A TREATMENT IMPROVEMENT PROTOCOL

Trauma-Informed Care in Behavioral Health Services

TIP 57

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

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Disclaimer

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

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What Is a TIP?

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

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

Foreword

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

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

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

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How This TIP Is Organized

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

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

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

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

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

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

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

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

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

Terminology

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Trauma-Informed Care: A Sociocultural Perspective

IN THIS CHAPTER

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

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

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

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

Scope of the TIP

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

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

Intended Audience

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

Before You Begin

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

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

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

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

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

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

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

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

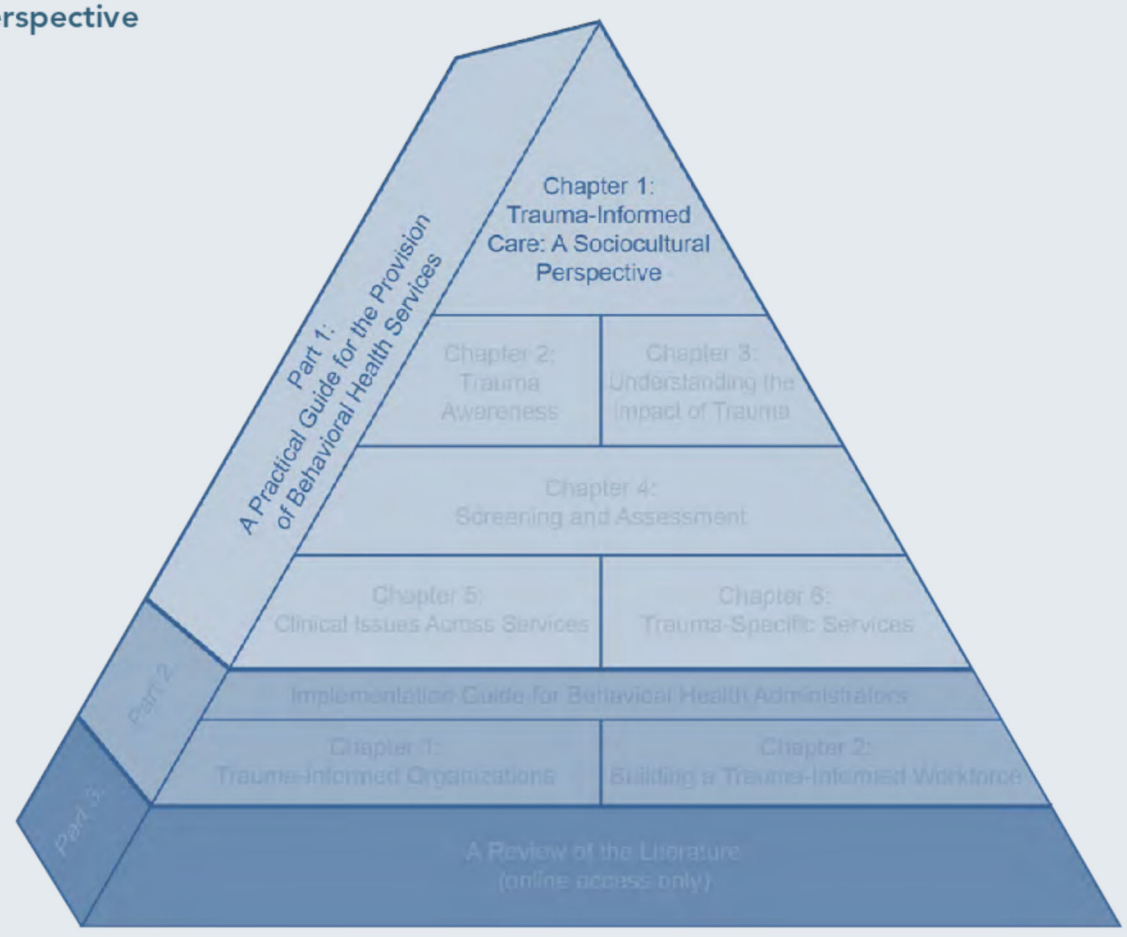
communities who have experienced trauma. The material presented in this TIP uses the wealth of their experience in addition to the available published resources and research relevant to this topic. Throughout the consensus process, the panel members were mindful of the strengths and resilience inherent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

Structure of the TIP

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

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

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



What Is Trauma?

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

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

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

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

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

Trauma Matters in Behavioral Health Services

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

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

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

Rationale for TIC

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

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

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

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

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

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

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

Advice to Counselors: The Importance of TIC

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

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

Trauma and Substance Use Disorders

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

Trauma and Mental Disorders

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

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

Trauma-Informed Intervention and Treatment Principles

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

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

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

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

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

Advice to Counselors: Implementing Trauma-Informed Services

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

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

Promote Trauma Awareness and Understanding

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

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

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

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

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

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

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

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

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

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

View Trauma in the Context of Individuals' Environments

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

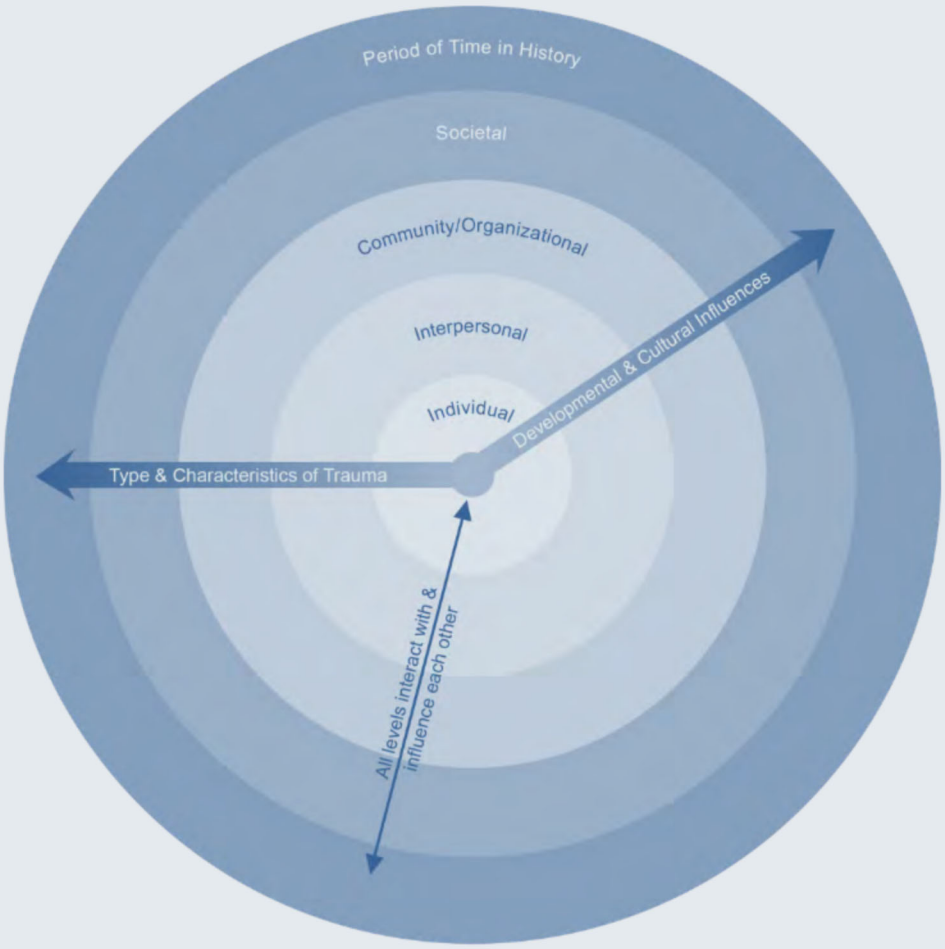
Trauma cannot be viewed narrowly; instead, it needs to be seen through a broader lens—a contextual lens integrating biopsychosocial, interpersonal, community, and societal (the degree of individualistic or collective cultural values) characteristics that are evident preceding and during the trauma, in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

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

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

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

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



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

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

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

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

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

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

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

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

Case Illustration: Marisol

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

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

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

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

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

strategies; and ways of providing hope and promoting recovery.

Minimize the Risk of Retraumatization or Replicating Prior Trauma Dynamics

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

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

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

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

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

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

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

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

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

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

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

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

Create a Safe Environment

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

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

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

Case Illustration: Mike

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

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

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

Identify Recovery From Trauma as a Primary Goal

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

Case Illustration: Jane

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

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

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

Support Control, Choice, and Autonomy

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

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

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

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

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

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

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

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

Case Illustration: Mina

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

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

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

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

Create Collaborative Relationships and Participation Opportunities

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

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

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

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

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

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

Familiarize the Client With Trauma-Informed Services

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

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

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

Incorporate Universal Routine Screenings for Trauma

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

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

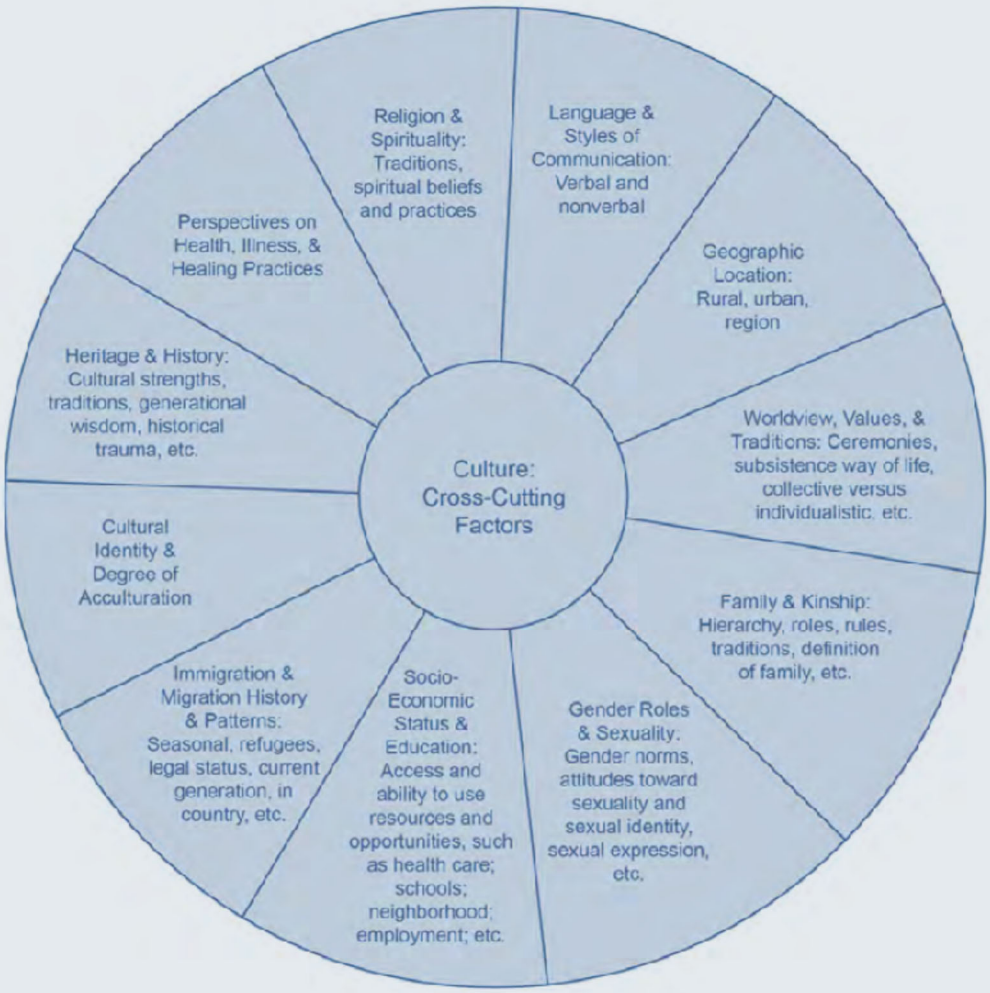
In addition, staff training on using trauma-related screening tools needs to center on how and when to gather relevant information after the screening is complete. Organizational policies and procedures should guide staff members on how to respond to a positive screening, such as by making a referral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

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

View Trauma Through a Sociocultural Lens

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

Exhibit 1.1-4: Cross-Cutting Factors of Culture



Culture and Trauma

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

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

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

Use a Strengths-Focused Perspective: Promote Resilience

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

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

Advice to Counselors and Administrators: Using Strengths-Oriented Questions

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

Potential strengths-oriented questions include:

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

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

Foster Trauma-Resistant Skills

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

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

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

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

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

Demonstrate Organizational and Administrative Commitment to TIC

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

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

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

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

Develop Strategies To Address Secondary Trauma and Promote Self-Care

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

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

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

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

Essential components of TIC include organizational and personal strategies to address

The Impact of Trauma

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

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

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

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

Provide Hope—Recovery Is Possible

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

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

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

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

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

As You Proceed

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

Appendix A—Bibliography

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