high standards in the education and training of traumatologists.

Appendix C—Historical Account of Trauma

Historically, symptoms of traumatic stress have been recorded in both military and civilian populations (Lasiuk & Hegadoren, 2006). Early accounts described the effect of battle conditions on soldiers; "soldier's heart" and "nostalgia" were the terms for traumatic stress reactions used during the American Civil War. As warfare techniques and strategies changed, so did the depiction of soldiers' traumatic stress reactions. The advent of heavy explosives in World War I led to the attribution of symptoms to "shell shock," giving a more physiological description of the effects from explosions (Benedek & Ursano, 2009). On the civilian side, the industrial revolution gave rise to larger and more dramatic catastrophes, including industrial and railway accidents. These, as well as other disasters, are noted in occupational health histories, newspapers, and contemporary literature.

Even with a more physical explanation of traumatic stress (i.e., shell shock), a prevailing attitude remained that the traumatic stress response was due to a character flaw. For instance, a soldier's pain at that time was often seen as a symptom of homesickness. In spite of the efforts of Charcot, Janet, and Freud, who described the psychogenic origin of symptoms as a response to psychological trauma (Lasiuk & Hegadoren, 2006), World War II military recruits were screened in attempt to identify those "who were afflicted with moral weakness," which would prevent them from entering military service.

At the same time, there were new treatment innovations for war-related trauma during World War II. One approach treated soldiers in the field for what was then called "battle fatigue" by allowing some time for rest before returning to battle. During the Korean and Vietnam wars, approaches began to focus more on the use of talk therapy. It was not until the post-Vietnam era that interest in developing treatment alternatives started to take hold. During this time, the U.S. Department of Veterans Affairs (then called the Veterans Administration) developed group therapy for posttraumatic stress disorder (PTSD). Beyond being cost-effective, the technique was well suited to the symptoms of the veterans and fostered socialization and reintegration (Greene et al., 2004).

The publication of the American Psychiatric Association's (APA's) *Diagnostic and Statistical Manual of Mental Disorders,* Third Edition (DSM-III), in 1980 marked the introduction of PTSD as a diagnosis, inspired by symptoms presented by veterans of the Vietnam War (Benedek & Ursano, 2009). The diagnosis in this iteration required the identification of a specific stressor—a catastrophic stressor that was outside the range of usual human experience (APA, 1980)—and classified PTSD as

Historical Approaches to Trauma Healing and Recovery

First Generation of Approaches to Trauma Healing and Recovery
The first generation approaches to trauma healing and recovery focused on individual and clinical interventions to address the symptoms of PTSD and moved toward integration of trauma effects into ongoing life activities. The rapidly developing recognition of additional groups with violence and trauma histories—beyond those with war and captivity experiences (e.g., survivors of natural disasters and terrorism, refugees and immigrants fleeing homeland violence and persecution)—presented issues and needs that incited a second generation of approaches to trauma healing and recovery.

Second Generation of Approaches to Trauma Healing and Recovery
The second generation approaches focused on psychosocial education and empowerment models designed to tap into self-healing forces to energize personal and social movement. These approaches often are based on group and peer support models, and provide both support and education on the management of trauma and its affects. These approaches are not designed to replace clinical or alternative therapies; rather, they provide a social context for care.

Concurrent to the development of psychosocial educational empowerment approaches, we also learned that if the approaches are not implemented in organizations or programs that are trauma-informed, they will not take root and may lose effectiveness.

Trauma-Informed Care: A New Paradigm for Public Health Services
Trauma-informed care is a new paradigm for organizing public mental health and human services. Trauma-informed care changes the opening question for those seeking services from "What is wrong with you?" (patient or consumer) to "What has happened to you?" (survivor). Trauma-informed care is initiated by assumption that every person seeking services is a trauma survivor who designs his or her own path to healing, facilitated by support and mentoring from the service provider.

In a trauma-informed environment, survivors are empowered to proactively set goals and to manage progress toward those goals. For most existing organizations or programs, that requires movement from a traditional "top down" hierarchical clinical model to a psychosocial empowerment partnership that embraces all possible tools and paths to healing. In a pluralistic public health system with many levels and types of services and treatment, this is coming to be accepted as a "sine qua non," or "without which not," for humane, dignified, cost-effective, genuinely person-centered support and assistance in moving forward.

Source: Salasin, 2011, p. 18.

an anxiety disorder (Lasiuk & Hegadoren, 2006). Beginning with this definition, the body of research grew, and the scope of application began to broaden, but not without considerable debate on what constituted a trauma.

The social revolution that began in the 1960s, combined with the women's movement and the call for more attention to diverse and disenfranchised groups, set the stage for an increase in the acknowledgement and treatment of victims of interpersonal violence and crime-related trauma (Figley, 2002). The introduction of rape trauma syndrome as a condition highlighted the psychological consequences of sexual assault and the subsequent lack of support from society and the social services system (Kramer & Green, 1997). Subsequently, research began to focus more on interpersonal violence, thus leading to the identification of risk factors and treatment approaches unique to this form of violence and trauma (Olff, Langeland, Drajer, & Gersons, 2007).

With input from international and national mental health organizations and research, the DSM-IV further modified the definition of trauma to include a broader interpretation of the identified stressor (Andreasen, 2010). DSM-5 has maintained the modified definition of trauma, but the criterion requires being explicit as to whether qualifying traumatic events were experienced directly, witnessed, or experienced indirectly (APA, 2013b).

Paralleling the change in DSM criteria, cognitive–behavioral therapy for traumatic stress was developed along with other skills-based approaches (Greene et al., 2004).

Researchers, such as Foa, Resick, D'Zurilla, and Michenbaum, added to the body of knowledge and gave clinicians a variety of tools; these approaches continue to develop and show efficacy even today. There was also renewed interest in the long- and short-term effects of childhood sexual abuse and domestic violence. Interest in documenting the effects of trauma expanded further, including traumatic brain injury, significant orthopedic injuries, and multiple traumas (Starr et al., 2004). So too, the consumer movement in health care began. Consumers insisted on patient rights, humane treatment, and involvement in the treatment process; as a result, the paternalistic approach to health care began to change. As consumers set the initial stage and Federal agencies (e.g., the Substance Abuse and Mental Health Services Administration and its centers) and national organizations promoted the need for trauma-informed policies and care, national studies began to demonstrate the prevalence of traumatic experiences. Research including the Adverse Childhood Experiences and the Women, Co-Occurring, and Violence studies clearly demonstrated the pervasive long-term impact of trauma, reinforcing the call for trauma-informed policies and care. (For more information on the development of trauma-informed care, see Harris and Fallot, 2001b, as well as Jennings, 2004.)

Appendix D—Screening and Assessment Instruments

This appendix provides a selected sample of available tools for screening and assessment of traumatic events and trauma-related symptoms. This is not an exhaustive list, nor does this list focus on screening instruments that capture a broader range of symptoms related to trauma (such as sleep hygiene and dissociation) or other features important in providing trauma-informed care (e.g., resilience level, coping skill style, resource availability). For more information on a broad range of available instruments, refer back to Part 1, Chapter 4. Many of the instruments listed below use criteria found in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR; APA, 2000), but with the release of the DSM-5 (APA, 2013a), instruments will evolve, and new versions will be available under the same contact information.

Screening and Assessment Measures

- Clinician Administered PTSD Scale (CAPS)
- Davidson Trauma Scale (DTS)
- Distressing Event Questionnaire (DEQ)
- Evaluation of Lifetime Stressors (ELS)
- Impacts of Event Scale Revised (IES-R)
- Mississippi Scale for Combat-Related PTSD (M-PTSD)
- Penn Inventory for Posttraumatic Stress Disorder
- Posttraumatic Diagnostic Scale (PDS)
- PTSD Symptom Scale-Interview (PSS-I)
- PTSD Symptom Scale: Self-Report Version (MPSS-SR)
- Screen for Posttraumatic Stress Symptoms (SPTSS)
- Structured Interview for PTSD (SI-PTSD)
- Trauma Assessment for Adults (TAA)
- Trauma Assessment for Adults (TAA)–Self Report
- Trauma History Questionnaire (THQ)
- Trauma Symptom Inventory (TSI)
- Traumatic Stress Schedule

Screening and Assessment Measures

Clinician Administered PTSD Scale (CAPS)

Domains:	Posttraumatic stress disorder (PTSD), acute stress disorder (ASD)
Timeframe:	CAPS-Sx: Lifetime and current (past week) CAPS-Dx: Current (past month)
Response format:	Other
Format of administration:	Structured
Number of items:	30
Completion time:	30–60 minutes
Qualifications to administer:	Administered by clinicians and clinical researchers who have a working knowledge of PTSD and by appropriately trained paraprofessionals
How to obtain scale:	Contact Danny G. Kaloupek, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Populations sampled: veterans, car accident survivors Reliability: alpha = .94, test-retest = .90–.98 Validity: sensitivity = .85, specificity = .95 (compared with Structured Clinical Interview for DSM Disorders [SCID]), r = .91 (with MS Scale for Combat-related PTSD) kappa = .77 against the SCID diagnosis; item-total correlations = .49–.82; internal consistency = .94
Author(s):	Dudley David Blake, Frank W. Weathers, Linda M. Nagy, Danny G. Kaloupe, Dennis S. Charney, and Terence M. Keane
Contact:	Danny G. Kaloupek, Ph.D. National Center for PTSD Boston VA Medical Center, 11B 150 South Huntington Avenue Boston, MA 02130
Relevant citations:	Blake, D. D. (1994). Rationale and development of the clinician-administered PTSD scales. *PTSD Research Quarterly, 5,* 1–2. Blake, D. D., Weathers, F. W., Nagy, L. M., Kaloupek, D. G., Gusman, F. D., Charney, D. S., & Keane, T. M. (1995). The development of a clinician-administered PTSD scale. *Journal of Traumatic Stress, 8*, 75–90.

Gray, M., Litz, B., Hsu, J., & Lombardo, T. (2004). Psychometric properties of the Life Events Checklist. *Assessment, 11*, 330–341.

Weathers, F. W., Keane, T. M., & Davidson, J. R. (2001). Clinician-Administered PTSD Scale: A review of the first ten years of research. *Depression and Anxiety, 13*, 132–156.

Davidson Trauma Scale (DTS)

Domains:	PTSD symptoms
Timeframe:	Current (past week)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	17
Completion time:	10–15 minutes
Qualifications to administer:	Bachelor's degree in psychology. Must have related field and course work in the use of assessment instruments or special training in the use of this instrument. Education/training requirements may be waived for those granted the right to administer tests at this level (B) in their jurisdiction.
How to obtain scale:	Contact Mental Health Systems, Inc.
Cost or public domain:	Cost: $15.00
Psychometrics:	Populations sampled: rape victims, veterans, hurricane victims, miscellaneous traumas Reliability: alpha = .99, test-retest = .86
Author(s):	Jonathan R.T. Davidson
Contact:	Mental Health Systems, Inc. 908 Niagara Falls Boulevard North Tonawanda, NY, 14120-2060 800-456-3003
Relevant citations:	Davidson, J. R. T., Book, S. W., Colket, J. T., Tupler, L. A., Roth, S., David, D., Hertzberg, M., Mellman, T., Beckham, J.C., Smith, R., Davison, R. M., Katz, R., & Feldman, M. (1997). Assessment of a new self-rating scale for posttraumatic stress disorder. *Psychological Medicine, 27,* 153–160. Davidson, J. R., Tharwani, H. M., & Connor, K. M. (2002). Davidson Trauma Scale (DTS): Normative scores in the general population and effect sizes in placebo-controlled SSRI trials. *Depression and Anxiety, 15*, 75–78.

Distressing Event Questionnaire (DEQ)

Domains:	Posttraumatic Stress Disorder (PTSD) for multiple events
Timeframe:	Lifetime
Response format:	Self-administered
Format of administration:	Structured
Number of items:	35
Completion time:	10–15 minutes
Qualifications to administer:	Contact Edward Kubany, Ph.D.
How to obtain scale:	Contact Edward Kubany, Ph.D.
Cost or public domain:	Contact Edward Kubany, Ph.D.
Psychometrics:	Population sampled: veterans, battered women Reliability: inter-item r = .93, test-retest = .95; validity: Pearson's r reliability coefficient = .83 (with Penn Inventory, Pearson's r reliability coefficient = .76 (with Beck Depression Inventory)
Author(s):	Edward Kubany, Mary Beth Leisen, Aaron S. Kaplan, Martin P. Kelly
Contact:	Edward Kubany, Ph.D. National Center for PTSD Pacific Islands Division Department of VA Suite 307 Honolulu, HI 96813 Kubany.Edward@honolulu.va.gov
Relevant citations:	Kubany, E. S., Leisen, M. B., Kaplan, A. S., & Kelly, M. P. (2000). Validation of a brief measure of posttraumatic stress disorder: The distressing event questionnaire (DEQ). *Psychological Assessment, 12*, 197–209.

Evaluation of Lifetime Stressors (ELS)

Domains:	Trauma history
Timeframe:	Lifetime
Response format:	Other
Format of administration:	Structured
Number of items:	56
Completion time:	10–20 minutes for screening, 1–3 hours for complete interview
Qualifications to administer:	Should be administered by trained clinicians only

How to obtain scale:	Contact Karen Krinsley, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Populations sampled: male veterans, female sexual abuse survivors Reliability: r = .4–1.0
Author(s):	Karen Krinsley, Frank W. Weathers, Elana Newman, Edward A. Walker, Danny G. Kaloupek, Rachel Kimerling
Relevant citations:	Corcoran, C. B., Green, B. L., Goodman, L. A., & Krinsley, K. E. (2000). Conceptual and methodological issues in trauma history assessment. In A. Y. Shalev, R. Yehuda, & A. C. McFarlane (Eds.), *International handbook of human response to trauma* (pp. 22–232). Dordrecht, Netherlands: Kluwer Academic Publishers. Krinsley, K. (1996). Psychometric review of the Evaluation of Lifetime Stressors (ELS) Questionnaire and Interview. In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation (*pp. 160–162). Lutherville, MD: Sidran Press.

Impact of Event Scale Revised (IES-R)

Domains:	PTSD for a single event
Timeframe:	Current (past week)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	22
Completion time:	5–10 minutes for screening
Qualifications to administer:	None
How to obtain scale:	http://consultgerirn.org/uploads/File/trythis/try_this_19.pdf
Cost or public domain:	Public domain
Psychometrics:	Populations sampled: earthquake survivors, emergency disaster workers, Vietnam veterans, violence and sexual assault victims Reliability: alpha = .79–.92, test-retest = .89–.94, Pearson's r reliability coefficient = .74–.87
Author(s):	Daniel Weiss and Charles R. Marmar
Relevant citations:	Sundin, E. C. & Horowitz, M. J. (2002). Impact of Event Scale: Psychometric properties. *British Journal of Psychiatry, 180,* 205–209. Weiss, D. S. & Marmar, C. R. (1996).The Impact of Event Scale-Revised. In J. Wilson & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 399–411). New York: Guilford Press. (Includes measure in its entirety.)

Mississippi Scale for Combat-Related PTSD (M-PTSD)

Domains:	PTSD for multiple events
Timeframe:	Contact National Center for PTSD at ncptsd@ncptsd.org
Response format:	Self-administered
Format of administration:	Structured
Number of items:	35
Completion time:	10–15 minutes
Qualifications to administer:	Contact National Center for PTSD at ncptsd@va.gov
How to obtain scale:	To order the scale contact the National Center for PTSD
Cost or public domain:	Free (ncptsd@va.gov)
Psychometrics:	Population sampled: veterans Reliability: inter-item r = .94, test-retest = .97 Validity: sensitivity = .93, specificity = .89
Author(s):	Terence M. Keane
Contact:	National Center for PTSD (116D) VA Medical Center 215 N. Main St. White River Junction, VT 05009 http://www.ptsd.va.gov/
Relevant citations:	Engdahl, B. & Eberly, R. (1994). Assessing PTSD among veterans exposed to war trauma 40–50 years ago. *NCP Clinical Quarterly, 4,* 13–14. Keane, T. M., Caddell, J. M., & Taylor, K. L. (1988). Mississippi Scale for Combat-Related Posttraumatic Stress Disorder: Three studies in reliability and validity. *Journal of Consulting and Clinical Psychology, 56,* 85–90.

Penn Inventory for Posttraumatic Stress Disorder

Domains:	PTSD for multiple events
Timeframe:	Current (past week)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	26
Completion time:	5–15 minutes

Qualifications to administer:	Contact Melvyn Hammarberg, Ph.D.
How to obtain scale:	Contact Melvyn Hammarberg, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Population sampled: veterans, oil-rig disaster survivors Reliability: alpha = .94, test-retest = .96
Author(s):	Melvyn Hammarberg
Contact:	Melvyn Hammarberg, Ph.D. Department of Anthropology University of Pennsylvania 325 University Museum 33rd and Spruce Street Philadelphia, PA 19104-6398
Relevant citations:	Hammarberg, M. (1996). Psychometric review of the Penn Interview for Post Traumatic Stress Disorder. In B. H, Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 231–235). Lutherville, MD: Sidran Press. (Includes measure in its entirety.) Steel, J. L., Dunlavy, A. C., Stillman, J., & Pape, H. C. (2011). Measuring depression and PTSD after trauma: Common scales and checklists. *Injury, 42,* 288–300.

Posttraumatic Diagnostic Scale (PDS)

Domains:	DSM-IV PTSD symptom clusters
Timeframe:	Current (past month)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	49
Completion time:	10–15 minutes
Qualifications to administer:	Bachelor's degree in psychology. Must have related field and course work in the use of assessment instruments or special training in the use of this instrument.
How to obtain scale:	Contact National Computer Systems (NCS)
Cost or public domain:	Cost: $15.00
Psychometrics:	Population sampled: accident/fire, disaster, assault, sexual assault, sexual abuse, major illness Reliability: alpha = .92, test-retest = .83 Validity: sensitivity = .89, specificity = .75

Author(s):	Edna B. Foa, Ph.D.
Contact:	National Computer Systems (NCS) 5605 Green Circle Drive Minnetonka, MN 55343
Relevant citations:	Foa, E. (1996). *Post-traumatic Diagnostic Scale manual.* Minneapolis, MN: National Computer Systems. Foa, E., Cashman, L., Jaycox, L., & Perry, K. (1997). The validation of a self-report measure of PTSD: The Post-traumatic Diagnostic Scale (PDS). *Psychological Assessment, 9*, 445–451. Steel, J. L., Dunlavy, A. C., Stillman, J., & Pape, H. C. (2011). Measuring depression and PTSD after trauma: Common scales and checklists. *Injury, 42,* 288–300.

PTSD Symptom Scale-Interview (PSS-I)

Domains:	PTSD single event
Timeframe:	Current (past 2 weeks)
Response format:	Other
Format of administration:	Structured
Number of items:	17
Completion time:	20 minutes
Qualifications to administer:	Can be administered by a master's level interviewer after a few hours of training.
How to obtain scale:	Contact Edna B. Foa, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Population sampled: female sexual assault victims, female assault victims Reliability: alpha = .85, test-retest = .80; validity: sensitivity = .88, specificity = .96 (compared with SCID); Pearson's r reliability coefficient = .48–.80 (with Impact of Events intrusion and avoidance, State portion of State-Trait Anxiety Inventory, and MPSS-SR)
Author(s):	Edna B. Foa and Gregory A. Leskin
Contact:	Edna B. Foa, Ph.D. Medical College of Pennsylvania Department of Psychiatry 3200 Henry Avenue Philadelphia, PA 19129-1137

Relevant citations:	Foa, E. B., Riggs, D. S., Dancu, C. V., & Rothbaum, B. O. (1993). Reliability and validity of a brief instrument for assessing post-traumatic stress disorder. *Journal of Traumatic Stress, 6*, 459–474. Foa, E. & Tolin, D. F. (2005). Comparison of the PTSD Symptom Scale-Interview Version and the clinician administered PTSD Scale. *Journal of Traumatic Stress, 13*, 181–191. Leskin, G. A. (1999). Screening for trauma and PTSD in a primary care clinic. *NC-PTSD Clinical Quarterly, 8*, 68–69.

PTSD Symptom Scale: Self-Report Version (MPSS-SR)

Domains:	PTSD for multiple or unknown events
Timeframe:	Current (past 2 weeks)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	17
Completion time:	10–15 minutes
Qualifications to administer:	Contact Sherry Falsetti, Ph.D.
How to obtain scale:	Contact Sherry Falsetti, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Reliability: alpha = .96–.97 Validity: sensitivity = .89, specificity = .65
Author(s):	Sherry Falsetti, Patricia A. Resick, Heidi S. Resnick, Dean G. Kilpatrick
Contact:	Sherry Falsetti, Ph.D. University of Illinois College of Medicine Department of Family and Community Medicine 1601 Parkview Avenue Rockford, IL 61107-1897
Relevant citations:	Bonin, M. F., Norton, G. R., Asmundson, G. J., Dicurzio, S., & Pidlubney, S. (2000). Drinking away the hurt: The nature and prevalence of PTSD in substance abuse patients attending a community-based treatment program. *Journal of Behavior Therapy and Experimental Psychiatry, 31*, 55–66. Coffey, S. F., Dansky, B. S., Falsetti, S. A., Saladin, M. E., & Brady, K. T. (1998). Screening for PTSD in a substance abuse sample:

Psychometric properties of a modified version of the PTSD Symptom Scale Self-Report. *Journal of Traumatic Stress, 11,* 393–399.

Falsetti, S. A., Resnick, H. S., Resick, P. A., & Kilpatrick, D. (1993). The Modified PTSD Symptom Scale: A brief self-report measure of post-traumatic stress disorder. *The Behavioral Therapist, 16*, 161–162.

Screen for Posttraumatic Stress Symptoms (SPTSS)

Domains:	PTSD for multiple or unknown events
Timeframe:	Current (past 2 weeks)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	17
Completion time:	5 minutes
Qualifications to administer:	Contact Eve Carlson, Ph.D.
How to obtain scale:	Contact Eve Carlson, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Population sampled: psychiatric inpatients Reliability: split half reliability = .91, test-retest = .82
Author(s):	Eve Carlson, Ph.D.
Contact:	Eve Carlson, Ph.D. National Center for PTSD (352-117-MP) Palo Alto Health Care System 795 Willow Road Menlo Park, CA 94025
Relevant citations:	Carlson, E. (2001). Psychometric study of a brief screen for PTSD: Assessing the impact of multiple traumatic events. *Assessment*, *8*, 431–441.

Structured Interview for PTSD (SI-PTSD)

Domains:	PTSD single event
Timeframe:	Current (past 4 weeks)
Response format:	Other
Format of administration:	Structured
Number of items:	17

Completion time:	20–30 minutes
Qualifications to administer:	Can be administered by mental health professionals or by paraprofessionals after some training.
How to obtain scale:	Contact Jonathan Davidson, M.D.
Cost or public domain:	Public domain
Psychometrics:	Population sampled: veterans Reliability: alpha = .94, test-retest = .71, intraclass r = .97 Validity: sensitivity = .96, specificity = .80 (compared with SCID), Pearson's r reliability coefficient = .61 (with IES), Pearson's r reliability coefficient = .51 (with Hamilton Anxiety Scale)
Author(s):	Jonathan Davidson
Contact:	Jonathan Davidson, M.D. Department of Psychiatry Box 3812 Duke University Medical Center Durham, NC 27710-3812
Relevant citations:	Davidson, J. R. T., Kudler, H. S., & Smith, R. D. (1990). Assessment and pharmacotherapy of posttraumatic stress disorder. In J. E. L. Giller (Ed.), *Biological assessment and treatment of post-traumatic stress disorder* (pp. 205–221). Washington, DC: American Psychiatric Press. (Includes measure in its entirety.) Steel, J. L., Dunlavy, A. C., Stillman, J., & Pape, H. C. (2011). Measuring depression and PTSD after trauma: Common scales and checklists. *Injury, 42,* 288–300.

Trauma Assessment for Adults (TAA)

Domains:	Trauma history
Timeframe:	Lifetime
Response format:	Other
Format of administration:	Structured
Number of items:	13
Completion time:	10–15 minutes
Qualifications to administer:	None specified
How to obtain scale:	Contact Heidi Resnick, Ph.D.
Cost or public domain:	Public domain

Psychometrics:	Populations sampled: adult mental health center clients; face validity established; feasible; validity established via archival records
Author(s):	Connie L. Best, John R. Freedy, Sherry A. Falsetti, Dean G. Kilpatrick, Heidi S. Resnick
Relevant citations:	Cusack, K. J., Frueh, B. C., & Brady, K. T. (2004). Trauma history screening in a community mental health center. *Psychiatric Services, 55,* 157–162. Resnick, H. S. (1996). Psychometric review of Trauma Assessment for Adults (TAA). In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 362–365). Lutherville, MD: Sidran Press.

Trauma Assessment for Adults (TAA)–Self Report

Domains:	Trauma history
Timeframe:	Lifetime
Response format:	Self-administered
Format of administration:	Structured
Number of items:	17
Completion time:	10–15 minutes
Qualifications to administer:	None specified
How to obtain scale:	Contact Heidi Resnick, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	None to date
Author(s):	Connie L. Best, John R. Freedy, Sherry A. Falsetti, Dean G. Kilpatrick, Heidi S. Resnick
Relevant citations:	Resnick, H. S., Falsetti, S. A., Kilpatrick, D. G., & Freedy, J. R. (1996). Assessment of rape and other civilian trauma-related posttraumatic stress disorder: Emphasis on assessment of potentially traumatic events. In T. W. Miller (Ed.), *Stressful life events* (pp. 231–266). Madison, WI: International Universities Press.

Trauma History Questionnaire (THQ)

Domains:	Trauma history
Timeframe:	Lifetime
Response format:	Self-administered
Format of administration:	Structured

Number of items:	24
Completion time:	5–15 minutes
Qualifications to administer:	Contact Bonnie L. Green, Ph.D.
How to obtain scale:	Contact Bonnie L. Green, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Populations sampled: psychiatric outpatients, college students, women with breast cancer Reliability: r = 0.7–0.9, intraclass = .76
Author(s):	Bonnie L. Green
Relevant citations:	Hooper, L., Stockton, P., Krupnick, J., & Green, B., (2011). Development, use, and psychometric properties of the Trauma History Questionnaire. *Journal of Loss and Trauma, 16*, 258–283. Muesser, K. T., Salyers, M. P., Rosenberg, S. D., Ford, J. D., Fox, L., & Carty, P. (2001). Psychometric evaluation of trauma and posttraumatic stress disorder assessments in persons with severe mental illness. *Psychological Assessment, 13*, 110–117. Norris, F. H. & Hamblen, J. L. (2004). Standardized self-report measures of civilian trauma and PTSD. In J. P. Wilson, T. M. Keane & T. Martin (Eds.), *Assessing psychological trauma and PTSD* (pp. 63–102). New York: Guilford Press.

Trauma Symptom Inventory (TSI)

Domains:	Trauma-related symptoms
Timeframe:	Current (last 6 months)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	100
Completion time:	20 minutes
Qualifications to administer:	Bachelor's degree in psychology. Must have related field and courses in the use of assessment instruments or special training in the use of this instrument.
How to obtain scale:	Contact Psychological Assessment Resources
Cost or public domain:	Cost: $15.00
Psychometrics:	Population sampled: general population Reliability: alpha = .84–.87

Author(s):	John Briere
Contact:	Psychological Assessment Resources Box 998 Odessa, FL 33556
Relevant citations:	Briere, J. (1996). Psychometric review of Trauma Symptom Inventory (TSI). In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 381–383). Lutherville, MD: Sidran Press. Briere, J. (1995). *Trauma Symptom Inventory professional manual.* Odessa, FL: Psychological Assessment Resources. Orsillo, S. M. (2001). Measures for acute stress disorder and post-traumatic stress disorder. In M. M. Antony & S. M. Orsillo (Eds.), *Practitioner's guide to empirically based measures of anxiety* (pp. 255–307). New York: KluwerAcademic/Plenum.

Traumatic Stress Schedule

Domains:	Trauma history
Timeframe:	Current (but author suggests any period)
Response format:	Other
Format of administration:	Semi-structured
Number of items:	10 (with 12 probes)
Completion time:	5–30 minutes
Qualifications to administer:	Can be administered by lay interviewer with training
How to obtain scale:	Contact Fran Norris, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Reliability: test-retest = .88, frequency of events equal to National Women's Study PTSD Module
Author(s):	Fran Norris
Relevant citations:	Norris, F. H. (1990). Screening for traumatic stress: A scale of use in the general population. *Journal of Applied Social Psychology*, *20*, 1704–1718. (Includes measure in its entirety.) Norris, F. H. & Hamblen, J. L. (2004). Standardized self-report measures of civilian trauma and PTSD. In J. P. Wilson, T. M. Keane & T. Martin (Eds.), *Assessing psychological trauma and PTSD* (pp. 63–102). New York: Guilford Press.

Appendix E—Consumer Materials

The following are samples of available consumer materials relating to trauma-informed care and traumatic stress. There is a plethora of consumer information available to meet the immediate and long-term needs of consumers of behavioral health services affected by trauma. In order to not waste effort creating new materials for your client's concerns, it is advisable to explore current science-informed resources. In most cases, consumer materials are already available and easily accessible for free.

AfterDeployment.org (2010). *Just the Facts: Resilience*. Available: http://afterdeployment.org/sites/default/files/pdfs/client-handouts/resilience-understanding.pdf

This Web site provides resources to address symptoms related to traumatic stress in addition to other postdeployment adjustment issues. This site provides information and handouts on resilience, triggers, and other trauma-related topics. It is appropriate for service members as well as civilians.

Blanch, A., Filson, B., & Penny, D. (2012). *Engaging Women in Trauma-Informed Peer Support: A Guidebook*. Available: http://www.nasmhpd.org/publications/engagingwomen.aspx

This draft technical assistance guide was created by the National Center for Trauma-Informed Care (NCTIC) and developed under contract with the National Association of State Mental Health Program Directors. This publication is designed to help make trauma-informed peer support available to women who are trauma survivors and who receive or have received behavioral health services. It is a resource for peers providing support in these or other settings who want to learn how to use trauma-informed principles in supporting women or in the peer support groups. It has been a resource used in the delivery of technical assistance through NCTIC.

Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., Steinberg, A., et al. (2006). Appendix E: Handouts. *Psychological First Aid: Field Operations Guide.* Available: http://www.ptsd.va.gov/professional/manuals/manual-pdf/pfa/PFA_Appx_E_handouts.pdf

Developed jointly with the National Child Traumatic Stress Network and the National Center for PTSD, this curriculum provides a science-informed approach to psychological first aid for response workers. The goals of this module are to assist survivors in the immediate aftermath of disaster and/or terrorism, reduce initial distress, and foster short- and long-term adaptive functioning. This link provides specific survivor-oriented material, such as strategies in seeking and giving support, education on common immediate reactions, and parental tips for children across developmental stages.

Center for Mental Health Services (2002). *Dealing with the Effects of Trauma-A Self-Help Guide.* Available: http://store.samhsa.gov/shin/content//SMA-3717/SMA-3717.pdf

This self-help guide gives practical information and tools to address and manage symptoms and other consequences of traumatic stress. It provides education on a variety of topics, including trauma-related symptoms, advice on the key ingredients of quality care, barriers to recovery, and practical strategies to enhance recovery and manage difficult emotions.

Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (2005). *Roadmap to Seclusion and Restraint Free Mental Health Services*. Available: http://store.samhsa.gov/product/Roadmap-to-Seclusion-and-Restraint-Free-Mental-Health-Services-CD-/SMA06-4055

This curriculum concerns the elimination of seclusion and restraint. It provides numerous handouts for consumers as well as staff. Several consumer handouts include common reactions to trauma, a trauma screening tool, and strategies to de-escalate agitation and distress.

Mead, S. (2008). *Intentional Peer Support: An Alternative Approach*. Sherry Mead Consulting. Available: http://www.intentionalpeersupport.org/apps/webstore/products/show/3408520

This interactive workbook is designed for individuals who are in peer support roles and those who use peer support services. It provides goals, tasks, competencies, and skills associated with peer support relationships and guidelines for first interviews.

Najavits, L. M. (2002). *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. New York: Guilford Press.

This evidence-based practice for individuals who have a history of trauma and a substance use disorder provides not only guidelines for clinicians but handouts for individuals. The consumer materials include information on PTSD and substance abuse and their interrelationship, key principles of the Seeking Safety program, coping skills to support safety, and grounding exercises. For additional information and resources, go to http://www.seekingsafety.org.

National Center for PTSD, U.S. Department of Veterans Affairs (2010). *Understanding PTSD*. Available: http://www.ptsd.va.gov/public/understanding_ptsd/booklet.pdf

This booklet provides consumer information on posttraumatic stress, common traumatic stress symptoms, effective treatments, and resources. The National Center for PTSD also provides additional professional and public resources specific to trauma for veterans and civilians.

Sidran Institute (2012). *Healing Self-Injury*. Available: http://healingselfinjury.org/about.html

This Web site provides numerous resources for consumers and professionals to understand self-inflicted violence. It offers publication links, archived newsletters, and a current blog focused on self-harm.

Appendix F—Organizational Assessment for Trauma-Informed Care

The following two resources are organizational assessments, which represent a key strategy in developing or re-evaluating trauma-informed services. The first assessment, presented by the University of South Florida, College of Behavioral and Community Sciences (2012), is designed for staff or key stakeholders. The second assessment comes from the *Trauma-Informed Organizational Toolkit for Homeless Services* (Guarino, Soares, Konnath, Clervil & Bassuk, 2009) and is a consumer version. There are several other assessment tools available, including Fallot and Harris's *Creating Cultures of Trauma-Informed Care (CCTIC): A Self Assessment and Planning Protocol* (2009).

Staff or Key Stakeholder Organizational Assessment Tool
University of South Florida, College of Behavioral and Community Sciences (2012). *Creating Trauma-Informed Care Environments: An Organizational Self-Assessment*. Available: http://www.cfbhn.org/assets/TIC/youthresidentialself%20assess%20Fillable%20FORM%20%282%29.pdf

Consumer Version: Organizational Assessment Tool
Guarino, K., Soares, P., Konnath, K., Clervil, R., & Bassuk, E. (2009). *Trauma-Informed Organizational Toolkit for Homeless Services*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, and the Daniels Fund, the National Child Traumatic Stress Network, and the W.K. Kellogg Foundation. See: pp. 82–93. Available: http://www.familyhomelessness.org/media/90.pdf

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Appendix J: Acknowledgments

Numerous people contributed to the development of this Treatment Improvement Protocol (TIP), including the TIP Consensus Panel (p. vii), the Knowledge Application Program (KAP) Expert Panel and Federal Government Participants (p. ix), SAMHSA Resource Panel (see Appendix G), TIP Field Reviewers (Appendix H), and the KAP Cultural Competency and Diversity Network participants (Appendix I).

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Index

P

Q

R

S

T

SAMHSA TIPs and Publications Based on TIPs

What Is a TIP?

Treatment Improvement Protocols (TIPs) are the products of a systematic and innovative process that brings together clinicians, researchers, program managers, policymakers, and other Federal and non-Federal experts to reach consensus on state-of-the-art treatment practices. TIPs are developed under the Substance Abuse and Mental Health Services Administration's Knowledge Application Program (KAP) to improve the treatment capabilities of the Nation's alcohol and drug abuse treatment service system.

What Is a Quick Guide?

A Quick Guide clearly and concisely presents the primary information from a TIP in a pocket-sized booklet. Each Quick Guide is divided into sections to help readers quickly locate relevant material. Some contain glossaries of terms or lists of resources. Page numbers from the original TIP are referenced so providers can refer back to the source document for more information.

What Are KAP Keys?

Also based on TIPs, KAP Keys are handy, durable tools. Keys may include assessment or screening instruments, checklists, and summaries of treatment phases. Printed on coated paper, each KAP Keys set is fastened together with a key ring and can be kept within a treatment provider's reach and consulted frequently. The Keys allow you, the busy clinician or program administrator, to locate information easily and to use this information to enhance treatment services.

Ordering Information

Publications may be ordered or downloaded for free at http://store.samhsa.gov. To order over the phone, please call 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

TIP 1 **State Methadone Treatment Guidelines**—*Replaced by TIP 43*

TIP 2 **Pregnant, Substance-Using Women**—*Replaced by TIP 51*

TIP 3 **Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents**—*Replaced by TIP 31*

TIP 4 **Guidelines for the Treatment of Alcohol- and Other Drug-Abusing Adolescents**—*Replaced by TIP 32*

TIP 5 **Improving Treatment for Drug-Exposed Infants**

TIP 6 **Screening for Infectious Diseases Among Substance Abusers**—*Archived*

TIP 7 **Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System**—*Replaced by TIP 44*

TIP 8 **Intensive Outpatient Treatment for Alcohol and Other Drug Abuse**—*Replaced by TIPs 46 and 47*

TIP 9 **Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse**—*Replaced by TIP 42*

TIP 10 **Assessment and Treatment of Cocaine-Abusing Methadone-Maintained Patients**—*Replaced by TIP 43*

TIP 11 **Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases**—*Replaced by TIP 53*

TIP 12 **Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System**—*Replaced by TIP 44*

TIP 13 **Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders**
Quick Guide for Clinicians
Quick Guide for Administrators
KAP Keys for Clinicians

TIP 14 **Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment**

TIP 15 **Treatment for HIV-Infected Alcohol and Other Drug Abusers**—*Replaced by TIP 37*

TIP 16 Alcohol and Other Drug Screening of Hospitalized Trauma Patients
Quick Guide for Clinicians
KAP Keys for Clinicians

TIP 17 Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System—*Replaced by TIP 44*

TIP 18 The Tuberculosis Epidemic: Legal and Ethical Issues for Alcohol and Other Drug Abuse Treatment Providers—*Archived*

TIP 19 Detoxification From Alcohol and Other Drugs—*Replaced by TIP 45*

TIP 20 Matching Treatment to Patient Needs in Opioid Substitution Therapy—*Replaced by TIP 43*

TIP 21 Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System
Quick Guide for Clinicians and Administrators

TIP 22 LAAM in the Treatment of Opiate Addiction—*Replaced by TIP 43*

TIP 23 Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing
Quick Guide for Administrators

TIP 24 A Guide to Substance Abuse Services for Primary Care Clinicians
Concise Desk Reference Guide
Quick Guide for Clinicians
KAP Keys for Clinicians

TIP 25 Substance Abuse Treatment and Domestic Violence
Linking Substance Abuse Treatment and Domestic Violence Services: A Guide for Treatment Providers
Linking Substance Abuse Treatment and Domestic Violence Services: A Guide for Administrators
Quick Guide for Clinicians
KAP Keys for Clinicians

TIP 26 Substance Abuse Among Older Adults
Substance Abuse Among Older Adults: A Guide for Treatment Providers
Substance Abuse Among Older Adults: A Guide for Social Service Providers
Substance Abuse Among Older Adults: Physician's Guide
Quick Guide for Clinicians
KAP Keys for Clinicians

TIP 27 Comprehensive Case Management for Substance Abuse Treatment
Case Management for Substance Abuse Treatment: A Guide for Treatment Providers
Case Management for Substance Abuse Treatment: A Guide for Administrators
Quick Guide for Clinicians
Quick Guide for Administrators

TIP 28 Naltrexone and Alcoholism Treatment—*Replaced by TIP 49*

TIP 29 Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities
Quick Guide for Clinicians
Quick Guide for Administrators
KAP Keys for Clinicians

TIP 30 Continuity of Offender Treatment for Substance Use Disorders From Institution to Community
Quick Guide for Clinicians
KAP Keys for Clinicians

TIP 31 Screening and Assessing Adolescents for Substance Use Disorders
See companion products for TIP 32.

TIP 32 Treatment of Adolescents With Substance Use Disorders
Quick Guide for Clinicians
KAP Keys for Clinicians

TIP 33 Treatment for Stimulant Use Disorders
Quick Guide for Clinicians
KAP Keys for Clinicians

TIP 34 Brief Interventions and Brief Therapies for Substance Abuse
Quick Guide for Clinicians
KAP Keys for Clinicians

TIP 35 Enhancing Motivation for Change in Substance Abuse Treatment
Quick Guide for Clinicians
KAP Keys for Clinicians

TIP 36 Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues
Quick Guide for Clinicians
KAP Keys for Clinicians
Helping Yourself Heal: A Recovering Woman's Guide to Coping With Childhood Abuse Issues
Also available in Spanish
Helping Yourself Heal: A Recovering Man's Guide to Coping With the Effects of Childhood Abuse
Also available in Spanish

TIP 37 Substance Abuse Treatment for Persons With HIV/AIDS
Quick Guide for Clinicians
KAP Keys for Clinicians
Drugs, Alcohol, and HIV/AIDS: A Consumer Guide
Also available in Spanish
Drugs, Alcohol, and HIV/AIDS: A Consumer Guide for African Americans

TIP 38 Integrating Substance Abuse Treatment and Vocational Services
Quick Guide for Clinicians
Quick Guide for Administrators
KAP Keys for Clinicians

TIP 39 Substance Abuse Treatment and Family Therapy
Quick Guide for Clinicians
Quick Guide for Administrators
Family Therapy Can Help: For People in Recovery From Mental Illness or Addiction

TIP 40 Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction
Quick Guide for Physicians
KAP Keys for Physicians

TIP 41 Substance Abuse Treatment: Group Therapy
Quick Guide for Clinicians

TIP 42 Substance Abuse Treatment for Persons With Co-Occurring Disorders
Quick Guide for Clinicians
Quick Guide for Administrators
KAP Keys for Clinicians

TIP 43 Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs
Quick Guide for Clinicians
KAP Keys for Clinicians

TIP 44 Substance Abuse Treatment for Adults in the Criminal Justice System
Quick Guide for Clinicians
KAP Keys for Clinicians

TIP 45 Detoxification and Substance Abuse Treatment
Quick Guide for Clinicians
Quick Guide for Administrators
KAP Keys for Clinicians

TIP 46 Substance Abuse: Administrative Issues in Outpatient Treatment
Quick Guide for Administrators

TIP 47 Substance Abuse: Clinical Issues in Outpatient Treatment
Quick Guide for Clinicians
KAP Keys for Clinicians

TIP 48 Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery

TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice
Quick Guide for Counselors
Quick Guide for Physicians
KAP Keys for Clinicians

TIP 50 Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment
Quick Guide for Clinicians
Quick Guide for Administrators

TIP 51 Substance Abuse Treatment: Addressing the Specific Needs of Women
Quick Guide for Clinicians
Quick Guide for Administrators

TIP 52 Clinical Supervision and Professional Development of the Substance Abuse Counselor
Quick Guide for Clinical Supervisors
Quick Guide for Administrators

TIP 53 Addressing Viral Hepatitis in People With Substance Use Disorders
Quick Guide for Clinicians and Administrators
KAP Keys for Clinicians

TIP 54 Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders
Quick Guide for Clinicians
KAP Keys for Clinicians
You Can Manage Your Chronic Pain To Live a Good Life: A Guide for People in Recovery From Mental Illness or Addiction

TIP55-R Behavioral Health Services for People Who Are Homeless

TIP 56 Addressing the Specific Behavioral Health Needs of Men

TIP 57 Trauma-Informed Care in Behavioral Health Services

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